The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Frankwood E. Williams, M.D. (May 18,1883-September 25,1936)

To cite this article: (1936) Frankwood E. Williams, M.D. (May 18,1883-September 25,1936), The Psychoanalytic Quarterly, 5:4, 465-466, DOI: 10.1080/21674086.1936.11925295

To link to this article: https://doi.org/10.1080/21674086.1936.11925295

Published online: 11 Dec 2017.

IN MEMORIAM

Frankwood E. Williams, M.D.

(May 18, 1883 - September 25, 1936)

It is with deep sorrow that we record the death of Frankwood E. Williams, for several years—until poor health and the excessive burden of his responsibilities made resignation compulsory—one of the editors of the QUARTERLY, and one of its earliest and most enthusiastic sponsors. When the idea of a psychoanalytic periodical was proposed to him, his pioneering spirit responded instantly, and he gave the project his unqualified support and editorial experience.

Dr. Williams brought to us the same foresight and enthusiasm that characterized his endeavors in the field of mental hygiene and social psychiatry which constituted his earliest interest and career. His association with the Mental Hygiene movement began soon after the conclusion of his medical studies, being attracted to mental hygiene because it linked clinical psychiatry with the social problems in which he was even then interested. This association culminated in his outstanding directorship of The National Committee for Mental Hygiene for a decade and his editorship of its official publication, *Mental Hygiene*. The period of his directorship was notable for a marked extension of mental hygiene activities, signalized by the First International Congress on Mental Hygiene which Dr. Williams organized. Never quite content, however, with the methods and position of mental hygiene, and rather disillusioned with them in the closing years of his life, Dr. Williams was foremost in urging the application of psychoanalytic concepts to the theory and practice of mental hygiene, in encouraging its workers to familiarize themselves with freudian psychology and undergo analysis, and in inviting the coöperation of trained psychoanalysts. It is significant that the First International Congress devoted a substantial portion of its program to the findings of psychoanalysis, and that

Dr. Williams made every effort to induce Professor Freud to cross the ocean to attend the sessions.

Dr. Williams progressively came to regard social conditions as of paramount importance in the functioning of mental hygiene, thus becoming one of our contemporaries who prefer to consider the structure of society responsible, equally with inner individual forces, for the formation of normal and neurotic behavior. His courageous endeavors in this little explored field led him to Soviet Russia, and he correlated his first tentative studies there in numerous addresses, articles and books. He was returning from investigations in this milieu of a changing society, with possibly more crystallized views and more conclusive results in this field, when death overtook him.

In reviewing Frankwood E. Williams' achievements it is evident that his main contribution to clinical psychiatry and psychoanalysis, and one of inestimable value to both branches, was his success in extending their application, in wielding a wide personal influence over social workers and educators, and in vigorously insisting upon the still unsettled problem of social influence in mental hygiene. Dr. Williams thus became an outstanding leader. The psychoanalytic movement that recently lost in Europe an older leader of similar inclinations now sustains a new loss in Dr. Williams' death.

Frankwood E. Williams will be missed for his broad, courageous mind, his sympathetic understanding, his never-failing readiness to assist fellow-workers, and last but not least for his great personal charm. A serious lover of music and the arts, he was altogether an exceptional personality.

THE EDITORS

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

A Miniature Psychotic Storm Produced by a Superego Conflict Over Simple Posthypnotic Suggestion

Richard M. Brickner & Lawrence S. Kubie

To cite this article: Richard M. Brickner & Lawrence S. Kubie (1936) A Miniature Psychotic Storm Produced by a Superego Conflict Over Simple Posthypnotic Suggestion, The Psychoanalytic Quarterly, 5:4, 467-487, DOI: 10.1080/21674086.1936.11925296

To link to this article: https://doi.org/10.1080/21674086.1936.11925296

A MINIATURE PSYCHOTIC STORM PRODUCED BY A SUPEREGO CONFLICT OVER SIMPLE POSTHYPNOTIC SUGGESTION

BY RICHARD M. BRICKNER *and* LAWRENCE S. KUBIE (NEW YORK)

It has long been realized that the phenomena of hypnotism have a special relationship to those of mental illness. With the work of Bernheim at Nancy, and of Charcot and his many students, this relationship became a little clearer, in that an analogy was recognized between the physical disturbances which could be produced by direct hypnotic suggestion and those of the conversion hysterias.[1] Freud has described the influence which his observation of this work had upon his own development; and perhaps the first direct reference to hypnotism from a psychoanalytic point of view is Freud's comment in The Three Contributions to the Theory of Sexuality (*3a*) that the influence of the hypnotist probably depends upon an unconscious masochistic libidinal tie between the subject and the hypnotist.

Since then there have been several important discussions of hypnotism in the psychoanalytic literature: Ferenczi (*2*), Freud (*3e*), Jones (*5*), Sadger (*8*), Rado (*7*), Schilder (*9*). These have dealt largely, however, with the nature of the unconscious relationship between the hypnotist and the subject, i.e., the unconscious fantasies which enter into the two rôles, and the identifications which make possible the whole phenomena. Because the present contribution is not concerned with this problem, and has nothing to add to these earlier and well-known formulations, there is no need to summarize them here.

Read before the N. Y. Psychoanalytic Society, May 19, 1936; and the American Neurological Society in Atlantic City, June 3, 1936. The observations reported here were made by R. M. B.; the theoretical deductions by L. S. K.

[1] Although it is not strictly relevant to the subject of this paper, it may be well to mention here that this analogy is only superficial,—a point which has also been alluded to by Schilder in his monograph (*9*).

Instead, our emphasis will be upon the fate of the impulses which are implanted in the subject in the phenomenon of post-hypnotic suggestion. Both Ferenczi and Jones allude to this question in their studies but do not investigate it; and in psychoanalytic literature the only other reference to it is found in a parenthetical remark of Freud's in the report of the analysis of little Hans (*3b*). Here, in a few words about something which he calls "subsequent obedience", Freud remarks that the effects of orders and threats in childhood may be observed in patients after intervals of many years.

Ferenczi and Jones both pointed out that this was essentially identical with the phenomenon of posthypnotic suggestion, a point which Freud himself had not mentioned; but up to the present no further consideration seems to have been given to the far-reaching implications of this identity.

It is probable that psychoanalysts have neglected this significant problem because their studies of the unconscious fantasies which seem to enter into all hypnotic situations aroused justified misgivings. The vista of unconscious aggressive or submissive tendencies and of the play of intense if disguised psychosexual impulses, the self-limited therapeutic results, as well as the exploitation of the subject by charlatans and vaudeville performers, have all influenced psychoanalysts to avoid the whole topic. It is fortunate, therefore, that in recent years three important investigations of this very problem have come from nonanalytic sources.

The three investigations referred to are those of Luria (*6*), of Huston, Shakow, and Erickson (*4*), and of Erickson (*1*). All three are concerned with the production of psychoneurotic and emotional disturbances of far greater complexity than were the simple physical manifestations, the so-called "hysteroid phenomena", of the Charcot-Bernheim period, or of Forel, Vogt, etc. These recent investigations show that although Koch's postulates cannot be realized directly and fully in the study of the etiology of mental disease, nevertheless an approach to a fundamental test of causal factors can be made through the application of hypnosis. In principle they demonstrated

that through hypnotism it is possible to implant alien impulses into some aspect of the psychic apparatus of normal human beings, impulses which thereupon may operate temporarily as though they were inescapable instinctual drives. These drives, thus experimentally induced, may be grossly incompatible with the subject's personality as a whole, or with each other, and according to the degree and nature of the incompatibility may give rise to significant internal conflicts which may in turn produce severe neurotic and emotional symptoms. An example of such a state is described in the work of Luria (*6*).

This Russian worker, using deep hypnosis, succeeded in suggesting to a number of subjects a series of extremely disagreeable experiences. To a young physician he suggested that she had performed an illegal abortion, in the course of which complications had arisen which threatened the patient's life. To other subjects the suggestion was given that they had, under the pressure of great need, stolen money from friends. A third suggestion was of a sudden rage and the severe beating and injury of a child. The seances were followed by spontaneous or suggested amnesia for the hypnotic experience. Luria studied the influence of these highly affective but "forgotten" experiences on the subjects' general emotional status, on their reactions in word-association tests, on the free flow of spontaneous word chains, and especially on the discharge of motor impulses. He came to certain conclusions which are of interest to psychoanalysts; because by this entirely independent technique they confirm basic psychoanalytic findings:

1. Even "forgotten" affective experiences leave effective and demonstrable traces in the psychic apparatus.

2. Repression is an active process, involving the isolation of the repressed data from any form of motor expression to a degree which runs *pari passu* with its isolation from consciousness. Luria thus demonstrates the close association of the consciousness-process with motor organization.

3. These experiments give experimental proof of the existence of a process of unconscious mentation. The hypnotically

induced unconscious conflict could be explored and revealed by the classical psychoanalytic technique of free association. In the subject's free associations, the disturbing problem, of which the investigator was aware but of which the subject was totally unconscious, was unwittingly reconstructed by the subject.

4. The process of repression was shown to be a protection against intolerable affective states. With the removal of the repression, these affective states were expressed as "emotional fits".

5. For unknown reasons, which Luria did not investigate, some subjects accepted the suggested traumatic experience and incorporated it into their psychic apparatus, whereas other subjects rejected it and apparently never incorporated it. These latter subjects were completely free from the emotional disturbances from which the first group suffered. Unfortunately the author's work did not include a study of the basis for these extremely important differences among his subjects.

Such basic facts are, of course, matters of daily observation in psychoanalysis; but in science it is always useful to check the conclusions reached through one technic by other methods.

Not long after the publication of the American translation of Luria's work, it was subjected to a critical and well controlled investigation by Huston, Shakow, and Erickson (*4*). These workers tested the validity of Luria's technic, subjecting the volunteers for their experiments to far less sadistic emotional strains. Thus, for instance, under hypnosis a young man was told that, with his cigarette, he had burned a hole in the new dress of a young lady whom he had taken to a dance, and that he had allowed her to go home thinking that she had burned the dress herself. What unconscious significance this particular story might have had for this young man was not investigated until later. On the other hand, during the period of posthypnotic amnesia his reactions to this repressed fantasy were observed carefully. For some time he reacted to the anxiety and guilt generated by the hypnotically induced and unconscious fantasy by pursuing a compulsive ritual of giving

cigarettes away. In turn he rationalized this behavior by explaining to his friends that he was giving up smoking because he had decided that it was bad for his health. Thus a minute compulsion neurosis was produced, whose symptoms expressed the dual purpose of avoiding the risk of repeating his slip and also of doing penance for his sin.

These studies were carried still further by Erickson (*1*), who had the good fortune to have as a voluntary subject for his experiments a man who suffered from ejaculatio præcox. In this subject Erickson produced by hypnosis a secondary neurosis, which in its conscious content symbolized and paralleled the indigenous psychosexual difficulty. The subject of the experiment did not know that the experiment concealed any therapeutic purpose, but thought that he was merely being used as a volunteer in an experiment in hypnotism,—a rôle which he had assumed on several previous occasions. Under deep hypnosis the young man was told the following story: that he had gone to call upon an older professor for academic advice and counsel, but that in the professor's absence he had been greeted by the latter's wife, who, in turn, after a kindly chat, had left him to the care of their shy and beautiful young daughter. After some hesitation the young man smoked, and presently placed a burning cigarette in a painted glass ash-tray which the young girl had made for her father. To the young man's confusion and dismay the ash-tray suddenly cracked, and after profuse apologies he left without seeing the older man for whom he had been waiting. He continued to feel strangely guilty over the mishap despite the young lady's assurances that she really did not mind his breaking her ash-tray.

During the succeeding hour or so of posthypnotic amnesia, the young man was under continual observation. His spontaneous conversation reverted constantly to bric-a-brac, valuable painted vases, broken glassware, and irreplaceable and fragile art treasures. Furthermore his stream of speech was insistently disturbed by stammering, blocking, repetitions of recurrent ideas, awkward and sudden shifts in emphasis, etc. At the same time his behavior showed certain phobic and

obsessive precautions. He could not bring himself to use a nearby ash-tray, but flicked the ashes from his cigarette into the cuff of his trousers, and manifested great uneasiness about cigarette butts and burnt matches, repeatedly looking to make sure that they were out, etc.

After some time, the patient was re-hypnotized and told to reconstruct the entire story upon awakening. He did so, but at first thought it had been an actual experience. Only at the conclusion of his story, with sudden bewilderment, amazement, and relief, he declared, "Why that was just a suggestion you gave me in a hypnotic trance, too!" Then, retrospectively, he was able to describe the content of his experience, his state of wretched misery, depression, and anxiety, and the discrepancy (which he characterized as "silly and foolish") between his emotional state and the pleasant surroundings in which he found himself. Furthermore he now recognized consciously the analogy between the story and his own psychosexual difficulties.

Three days later the patient came to the laboratory to announce his first act of successful sexual intercourse. The ability to repeat this experience persisted at least for some time. A partial relapse occurred some months later, but he found that he could recover potency by calling to mind the story of the experiment.

This observation is of extraordinary interest from many points of view; but most relevant to our own observation (R. M. B.) is the intensity of feeling which gathered around a trivial accident because of the peculiarly symbolic value of that accident in terms of the patient's indigenous conflicts. It is only by taking into account the relationship between the trivial act and its unconscious significance in terms of the patient's underlying problems that the extraordinary dynamic and emotional power of the episode becomes clear.

Protocol:

The experiment was not planned. Twelve medical students had come to the home of one of the authors (R. M. B.) for an

informal evening. In the course of a discussion of hypnotism, several of the students requested that hypnotism be attempted with one of them. Reluctant to accede to this desire, the host turned the conversation into other channels, but the request was insistently repeated. Eventually one of the students, who had not been one of those who originally requested the procedure, volunteered and was selected.

The subject was a male, twenty-two years of age. He was a newcomer to the group and relatively a stranger. He was a quiet, unobtrusive person, pleasant in manner, but not quite at ease at the beginning of the evening. Later it was learned that he was highly intelligent, alert, hardworking, perhaps over-conscientious, neat, rather passive, and notably dutiful in his relationship to both of his parents. He suffered from no overt neurotic symptoms. He had had no trouble in making his way in medical school, nor in his career in general.

The hypnosis:

The session took place in the living room, adjoining the dining room. The entire procedure was conducted in the presence of the eleven other students. The stages were as follows:

1. The subject was placed in a stiff, high-backed chair. He was instructed to allow his head to rest as far backward as possible over the back of the chair and to fix his gaze upon a lamp behind him (the only illumination in the room at the time). He obeyed the command. For a period of two or three minutes the subject was told that his eyes and neck were strained, that the pain and discomfort were great and that he could escape these difficulties through sleep. He was told that his eyelids were growing increasingly heavy, that the impulse to sleep was overpowering him, and that it was difficult for him to resist closing his eyes. He was ordered to hold his eyelids open until permission was given to close them, at which time, he was told, he would fall asleep. The subject's eyes became reddened and moist, and it was obvious that he would actually experience great relief when permitted to shut them. Never-

theless, when permission was given he refused to allow his eyelids to close. *This was his first overt manifestation of resistance.* It was necessary to order the subject, imperatively, to close his eyes. Thereupon he obeyed the command and appeared to go to sleep. This entire stage occupied approximately five minutes.

2. The subject was told that the depth of sleep would increase as the hypnotist counted. (Throughout the session, each time the depth of the sleep was increased the subject was told that after he awoke he would remember nothing of what had occurred during the hypnosis.)

3. After about one minute of counting, the subject, who was sitting in a strained position, was told to open his eyes, walk to a nearby sofa, lie down on his back in a comfortable position and close his eyes again without awakening. The order was obeyed.

4. The depth of sleep was increased still further by direct suggestion and counting.

5. The first suggestion of a posthypnotic act was given. The subject was told that ten minutes after awakening he should go into the adjoining dining room where he would find two empty drinking glasses on the table,—one inverted and one upright, and that he should invert the upright one. The order was repeated, for the sake of emphasis.

6. Sleep was deepened still further by the procedures which have been mentioned.

7. The telephone in the adjoining hall rang, audibly to everyone in the room. The hypnotist answered the telephone in a clearly audible voice and returned in approximately half a minute.

8. The depth of sleep was still further deepened.

9. The second posthypnotic suggestion was given. The subject was ordered to make a tight fist with his right hand. This he promptly did. Then he was told that he would be unable to open his hand until he heard the number *one-and-one-half.* The order was repeated for the sake of emphasis.

10. The depth of sleep was still further deepened.
11. The subject was awakened.

Posthypnotic Behavior:

The subject sat up on the sofa and, after a moment of slight confusion during the process of awakening, appeared to be in his usual quiet, pleasant and coöperative mood. His right fist remained closed. When asked whether he was able to open it, he stated that he was sure he could. It was suggested that he make the attempt, but he declined to do so, declaring that "it is more comfortable this way". Within one to two minutes after the awakening, one of the students repeated a series of numbers; and at the mention of the number *one-and-one-half* the subject opened his fist.

Two or three days later the subject wrote an account of the proceedings, in which he described this part of it as follows:

"When I awoke I noticed that, although my left hand was relaxed, the right was clenched, but not tightly. This fact didn't surprise me, although it appeared to astonish the men about me. They asked me to open my fist, but I didn't—not because I felt it physically could not be done, but simply because I didn't want to. I don't know why I felt so. It was merely comfortable to have my left hand relaxed and my right hand clenched. No reason to open the latter was greater than the desire to keep it closed. *I remembered no signal.*

"Then X counted out a series of numbers. When he reached 'one-and-one-half' my fingers relaxed and both hands were now extended. *As soon as my palm opened I knew it was at the sound of the number 'one-and-one-half'.*"

The general conversation was promptly resumed by the group and no special attention was paid to the subject, who remained sitting on the sofa apparently in a normal condition. However, in approximately five minutes he complained of feeling drowsy, weak, tremulous and nauseated, and *asked for a glass of water.* He was taken into the kitchen, which necessitated his passing through the dining room by the table on which stood the empty glasses. He appeared to avoid looking

at the glasses. In the kitchen he was placed in a chair next to an open window and was given a glass of water. Despite the complaint of nausea there were no changes in color or pulse, nor was there any salivation. The subject soon stated that he felt better and was brought back to the living room, where he resumed his seat on the sofa. In his retrospective account he wrote that he "was still weak and unaccountably disturbed" on his return to the living room.

Thereafter the subject sat with his head buried in his hands, except for a few moments shortly after his return when he went to a bookcase and looked aimlessly at a few book titles, lit a cigar and toyed with an ashtray. Other than this, he said nothing and made few movements. The general conversation around him continued and there was no mention of hypnosis, and no special attention was paid to the subject. It was notable that he took no part in the discussion.

Suddenly, thirty-four minutes after awakening from the hypnotic sleep, the subject leaped to his feet, ran into the dining room, and inverted the glass. Then he walked back into the living room smiling shyly, and with an appearance of great relief. He immediately resumed an active rôle in the group, took part in the general conversation and began to describe his experiences.

On his own initiative the subject said that on awakening he had had a vague recollection of having been ordered, during the hypnosis, to invert an empty glass in the dining room. He said that he had at once determined that he would not do "such an idiotic thing" simply because he had been told to "as a hypnotic stunt". He stated that he was particularly averse to executing this order because his whole tendency was to be neat and orderly, that it would have been a violation of his normal code to invert the glass, and that instead the most natural act for him would have been to right the glass which was already inverted. He also said that he had been intensely disturbed inwardly throughout the subsequent period of conflict over this command.

On questioning, it developed that the subject had a hazy

memory of everything that had happened up to, but not including the ringing of the telephone,—namely, of his initial refusal to close his eyes, of walking from the chair to the sofa, and, as has been stated, of the suggestion to invert the glass. He had no recollection of the ringing of the telephone which had been audible to everyone else in the room, nor of any of the events which had occurred subsequently. For the second suggestion, i.e., to clench his fist, the subject had had a complete amnesia, until the moment of release from the command by the given signal.

Thus the two posthypnotic commands, and their reception and execution by the subject, present certain significant contrasts. The *Fist* command was given in a period of the hypnosis for which the patient had a total amnesia, and was completely accepted by him and faithfully executed. The *Glass* command, however, was given earlier, during the period of the hypnosis for which the subject had a faint recollection; and this met with a conscious obstructing judgment,—to wit, that it was "idiotic" and contrary to his own standards of neat and sensible behavior, and that therefore he would try not to obey it.

Despite the feeling of nausea which he experienced, he stated afterwards that prior to the expiration of the prescribed interval of ten minutes he did not feel emotionally disturbed. After the lapse of this interval, however, he found, to his surprise, that the failure to carry out the command produced a conflict of increasing intensity. He discovered that he was unable to think of anything other than his determination not to yield. The impulse to obey was very strong and it required a great effort for him to keep from carrying it out. The struggle between these two forces was so severe that he was completely obsessed by his indecision. He found that he was unable even to follow the conversation around him, let alone take part in it. Furthermore he became anxious, troubled, and agitated, and looked depressed.

Eventually the subject began to feel that he was losing the benefit of the entire evening, an occasion which he had eagerly

anticipated. He became convinced that he was helpless and would remain so unless he carried out the command. Ultimately, therefore, and with a sudden decision, he executed it rapidly, experiencing complete resolution of the conflict and immediate relief from all pathological feelings.

In the account which the subject wrote out several days later, he minimized the intensity of the emotional disturbance, although he had admitted it freely immediately after the occurrence of the episode. His own words are:

"From where I sat I could see two tumblers on a table in the next room and knew that I had to turn one of them upside down. This idea was ridiculous to me for two reasons,—first, one was already upside down, and if I were to do any turning at all, my natural tendency would have been to right this one rather than upset the other. Secondly, I could not understand why I should want to walk into the next room just to turn a glass upside down, particularly since this would entail a rude interruption of a conversation which was evidently taking place. *The whole business was very annoying,* and I did my best to ignore my promptings. I tried to pay attention to the speaker, but failed completely.

"Y asked me if I felt all right. I knew he had been observing my discomfort, and I confessed that I had been unable to follow the discussion. Asked why, I refused to answer because the reason was so inadequate and silly to me. I decided that if I tried to sit quietly long enough I would be able to defeat my inexplicable restlessness. I forced myself to remain seated for a long while.

"Finally I knew that I was missing the entire proceedings, and made up my mind to turn the tumbler, despite my embarrassment. I felt this would relieve me. I walked into the next room, reversed the glass, and immediately felt composed."

Discussion:

Full understanding and interpretation of such experiences become possible only when the subject of the hypnotic experiment is under psychoanalytical observation. Nevertheless in

the instance reported here indirect sources of information, and the subject's own retrospective notes, make it possible to use the material to throw light on three problems: (a) the origin and resolution of the transient emotional storm itself; (b) certain differences between the analytic resolution of hysterical and of obsessional symptoms; (c) the nature and origin of repetition compulsions, and their relation to superego functions in general.

(a) The Origin and Resolution of the Emotional Storm:

The personality of the subject has already been described. As one might expect in one of his type, his initial acceptance of the rôle of the subject was quiet and unperturbed. Towards the experimenter his attitude was one of sober trustfulness; and it is not without significance that both posthypnotic commands were obeyed in the end. The one *which concerned his own body alone* (the fist-clinching) was carried out without evidence of conflict, beyond that revealed by his need to rationalize his docility with the specious explanation that he kept his hand clenched "because it felt more comfortable in that position".

The second command, however, brought him into conflict with his basic attitudes towards the world; and although the content of the conflict was absurdly trivial in itself, his reaction to the struggle was of major intensity. By his own testimony he found himself unable to violate his customary codes of neatness and orderliness; an attitude which we may safely assume to have been connected with his deferential relationship to his parents and derived from the earliest phases of his moralistic training in cleanliness. Thus in this trivial command the new and temporary parent (the hypnotist) had confronted him with a challenge to a fundamental aspect of his personality,—i.e., the psychic structure of cleanliness and of morality, built out of his relationship to parental images. One cannot but be amazed at the intensity with which he was compelled to fight against such a trivial violation of his code, and at the acute and agonizing discomfort which this struggle cost him. Nor can

one fail to be impressed by the rigidity and the literal-mindedness of such a habitual conscious and unconscious conscience (i.e., his superego mechanisms).

Even in the absence of direct analytical data we may hazard the guess that on the one side were focussed all of the yearnings and taboos which can gather around oral functions, and which for this patient were evidently implicit in the drinking glass. To an individual of somewhat passive disposition, with traits which suggest the activity of strongly developed oral components, a drinking glass is a utensil which is treated with respect and a host of minute and wholly unconscious rituals in the homely details of daily life. The command to invert the glass violated this deep feeling and these attendant rituals.

In the struggle he developed first a true hysterical conversion symptom,—to wit, the nausea, which led to a request for a glass of water.[1] At the time, he had no realization that this nausea was connected with his conflict; but his attitude towards the water glass on the table as he went past it makes it probable that he dimly or else quite unconsciously entertained the hope that the request for a glass of water would allow him to manipulate the glass which had been pointed out by the hypnotist, thus enabling him indirectly to get rid of his dilemma. This would be a typical hysterical device,—i.e., to make use of an offending organ (or implement) to gratify *indirectly* a forbidden desire. However, since he was not allowed to use this special glass in securing his drink, his unconscious device failed; and it was after this failure that he sank into the deep state of depressive and obsessive rumination in which everything that was going on around him was blotted out.

It was not long, however, before this state began to rouse in him a feeling of anxiety. Gradually it became clear that what he was fearing was the loss of the entire evening, which meant to him the loss of an opportunity to establish warm contacts with his classmates and with the experimenter.

[1] This is not to be confused with the pseudohysterical manifestations which were produced by direct suggestion in the course of old-fashioned demonstrations of hypnotic trances.

Retrospectively one can see that it was at this point that the reaction took on the aspect of a miniature psychotic storm. In his struggle over a command which at the same time both *must* and *must not* be obeyed, he was unable to make any decision or any choice, and became lost in a state of tense agitation and compulsion, such as characterizes certain types of severe obsessional depressions. Furthermore it would seem that he must have remained caught in that state indefinitely had it not been for the mounting fear which finally forced him to submit to the more recent authority of the hypnotist and to reject the more remote authority which was embodied in his conscience.

(b) The Resolution of Hysterical vs. that of Obsessional Symptoms:

Implicit in the whole experience is a hint that may clarify certain aspects of psychoanalytic therapy. As has been pointed out already, the subject obeyed without conflict the orders to clench his fist, to keep it clenched, and to open it only when he heard the number "one-and-one-half". Furthermore, he obeyed this group of commands quite without remembering that he had been ordered to do any of these strange things. It was only at the moment when he was released from the command to keep his fist clenched, by hearing the number "one-and-one-half", that the posthypnotic amnesia was suddenly dispelled. This is comparable to a patient's sudden perception of the emotional relationships between certain events and certain symptoms, when an interpretation of these symptoms can be made convincingly in terms of the patient's own history. It is analogous also to the sudden perception by Dr. Erickson's patient of the relationship between the hypnotic experience and his own conflicts, as the patient reconstructed posthypnotically the story which had been told to him under hypnosis (*1*).

On the other hand, as is well known in psychoanalysis, contrasting situations are encountered in which, despite accurate interpretations which are clearly grasped by the patient, no release from the symptom occurs. This is analogous to the

plight of the subject in his conflict over the water-glass-command. He knew all along that his impulse to invert the glass was merely the result of what he remembered as the "idiotic" suggestion of the hypnotist. No interpretation was needed in order to call to his mind the source of his impulse nor its moment of origin. Analytically speaking, then, he understood and remembered the specific history of his symptom. No one had to point out the trivial folly of the impulse, and he was fully resolved to resist it: nevertheless he ultimately had to obey. Clearly, the conflict over the glass had become a mere screen for a much deeper struggle,—namely his need for love both from his natural parents and from his hypnotist, and from his contemporaries as well. *Thus the command in question had brought him into conflict over his allegiances to contending superego figures.* For this reason the struggle over carrying out the symbolic act persisted despite the subject's knowledge that it was merely a posthypnotic suggestion. It is in this way that compulsive rituals may persist in the face of layer after layer of accurate analysis.

Under such circumstances, only two roads to therapy are open. The simpler is always to obey the more immediate command. This the subject of our experiment chose. Had the compulsion, however, been toward some more disastrous form of behavior (as, for instance, the not uncommon obsessive impulse of a neurotic mother to kill her child), such an easy way out of the conflict would have been closed to him. In that case, the only release possible would have been through the analytic resolution of the struggle between conflicting inner commands, commands which had been imposed by powerful superego figures to all of whom he felt bound in deep allegiance. It is well known that the release from such a struggle through analysis is difficult because it involves a dislodging of these superego allegiances themselves. This may in part explain why in analysis the relief of an obsessional neurosis is so much more difficult than that of a conversion hysteria.

(c) Posthypnotic Phenomena, Repetition Compulsions, and the Superego:

Our final consideration deals with the relationship of the phenomena of posthypnotic suggestion to repetition compulsions and the superego. The development of Freud's theories in this direction were foreshadowed in his side-remarks about "subsequent obedience", in the analysis of little Hans *(loc. cit.) (3b).* It may be said, however, that the concept of the repetition compulsion has not yet received a clear, consistent, and safely usable definition, whether in its first full presentation in Beyond the Pleasure Principle (*3d*), or in such more recent references to it as those in the last series of Introductory Lectures (*3g*).

A full discussion of this question must be reserved for another place; but some indication is needed of the sense in which the words will be used here. In his original exposition, Freud identified the repetition compulsion with basic biological forces,—i.e., both the instincts of complex forms of animal life and the elementary chemical forces of protoplasm (*3b*). In this sense, however, every self-sustaining and repeated instinctual act, such as eating, excreting, sleeping, etc., would manifest the repetition compulsion (cf. New Introductory Lectures, page 145: "As soon as a given state of things is upset there arises an instinct to recreate it"). Without discussing the validity of this statement, we will avoid using the concept in any such sense because it seems to us that the term then becomes so all-inclusive as to lose any usefulness for the characterization of special psychological or psychopathological phenomena. With regard to this point, furthermore, the implications of Freud's various statements are not always consistent; but the general bent of his thought is indicated by his effort to identify and isolate the so-called "death instincts" by attributing to them a special tendency towards repetition compulsions, and by the absence of this phenomena from the expressions of the erotic instincts.

In other connections, however, the term has been used by

Freud to cover any symptom which occurs again and again. Of *all* symptomatic acts, however, it is characteristic that the substitutive gratifications which they bring do not for long satisfy the resurgent neurotic needs (perhaps this is one distinguishing mark between a symptom and a sublimation). Therefore, in this sense too, the concept becomes so all-inclusive as to be of doubtful value.

Repeatedly, however, and with greatest emphasis even if without complete consistency, Freud tends to differentiate erotic instinctual drives from the death instincts by means of a special relationship which he sees between the death instincts and the phenomena of repetition compulsion,—in turn linking death instincts most closely to masochistic phenomena, guilt-reactions, and superego functions in general. It is to this use of the concept that we will turn,—but without in any way committing ourselves to a belief in the existence of death instincts as such. We will simply take as our working premise Freud's implicit point that there is a close connection between the superego and the compulsion to repeat. This we would formulate tentatively as follows: that just because all erotic instinctual drives must by reason of their biochemical origins make their demands again and again throughout life, the superego must likewise be called into action again and again in the task of controlling and directing them. The *instinctual* repetitions are biochemical in origin. The *superego repetitions* are primarily reactive to the recurrent manifestations of the instincts. But in addition to these primary repetitions, whenever in an effort to expiate past sins, or in order to avoid the danger of future sins, the superego begins to demand certain repeated ritualistic performances apart from the direct and immediate urgency of instinctual needs, we have what is clinically recognizable as the repetition compulsion. (Although this is not the place for a full discussion of the point, it may be noted in passing that this definition would include Freud's use of the concept in connection with the play of children and the symptoms of the traumatic neurosis.)

Since all systems of morality express both of these purposes,

one finds the repetition compulsion, as so defined, at work, consciously rationalized, in the rituals of religious ceremonies, in art, and, wholly unconsciously, in all symptomatic acts which are dictated by an uneasy superego. In the miniature psychotic storm which was described in the protocol of this experiment on posthypnotic suggestion, the warring forces were derived from immediate and remote superego figures. So much was directly observable; but at this point we venture upon a speculation,—to wit, that had some external circumstances prevented the subject from carrying out the posthypnotic command, he would have been left with an uneasy superego; and that at the insistent bidding of that superego he would have manifested some form of repetition compulsion, just as was observable in the experiments of Luria, of Huston, Shakow and Erickson, and of Erickson.[1]

If we apply this speculation to what we know of the origin of the superego in childhood, we must conclude that for the existence of repetition compulsions parents and educators are responsible, in that they operate as unwitting hypnotists, giving commands, which the child, like the hypnotic subject, incorporates into an internal "must" system. When such commands are accepted and then violated, whether out of a spirit of defiance and resentment, or because external events have intervened to prevent their execution, the child is left with a superego charge which must find some form of expression. This is not a merely theoretical and academic point. Childhood may be looked upon as the stage of development in which the individual is subjected incessantly to the action of

[1] This point of view on the repetition compulsion was foreshadowed in 1905 in Freud's *Fragment of an Analysis of a Case of Hysteria*, Collected Papers III. In discussing on page 102 the repetition of the first dream, Freud writes: "The dream . . . corresponded . . . to a resolution which Dora carried with her into her sleep. It was therefore repeated each night until the resolution had been carried out; and it reappeared years later when an occasion arose for forming an analogous resolution." That this aspect of the dream is a derivative of superego function is manifest; and it is interesting that Freud recognized that the repetition of the dream was a function of the unfulfilled resolution (superego command) and not of the simultaneous disguised libidinal drive.

"hypnotic" commands and "posthypnotic" suggestions, many of which must remain forever unexecuted. Life changes, the moment goes beyond recall, and the child, like the hypnotic subject, becomes the bearer of another unexecuted and unexecutable inner law.

It is our suggestion that the repetition compulsion itself is the direct and active manifestation of the commands of superego figures, deeply ingrained in the personality exactly as the hypnotic command becomes ingrained in the subject. Thus this well-known and banal phenomenon of posthypnotic suggestion becomes an experimental demonstration of the fact that in addition to unconscious wishes, unconscious commands are operative in the human personality,—i.e., it becomes the experimental proof that the forces included in the terms "superego" are real, and not mere abstractions.

Connected with this whole problem is the ancient superstition that if a hypnotic command is impossible of execution, the subject will go crazy,—a superstition which may be not without its profound elements of truth when one substitutes for the hypnotist his primary prototype, the parent.

Throughout this paper there have been repeated suggestions that this work will be incomplete until hypnotic studies are made upon subjects who are under analysis, so that the relationship of post-hypnotic commands to the preëxisting personality can be worked out in detail. If this report serves to stimulate the development of studies in this direction, it will have served its purpose.

BIBLIOGRAPHY

1. ERICKSON, MILTON H.—*A Study of an Experimental Neurosis Hypnotically Induced in a Case of Ejaculatio Præcox.* British J. of Med. Psychology Vol. XV, Part 1, 1935.

2. FERENCZI, S.—*(a) Introjection and Transference. II. The Part Played by Transference in Hypnotism and Suggestion.* Contrib. to Psycho-analysis. Boston: Badger, 1916. (Germ. ed.: Jahrb. für Psa., 1909.)

(b) The Psycho-Analysis of Suggestion and Hypnotism. Transactions of the Psycho-Medical Society III, Part IV. London, 1912. Pp. 3–11.

3. FREUD, S.—*(a) Three Contributions to the Theory of Sexuality.* 1st Germ.

ed., 1905; trans. into English by A. A. Brill, 1910. See page 15, note 14, of 2nd edition of Eng. trans., 1916.

(b) Analysis of a Phobia in a Five Year Old Boy. Germ., 1909; trans. 1925. Collected Papers III, p. 178.

(c) Introductory Lectures on Psychoanalysis. 1st Germ. ed., 1916; British trans., 1922. London: Allen & Unwin.

(d) Beyond the Pleasure Principle. 1st Germ. ed., 1920; 2nd Germ. ed., 1921; Eng. trans. from 2nd Germ. ed. 1922. New York: Boni & Liveright.

(e) Group Psychology and the Analysis of the Ego. Germ. ed., 1921; Eng. trans., 1922.

(f) The Ego and the Id. Germ. ed., 1923; Eng. trans., 1927. London: Hogarth Press.

(g) New Introductory Lectures on Psychoanalysis. Germ. ed., 1933; Eng. trans., 1936. New York: W. W. Norton.

4. HUSTON, PAUL E.; SHAKOW, DAVID; ERICKSON, MILTON H.—*A Study of Hypnotically Induced Complexes by Means of the Luria Technique.* J. of General Psychology II, 1934. (Cf. this QUARTERLY IV, 1935, pp. 347–349.)

5. JONES, E.—*The Action of Suggestion in Psychotherapy.* J. Abnor. Psych. V, 1910; or *Papers on Psychoanalysis,* Chap. 12. London: Baillière, Tindall & Cox, 1913.

6. LURIA, A. R.—*The Nature of Human Conflicts: An Objective Study of Disorganization and Control of Human Behavior.* Translated and edited by W. Horsley Gantt. New York: Liveright, Inc., 1932. (Cf. this QUARTERLY II, 1933, pp. 330–336.)

7. RADO, S.—*The Economic Principle in Psychoanalytic Technique.* Int. J. Ps-A. VI, 1925, p. 35.

8. SADGER, J.—*(a) Zur Wertung der Hypnose.* Therapeutische Rundschau III, Nr. 45, 1909.

(b) Zum Verständnis der Hypnose und des hysterischen Delirs. Zentralbl. f. Psa. I, p. 98.

9. SCHILDER, P.—*Lehrbuch der Hypnose.* Vienna & Berlin: J. Springer, 1926. *Hypnosis;* trans. by Simon Rothenberg, Nervous & Mental Disease Monograph 46, 1927.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Psychological Factors in Urological Disease

Karl A. Menninger

To cite this article: Karl A. Menninger (1936) Psychological Factors in Urological Disease, The Psychoanalytic Quarterly, 5:4, 488-512, DOI: 10.1080/21674086.1936.11925297

To link to this article: https://doi.org/10.1080/21674086.1936.11925297

PSYCHOLOGICAL FACTORS IN UROLOGICAL DISEASE

BY KARL A. MENNINGER (TOPEKA, KANSAS)

This paper is an attempt to investigate the contribution of emotional factors to pathological tissue alterations in the genital apparatus, particularly the prostate.

Urological afflictions are, of course, seen more frequently by urologists than by psychiatrists and psychoanalysts, and investigation of the psychological factors in these conditions is therefore, for practical reasons, rare. A man suffering with suppurative prostatitis, for example, is naturally impelled toward direct mechanical or chemical relief and neither he nor his urologist are likely to have much patience with the propsoal that psychological factors are involved in the illness. Their existence might even be conceded but their practical importance would certainly be discounted.

Our knowledge of anatomy, bacteriology and immunology is so much more complete than our knowledge of psychology that even this theoretical invasion of the urologists' field seems presumptuous, especially while thousands of urologically afflicted patients are being successfully treated every day without any particular consideration of psychological factors.

Notwithstanding this fact, the occasional glimpses obtained by the psychiatrist into the emotional factors pertaining to a specific instance of urological disease cannot but lead to conclusions, and tempt one to further speculations in the interests of furthering our understanding of this acknowledgedly undeveloped field. In this we are met with encouragement by many urologists and clinicians whose intuitive skill in therapeutic work is by their own admission and conviction due to a hazy but highly capitalized recognition of the contribution of

Read at the Midwinter Meeting of the American Psychoanalytic Ass'n, Chicago, Dec. 22, 1934.

the emotional factors to the development of the pathological condition.

Such urologists speak and work from intuition, however, rather than from definite knowledge and certainly without any authoritative help from the generally accepted body of medical knowledge and theory. This is particularly striking with respect to the symptom of sexual impotence for which practically all prescribed treatment is mechanical and chemical, even by those authorities who suggest that some cases are psychogenic in origin. Yet impotence is a symptom which brings some patients to the psychiatrists as well as to the urologists and it is interesting to observe the radical differences in their respective attitudes toward this condition.

These differences in attitude must be ascribed primarily to the illusion of partial examination. The urologists examine the patient's genitalia and the psychiatrists examine the patient's emotions and they come to conclusions from these respectively local examinations which are comparable in their incorrectness to the conclusions of the celebrated blind men who palpated different parts of a passing elephant and argued for days thereafter about their contradictory impressions. Few psychiatrists are competent to make urological examinations, few urologists are interested in making psychological examinations. It is seldom, therefore, that a patient with urological pathology is studied simultaneously from both standpoints. Were this more frequently possible a quite different total conception than those generally held might be arrived at, one relating not only to this symptom (impotence) but to more complicated conditions.

Let us, for example, examine more minutely the respective findings and theories of the urologists and the psychiatrists with respect to the symptom of impotence.

The urologists have made certain observations concerning the organs involved in impotence which cannot be disputed. They find, with some degree of regularity, that many patients complaining of impotence show definite congestion and inflammation of the posterior urethra, especially of the verumonta-

num, and tenderness, enlargement and congestion of the prostate, with or without definite evidence of infection and suppuration. The interpretation generally given these data by the urologists is something as follows. The prostate becomes the site of a local infection owing to a concatenation of factors—for example masturbatory congestion plus influenza, or local injury plus streptococcus localization of a bacteræmia. The resulting inflammatory reaction impairs functional activity (impotence). The impotence causes the patient mortification and anxiety—he is driven by this distress to seek medical advice and treatment and comes to the urologist. The urologist treats the local condition (by massage, irrigation, endoscopy, chemotherapy, and so on) and it shows improvement. The impotence then (sometimes) disappears, and the theory is substantiated. If, however, both inflammation and impotence persist, this may be regarded as evidence for the theory of an organic lesion which resists efforts toward removal.

In justice to the urologists it must be stated that not all of them subscribe to this theory, even though they may carry out this routine. The treatment is sometimes successful out of all proportion to the amount of treatment administered, just as the symptoms are sometimes out of all proportion to the degree of pathological alteration discovered. Hence a vague generalization about "psychological factors" is frequently invoked to bolster up the theory of etiology and the old illusion of "suggestion" is brought in to explain the success of treatment.

So much for the findings and theories of the urologists. Psychiatrists, on the other hand, using the psychoanalytic technique, have also made some findings with a fair degree of regularity in cases of impotence which should be taken into account. Just as the urologists make vague and inexact references to psychological factors, so the psychoanalysts are apt to make vague and inexact references to the organic status. But the data resulting from psychoanalytic investigations must be accepted—as are the special findings of the urologists—in good faith.

Psychoanalysts find that patients suffering from impotence

prove upon examination to have a definite psychological need for this inhibition, in spite of their distress about it. In other words, they have unconsciously *wanted* or needed to be impotent to satisfy certain unconscious emotional tensions. It will not lead us too far afield to list some of the specific emotions which, though they exist only in the unconscious, exert a contrary and prohibiting effect upon the sexual function.[1] These consist in one or more of the following: first, fears, especially of punishment or of injury; second, hostilities toward the love object; third, conflicting loves, particularly parental and homosexual fixations; and fourth, rejection of the masculine (or feminine) rôle with its responsibilities.

Associated with and dependent upon these emotions is a great sense of guilt, and experience has shown that the relief of this sense of guilt by any one of several devices will frequently serve to free the patient from his fears and thus from his inhibitions. The psychoanalysts therefore are quite ready to believe that urological treatment frequently cures patients but they ascribe it not to the structural changes effected by the treatment but to the gratification of the need for suffering always associated with the sense of guilt—for example, guilt over masturbation. In support of this, they point to the fact that devices for relieving anxiety which do not involve any tissue manipulation are also used successfully as treatment, and to the fact, well known to urologists themselves, that some patients seem to erotize and enjoy urological treatments, even though painful. Wälder [2] reports the case of a man in whom this erotization of urological treatment went so far that he could even produce an orgasm by passing a sound into the posterior urethra. Dr. Walter Brunet, a prominent Chicago urologist, told me of a case he had seen in which urethral

[1] These have been reported severally in many psychoanalytic writings and I have recently summarized them in an article entitled *Impotence and Frigidity from the Standpoint of Psychoanalysis* published in Journal of Urology *34*, 166–183, 1935.

[2] Wälder, Robert: *Das Freiheitsproblem in der Psychoanalyse und das Problem der Realitätsprüfung.* Imago XX, 1934. (Trans. Int. J. Ps-A. XVII, 1936.)

catheterization had been necessary for examination some five years previously; the patient had been so relieved of nervous tension by the process that once a month since that time he had insisted upon a repetition of the procedure to combat insomnia!

I have already passed from the findings of the psychoanalysts which we must accept at their face value to some of their theories. We do not absolutely know that the explanation just offered accounts for the manipulative cure of some cases of impotence. In general the psychoanalytic theory is that fear and the other emotions mentioned above develop a high degree of effectiveness in certain individuals on account of sensitizing childhood experiences and are then activated by events in the patient's contemporary life resulting in the necessity for inhibitions. Here psychoanalysts generally stop, ignoring or disregarding the structural factors which the urologists have shown to exist. If they take cognizance of them, as of course some do, they are apt to depart from the logic of their own experience and, reverting to their medical school traditions, ascribe the infection to accidental or at least extraneous factors. Nor is this altogether erroneous in some instances. For example, what we frequently see is that the patient suffering from impotence feels impelled to relieve his anxiety by demonstrating that he is not impotent and in such compulsive overcompensations, which are probably also motivated by a sense of guilt, he indulges in indiscretions which his conscious intelligence would ordinarily prohibit in the interests of safety. By such a technique such individuals frequently succeed in infecting themselves with gonorrhœa in spite of their impotence.

However, it is not to such adventitious infections resulting from conscious activities that I refer, but rather to the nonspecific infections and the inflammatory processes without infection which, as we have said, while not demonstrably the cause of impotence, frequently accompany it and, of course, occur in many instances not accompanied by impotence. The logical extension of the psychoanalytic theory would be that

the results of such inhibition of a strong instinctual tendency must tend to appear in a concrete form. Some of the energy is of course dissipated in the form of anxiety, but every clinician knows that anxiety can be focused upon certain organs and it was long ago suggested by Ferenczi that the anxiety actually becomes, as it were, *invested* in an organ so that the patient, instead of a vague generalized sense of uneasiness and distress is aware only of local distress. The conservative, shall we say orthodox, psychoanalytic view is that this is in the nature of an illusion, depending upon purely symbolic and ideational connection of the organ with the anxiety. But there is nothing in the known facts about the automatic defenses of the body which would contradict a more literal and specific operation of this principle. It might be assumed, for example, that the results of psychic inhibition would be physical inhibition (impotence), the unconscious fear being relieved by this symptom, the conflicting impulses being transferred, as it were, from the psychic sphere to the physical sphere, in such a way as to produce vascular dilatation, congestion, and perhaps some unknown changes in the humoral efficiency or consistency such that infection is invited even to the point of suppuration. This symptom then brings the patient to the doctor. Later we shall examine in more detail the structure and plausibility of this theory.

It certainly does not seem possible to resolve the matter into such naïve conclusions as that (1) impotence may result from prostatitis, or that (2) prostatitis may result from impotence, because neither proposition would be unequivocally supported by the data of either the urologists or the psychiatrists. But both groups would (probably) agree that (3) impotence and prostatitis are frequently found in conjunction.

At this point there comes real divergence in opinion. Most urologists share the prevalent conception of infection—that it is entirely determined by relatively accidental factors which substantially defy analysis. This view concedes the descriptive data of the serologists—namely, that the humoral and tissue defenses of the body fluctuate and may be taken advantage of

by a particularly virulent or persistent strain of bacterial invaders. It concedes, or at least some of its defenders do, the concepts of organ inferiority and of *locus minoris resistentiæ*. But that processes connected with the thought, feeling and behavior of the subject have anything to do with these defenses is almost totally foreign to most medical thinking.

Not entirely, however; the current literature contains an increasing number of clinical contributions in which the psychological factors relating to the acquiring or retaining of the infection are acknowledged. Leshnew,[1] for example, reports several cases of which the following is typical:

> A young mechanic was being treated for urethritis and prostatitis. At the close of the treatment the urologist told the patient that he was well but that he really should have had one more treatment; this, however, was impossible since the urologist was leaving the city. The patient returned home happy over his recovery but with the notion of the incompleteness of the treatment firmly fixed in his mind. For six months he went from one specialist to another attempting to find one who would perform the cauterization which he assumed to be necessary. (The author implies that a slight discharge persisted.) Finally he came to the author, who found him in good condition so far as the local findings were concerned. *For purposes of psychotherapy* (italics mine) urethroscopy was done and the patient's symptoms disappeared.

Another prostatic case but without the factor of infection is reported by Dr. Frank J. Clancy[2] of Seattle, Washington, who comments that physicians "who are most meticulous in regard to diagnosis and treatment of organic pathology are apparently satisfied with the most unscientific information in regard to psycho-pathology".

[1] Leshnew, N. F.: *Psychogene Erkrankungen und die Urologie.* Ztschr. f. Urol. XXII, 1928.

[2] Clancy, Frank J.: *Urologic Symptoms of Psychogenic Origin.* Urol. & Cutan. Rev. *37*, 1933.

"A man 65 years of age from a neighboring city presented himself for urologic study. Chief complaints: frequent and painful urination, pain in the region of the prostate, intermittent in character, day urination every hour, night four or five times, duration several weeks. He had been seen by his personal physician who advised prostatectomy and suggested the possibility of malignancy. He was also seen by an urologist who was for immediate operation. The patient by this time was in a highly agitated state, and if the diagnosis was substantiated was to go to an eastern clinic for operation. Examination: rectal palpation, prostate only moderately enlarged, residual urine 60 c.c., clear, containing a few pus cells. Cystoscopic examination of the bladder neck failed to show any pathology.

"A man of 65 does not come in complaining of urologic symptoms, even willing to submit to a serious major operation, unless there is a real condition. The patient was questioned carefully again regarding his symptoms, and a casual inquiry made if he was worried over any particular thing before the symptoms came. This key opened the lock. The man, a highly respectable and retired business man, married and with married children, had had an extramarital experience. This had preyed on his mind until he had worked himself into an hysterical state, but to all outward appearances he covered up his mental turmoil.

"One is led to suspect that many of the urethral strictures so promptly relieved by the passing of a single catheter are of a psychogenic rather than an organic nature." [1]

[1] This opinion is confirmed by a urological colleague, Dr. Arthur Gray, who in a personal communication told me of a patient who takes a periodical "grand fling" at the end of which he comes to his urologist, Dr. Gray, demanding that a series of sounds be passed, for which he refuses to have a local anæsthetic. He insists that the drinking and sexual activity bring back the "old stricture". He leaves thoroughly relieved in mind and body and has done so now for six years. "But", Dr. Gray drily comments, "he has no stricture"!

In further substantiation of the value of the illness as a form of suffering to gratify the sense of guilt, Dr. Gray also related a case of a college student with an acute gonorrhœa who quit school until he should be well because "although it was very hard to do" he felt he "had no right to mingle with 'clean' people". He told every member in his family, in compliance with his confession ritual, so that they might know, as he put it, what sort of a fellow he was and protect

Such cases, however, leave us in doubt as to the precise way in which the susceptibility to infection was increased psychologically. This is, in part, a problem for the physiologists. It is for them to tell us just how certain *wishes* (to use the accepted psychoanalytic term) can be expressed through the autonomic nervous system and the organs and tissues innervated by it. The task of the psychiatrists is to indicate as specifically as possible jut what these "wishes" are, why and how they arose, and in what discoverable way they are gratified by the organic changes effected.[1] That such investigations and the accompanying emotional alterations may benefit the patient is of clinical interest, but a step removed from our immediate research problem.

Our theme is that it is conceivable that in some instances the emotional factors so alter the physiological processes of a part of the body that a train of pathological results ensues. Sometimes this seems to be accomplished without the aid of any extraneous factors and a spontaneous pain [2] or hæmorrhage, for example, occurs. In others an infection appears to be invited and (as we have put it) *accepted* by the local tissues to develop and wreak havoc in the well-known ways characteristic of different infections. In still other instances there is less evidence that the receptivity to the infection was greater than average, but the external behavior of the patient makes up for any "reluctance" on the part of the tissues, and he, so to speak, forces an infection upon himself with purposive indiscretion and then appears to capitalize and keep it in defiance of all ordinary efficacious therapeutic attacks. I cite examples of each of these.

themselves against him. This patient had left another physician and stopped an entirely satisfactory course of treatment because he was getting well faster than he thought desirable, as he "figured it would be better if it ran awhile".

[1] It is surprising how seldom this has been done or at least how scanty are the reports in the psychoanalytic literature. There are numerous brief references but almost no full accounts of the development of uropathological lesions. Perhaps some have eluded my search.

[2] Dr. Paul Schilder, in the discussion of this paper before the Psychoanalytic Association, referred to a patient seen by him who developed spontaneous attacks of severe pain in the perineum later traced to early childhood experiences.

Spontaneous Lesions

A spontaneous organic urological lesion manifested by the symptom of hæmaturia was reported by Dr. Alan Finlayson of Cleveland before the Chicago Psychoanalytic Society in 1933. This incident was so closely related to the patient's material and characterology that Finlayson seems entirely justified in having regarded it as "psychogenic hæmaturia". The patient was a professional man of thirty-three whose presenting symptoms had centered about an extreme phobia lest anyone see him urinate, with a resulting inability to urinate when anyone was present. So great was this phobia that it affected practical arrangements with respect to every department of his life; he was unable, for example, to take an automobile ride of any length lest, as he assumed, he would be unable to retire to the toilet unaccompanied. This symptom had been present since the age of five. It developed that during his early manhood the reciprocal tendency of voyeurism was manifested so that he would spend much of his time visiting men's toilets for the purpose of watching them urinate. This excessive interest in the process of urination had been a marked characteristic during most of his life.

The hæmaturia occurred at a time when he was frankly avowing his wish to be a woman, a tendency which as one might expect, was very strongly developed and was related to his masturbation anxieties and his urination phobia. As a child he had been called a sissy and was fond of dressing in his mother's clothes. With his wife, and in fact with all women, he was for the most part impotent.

He had complained one day of a pain in his right flank which he ascribed to gas. That night he dreamed that he was looking for a place to urinate, saw a boy sitting on the toilet masturbating, marvelled at the boy's audacity and began immediately himself to have an orgasm, the semen being bloody. He awoke with a start and went to the toilet, urinating with some pain (but no blood at this time). After returning to bed he did not go to sleep for some time as he was disturbed by the dream. About two hours later he awoke with a terrific pain in the

right side. A physician was called and morphine 1/3 gr. was given by hypodermic, but as this failed to relieve the pain more morphine was given four hours later. A specimen of urine voided at this time showed microscopic blood. The patient was admitted to the hospital and a tentative diagnosis of renal or urethral calculi was made. An attempt to take x-ray plates was made but without avail because of intestinal gas. Enemas were given, each one setting up violent vomiting. When the analyst visited the hospital the afternoon of the first day the patient looked very sick and was vomiting. He greeted the analyst with the remark, "I thought you would come around to see if the pain was a fake".

He remained in the hospital several days and during this time several specimens of urine showed microscopic blood. The x-rays were negative for calculi and the vomiting ceased with the suspension of the enemas. On one occasion after returning home the blood appeared again in the urine after a repetition of the first dream; this time the blood was macroscopic. The pain reappeared three other times, two of the attacks occurring during the psychoanalytic treatment hour.

The subsequent associations of the patient to the incident and to the dream and his previously clearly defined tendency would strongly suggest that the hæmaturia incident was superficially the symbolic enactment of his conflicting wishes to masturbate and the fear that if he did so he would be castrated and made into a wounded and menstruating woman, a rôle which he unconsciously accepted and sought for as the price of his irresistible and illogical instinctual impulses.

But such symbolic gratifications as these episodes of hæmaturia could not have been possible had there not been deeper determinants and a long period of organic preparation. In this case, however, the lifelong gratification afforded by urination, i.e., the increased erotic value, is presumptive in the light of the history. To put it more simply, if one has concentrated his sexual life on the urinary process for twenty-five years it is not inconceivable that the urinary apparatus has been modified in some minor way to afford a maximum organic adaptation to

this perverted psychological demand. Whether this modification is in the form of greater vascular supply, more fragile endothelium, a change in the arrangement or sensitivity in the nerve endings or some other device must, of course, be left entirely open; even speculations concerning it would take us too far beyond the known facts.

Spontaneous Infection

I myself studied a case in which hæmaturia occurred, apparently as the result of emotional conflicts, although its origin was prostatic rather than renal. This case will illustrate a second form in which the unconscious wish is carried out organically. In this form it is accomplished with the coöperation of bacterial invasion, which seems to be invited not through behavior but through some compliance on the part of the local resistance.

This patient was a man of thirty-five whose previous life had been uneventful from the psychiatric standpoint. He had been sent to a distant city as a temporary representative of the firm which employed him and took this occasion to enter into a liaison with the wife of an acquaintance with whom he was thrown into contact in his new location and who had shown him some business favors. The affair began upon a platonic basis, but when sexual relations were attempted later he was entirely impotent. He was so disturbed by the experience that he left his post of duty and returned home to his wife, with whom he found himself to be quite potent, thus relieving his anxiety temporarily.

Later, however, he returned to the city in which he had been stationed and resumed his friendship with the woman he had disappointed. A tentative engagement was made for another night together, but forty-eight hours prior to the appointment he developed a urethral discharge. He went immediately to a competent urologist, who made a diagnosis of nonspecific (staphylococcus) infection of the urethra and prostate and prescribed the customary treatment—irrigation, instillation, prostatic massage.

The patient persisted in this treatment faithfully for six months but the symptoms showed no improvement. There was at times a profuse discharge, at other times almost none. Ulcers and small abscesses formed in the prostate, so that there was for a time bloody urination and a bloody discharge. The symptoms did not show any tendency to subside until after instrumentation by the urologist, who found that some adhesions and pus pockets had been formed in the prostatic structure.

Meanwhile the patient was greatly disturbed emotionally, ostensibly because of his impotence. However, the urologist ascribed this to the local pathological condition and urged the patient to disregard it. He consulted another urologist, who concurred in this opinion and also in the diagnosis, but recommended psychotherapy and referred him to me. I proposed psychoanalytic treatment which the patient accepted and carried through successfully.

I shall bring out only such of the psychoanalytic material as is pertinent to the prostatic infection. It was clear that the illness was precipitated by the abortive episode with the woman. The fact of the matter was that the affair was entirely compulsive, that is, it was an activity into which he entered not so much for conscious and intelligent reasons, as for some unconscious reasons which he later came to recognize. In the first place, the woman was the wife of a man to whom he had become very much attracted (homosexually), a fact which he kept deeply concealed even from himself. His relations with her thus represented a means of homosexual gratification in a heterosexual disguise, which explains the extraordinarily severe conscience prohibition. In the second place, the affair was intended unconsciously as an aggression against his wife, to whom he had been nominally faithful but only through fear of detection and because of a feeling of inferiority to her. In the third place, as we learned only after a very deep analysis, the woman unconsciously represented his mother (not only resembled her in some respects but treated him in the manner of his mother, whose pet he had been). Thus the act was in

several senses a repetition of the "Œdipus Crime": he took the woman away from a man toward whom he had mixed feelings of love and fear, and secondly, he attempted relations with this woman which in his unconscious were incestuous.

This enables us to see certain purposes in his illness, and where purposes exist there must be unconscious striving toward that end. Whether this purpose and striving are participated in and realized biologically is, of course, begging the question; let us see just what usefulness and therefore what purpose this illness subserved. It was, as we have indicated, a solution for the *impasse* into which he was forced by the irresistible strength of his instincts and his sense of inferiority on the one hand, and his conscience and reason on the other hand. The first solution for this was impotence, which not only eliminated the hazard of the temptation but punished him for having so much as enterained the wish for the incest crime.

But the sexual impotence was not a satisfactory solution, because of the terrific blow to his narcissism which it entailed. It was not only a deep humiliation in the eyes of the woman whose esteem he sought, but it was equivalent to a castration and feminine identification for him which must have aroused strong instinctual conflict-tension. He had good reasons, therefore, for "accepting" the infection and the related structural pathology in place of the functional inhibition. The narcissistic injury was thereby salved, since we do not hold a person responsible for his physical illnesses. *The narcissistic injury was, so to speak, transferred from a general to a local focus; only the narcissism of the prostate now suffered.* The narcissistic injury was also replaced by physical suffering—pain, hæmorrhage, anxiety. It more than balanced the sense of guilt created by the original episode. The economic consequences of such a circumstance are that an individual not only makes atonement for past sins but feels that he has bought indulgences for the future as well. From this we can understand why this patient subsequently regained his potency and with the additional punishment of the urological treatment even gave up the organic penalty.

But there is a third element of purpose in the illness which cannot have escaped the sharp eyes of the reader. This relates to the capitalization of the displeasure, first masochistically in the enjoyment and exhibition of the suffering, and secondly in the gratification of the feminine components of the personality which were in such a fair position to be gratified by an illness which simulated feminine identification, even to the extent of supplying a genital discharge, mucoid, purulent and hæmorrhagic. This patient once showed me how the blood oozing from his urethra had bespattered and stained his underclothing, an act of exhibition and feminine identification which even he himself promptly recognized and (indicating its erotic and aggressive significance) apologized for.

This phenomenon of man wanting to be feminine seems so extraordinary and perverse to the average physician that a word might be said as to its great frequency as revealed by psychoanalytic study. Naturally it is usually a deeply repressed tendency, although I have occasionally been consulted by men who secretly confessed consciousness of such wishes. That some men surreptitiously enjoy putting on their wives' or sisters' clothing (so-called transvestitism) is better known. And I once had a married man, entirely "sane", referred by the Mayo Clinic, who seriously sought to have himself surgically altered so that he would be more nearly female. He was even willing to have an artificial vagina constructed if plastic surgeons would undertake it. In its repressed form these wishes more usually express themselves in an identification with the mother and the development of maternal attitudes toward other people. Vicarious menstruation as a kind of symbolic representation of it is occasionally seen—and various forms of submission of a symbolic character are familiar. The patient of Wälder cited above would plunge a sound into his own urethra and utriculus and produce an *orgasm* and a *bloody* discharge.

In this case we have illustrated the same mechanisms with which we have become familiar from the study of other types of self-destruction, namely, the original aggressive purposes, the

inhibition of these aims and consequent direction of the destructive impulse upon the body, the augmentation of this reflected aggression from conscience elements, and the erotization of the whole process. Furthermore, just as we have seen in the study of self-mutilations [1] that there is a tendency to make successive bargains with the conscience so as to yield the maximum satisfaction at the minimum cost, so we see here that the organic illness succeeded the impotence because it more completely satisfied the psychological requirements. Whether this was done in this case through the lowering of local resistance or of general immunity so that an omnipresent bacterial infection could come to the assistance, so to speak, of the self-destructive needs, again we can only speculate.[2]

Capitalization of Infection

That individuals with strong sexual needs and equally strong conscience denials will sometimes relieve the former at the expense of the latter is well known. It is perhaps less well known that they sometimes seem almost deliberately to involve themselves in difficulties over their sexual satisfactions as if to satisfy or appease these conscience demands. In fact, it is a familiar experience that it is the highly moral and rarely transgressing individuals who are most apt to do this—for example, to acquire venereal infection after a single isolated exposure. Psychoanalytic study of such individuals has led us to the conviction that this is unconsciously done for the very purpose of

[1] Menninger, Karl A.: *A Psychoanalytic Study of the Significance of Self-Mutilations.* This QUARTERLY IV, 1935.

[2] The urological literature contains in recent years considerable emphasis upon the fact that nonspecific infections of the prostate are of very common occurrence. Following the influenza epidemic of 1918, many such were reported, and were first ascribed to influenza; later the opinion seemed to prevail that the influenza had weakened the resistances of the organism so that local prostatic infection could occur from the ordinary in-lying pathogenic bacteria. From this—and I think I present urological opinion correctly—the theory was extended to the view that nonspecific prostatic infections had always been more numerous than had been recognized, and that certain of the cases diagnosed as gonorrhœa were not so at all. One authority goes so far as to say that 90 per cent of adult males have chronic prostatic infection.

placating the conscience—a form of self-inflicted punishment to relieve the sense of guilt.

This much is well known to psychoanalysts. What is less well understood by them is how (or whether) some individuals can, through their bodily devices and physiological mechanisms, unconsciously control in some way and to some extent the retaining or rejecting of such a deliberately acquired infection. Sometimes they seem to have an extraordinary ability to throw off the infection. Oberndorf has reported [1] two cases, in both of whom gonorrhœa was acquired because of such guilt-reducing motives as I have indicated. One patient made a complete recovery in three weeks. The other dragged along in his treatment for months, then changed to another urologist who, however, administered the same treatment. Nevertheless, the patient recovered almost immediately. This strongly suggests some unconscious autonomic control over the processes of immunity and antisepsis. A more detailed study of the following two cases will perhaps make this more specific.

The first is a case which I studied over a period of two years, in which the infection of the prostate seemed definitely "retained" to satisfy certain emotional needs and relinquished when these needs no longer demanded such satisfaction, suggesting some operative relationship between the psyche and the local and generalized immunological defenses.

The patient was an intelligent but extremely neurotic young man who expressed his illness not so much in symptoms as in neurotic behavior, the net result of which was to cause him great embarrassment, humiliation, loss of friends, loss of money and other "misfortunes". During his analysis this propensity for getting himself into trouble from which he was extricated only at great emotional and sometimes monetary expense was brought into sharp focus. He would act in defiance of the analyst in a direction which could easily be seen beforehand to be fraught with danger, and emerge displaying the scars of battle remorsefully but

[1] Mentioned in his discussion of this paper before the Am. Psa. Ass'n.

reproachfully. Among other things he acquired gonorrhœa under circumstances so grotesque and externally senseless as to leave no doubt as to its compulsive motivation. He submitted himself for urological treatment to a very intuitive urologist, to whom I am indebted for urological data included in the study of the case.

It is unnecessary to include all of the long history of subsequent events. The upshot of it was that he carried through the orthodox treatment for acute gonorrhœa and up to a certain point made a prompt, positive therapeutic response. The discharge diminished almost to non-existence. Pain ceased altogether and digital examination confirmed a recession of an inflammation which had originally extended to the prostate.

During this period the patient instituted for himself an exaggerated hygienic regime. Taking the urologist very literally he "rested" twenty-three hours out of the twenty-four by lying flat in bed. He would scarcely move about in the bed for fear of violating the injunction not to be too active. When it was pointed out that such extreme measures were defeating the purpose of the advice and that nourishing food was no less necessary during gonorrhœa than at any other time, he permitted himself the indulgence of getting up for meals and for his psychoanalytic hour.

Gradually he relinquished his burlesque of the treatment and for a time acted in a more normal fashion. He grew interested in the unconscious material that was produced in his analytic session with reference to the motives for his becoming (and remaining) infected, the gist of which was his strong wish to sacrifice his own virility, i.e., self-castration. One root of this lay in his guilt feelings on account of the terrific aggressions constantly made toward all members of society with whom he came in contact, including the analyst and the man from whom he acquired the gonorrhœa, both of whom represented a brother who had been the patient's bitterest childhood foe.

The other root lay in the erotic capitalization of this sacrifice of his virility, i.e., his unconscious passive homosexual wishes toward the analyst. He talked constantly of his homosexual feelings which he declared were entirely conscious but which he always insisted were desires for playing the active, i.e., the masculine rôle. It was in the course of acting out this professed homosexual wish

that he acquired the gonorrhœa. Everything in his life, however, as well as in his dreams and free associations, showed that it was the passive feminine rather than the active homosexual rôle which he desired.

His violently aggressive behavior was actually a histrionic denial of these feminine wishes. While still denying them he began to act them out in so obvious a form that they ultimately became clear to him even in spite of his enormous resistance. For instance, with a rationalization that by cooking in his own room he could save himself the exertion of going out for his meals which might make his gonorrhœa worse, he secured a set of cooking utensils and at enormous pains, with much blundering and the concoction of wretched food, he "kept house" for himself for some weeks, washing the dishes in the bathroom bowl, cooking over a gas stove designed for heating the room and eating his meals from a board placed on the bed (his table was full of books and he could not permit himself the exertion of moving them). He tried draping clothes about himself to look like a woman and he bought a pair of women's stockings and wore them instead of socks. In his dreams he continued to portray himself as a girl, usually a girl who was being made to suffer by a cruel and relentless man.

As the patient realized more and more fully how much he wanted to be a woman, he began simultaneously to compare the way in which he reacted to his gonorrhœal discharge with the way in which a woman reacts to her menstrual discharge. For example, he would comment upon the fact that it would be present for a few days and then gone for several weeks. When it reappeared he would be very depressed, a state which he compared with similar emotional reactions in women. To protect his clothes he would wear cloths similar to sanitary napkins. Most impressive of all to the patient was the fact that he could predict precisely when the discharge was about to reappear. This he did on several occasions which I knew of and can corroborate. Each time it would reappear he would return to the urologist for treatment. It would generally begin by his saying that he awoke in great fear from a dream which indicated that the discharge was about to return. He would examine himself carefully and find this to be untrue. This, however, he thought must mean that an unconscious wish for its

reappearance was near the surface and that he could consistently expect it in a day or two. (How much this resembles the anticipation by a woman of her menstrual period is striking.) A day or two later the discharge would indeed reappear.

How he used this symptom to obtain attention and care from the urologist of a sort he was unsuccessful in obtaining from the analyst became quite clear to him. To forestall a continuation of neurotic satisfaction in the illness, he decided not to return to the urologist for treatment. I felt some apprehension in not insisting that he do so, but thinking to make a trial of the matter I let him decide without interference. No sooner had he determined not to go back for physical treatment for a condition which he was convinced he was psychologically producing than the discharge ceased, and did not return!

After this had happened he relieved his sense of guilt for having "continued" his infection so long by projecting the blame upon the urologist, attempting to put him in the wrong and refusing to pay the last portion of his bill.

"That fellow didn't do me any good", he declared, "he knew this was psychogenic and he played into the hands of my neurosis not only by permitting me to keep coming but by advising me to. He gave me justification for continuing the illusion that I had no responsibility for the illness except to submit to his treatment and of course that was exactly what the feminine elements in me wanted."

I reminded him that microscopic examination of the discharge had shown gonococci to be present even at the last emission, a fact which in reality considerably perplexed and disturbed my urological colleague. But this did not cause my patient the least discomfiture.

"Doctor", he said, "I don't believe that those bugs disappear merely because you put some chemicals in their vicinity. It may discourage them, but I think something in the individual himself helps to kill them. I don't know how it works, but time after time when I wanted that discharge to come back it came and as soon as I recognized my perverse wish and really renounced it the discharge went away."

One does see, as in the first case cited, that when psychic or behavioristic symptoms fail, that is, when they are insufficient

to relieve the demands of the conflict or when they become too costly, organic symptoms on a structural basis supplant them and in such a manner as to make it seem probable that they occur by reason of some inner design or intent. The same pattern of focal self-destruction as was outlined in the preceding case is again visible in this case.

Dr. George Wilson, of Chicago, very courteously put at my disposal the details of another psychoanalytically studied case much like the preceding, but with certain details which make my patient's extravagant convictions about the psychogenesis of gonorrhœa seem less absurd.

This was a twenty-six year old man who came for psychoanalytic treatment because of impotence. He had never had successful intercourse in spite of repeated attempts. He had always lived with his mother and for four years had been entirely supported by the mother and younger sister. After approximately seven months of analysis he decided to attempt intercourse with a prostitute whom he had known for some time. She often came in to buy cigarettes in the store where he clerked. In some unknown manner this woman sensed his psychic impotence and made the suggestion that he come to see her, that she understood and would assist him.

He was not encouraged in this project by the analyst but cautioned that if he pursued it, he should use a condom and a prophylactic. He disregarded all advice—attempted, and at the third attempt was successful in having—intercourse, but used neither condom nor tube. (In this he clearly demonstrated by his *actions* that he wished to invite infection.)

A few days later he developed undoubted symptoms of gonorrhœa, to the consternation of the patient but no less so of the woman, who had assumed a maternal attitude toward him. She protested stoutly that she had recently undergone examination and was positive that she did not have a gonorrhœal infection. She was quite willing to have an examination at the same place as the patient *and did so.* Surprising as it may seem, both vaginal and cervical smears were entirely negative for gonorrhœa.[1] Further-

[1] The urologists inform me that this is less of a paradox than it seems, since smear detection can sometimes be evaded by a skillful woman by thorough

more, several acquaintances of the patient claimed to have had intercourse with her without infection (and presumably without prophylaxis).[2]

The patient's gonorrhœal infection persisted for approximately six months, during which time he was seen three times a week at the Chicago Public Health Institute. He became somewhat of a curiosity at the clinic and at one time the urologist suggested that he see my brother, Dr. William Menninger, because of the unusual persistency of the symptoms, "as if he wanted to hang on to his infection". The infection would clear up and they would begin to pass sounds, beginning with smaller calibers and increasing in size, only to have the infection recur.

A dream that he reported during this process was significant as to the value of the illness and treatment.

douching; also from the statistical fact that 7 out of 10 exposures to known sources of gonorrhœal infection escape it.

[2] In the discussion of this presentation at the American Psychoanalytic Association meeting in Chicago, Dec. 22, 1934, the President, Dr. A. A. Brill, reported two similar cases—one of which he kindly wrote out for me to include here.

"The patient, a man of thirty, is now a very talented and well-known artist. An only son, his father always objected to his art, and wanted him to be a business man. He had already achieved eminence as an artist, but his father still disapproved of it. The patient suffered from anxiety, in addition to definite manic attacks (both depressions and elations). His mother was of the same type, and killed herself.

"One day he came to me and complained of an irritation in his left eye. The eye looked very ugly to me, so I advised him to see one of our leading ophthalmologists. The doctor made the diagnosis of gonorrhœa after microscopic examination of the secretion. The patient remained in the hospital for a few weeks, and fortunately his eye was not damaged. On investigating how he contracted this disease, I found that about 36 hours before the symptoms appeared, he had had relations with a married woman, who was highly indignant when it was suggested that she might have gonorrhœa. She insisted on an examination, and was examined by the same physician who made the diagnosis of the eye condition, but no gonococci were found. I concluded that the eye infection was determined by the conflict—to be or not to be an artist—which was very marked for many years (in fact, until after the completion of the analysis), and secondly, castration for an incestuous act with a mother substitute. The patient was very suicidal, so that soon thereafter I had to send him to a sanitarium for a few months. I have no doubt at all that the eye infection was a partial suicide, although at the time, I did not think of it."

Dream 1: He is walking down the street behind a man whom he knows, with his penis in this man's rectum.

Dream 2: He has no penis. He feels a peculiar "sound" in his throat with genital sensations referred to the perineum and has an orgasm.

The *associations* to these dreams confirmed the almost transparent interpretation, namely, that he has sacrificed his penis and become a woman to pay the penalty for his aggressive sexual (oral and anal) wishes toward men.

This interpretation was fully borne out by the patient's outside life. As already indicated, he lived a parasitic existence with his mother and sister. Later he moved away from home and lived with a married man whose wife was away on a visit, playing the housewife to this man, including the duties of cooking and housekeeping. Similar to my own case also is the fact that for several weeks during his infection he remained constantly in bed, waited upon slavishly by his mother.

The details of this case material are insufficient to indicate all of the reasons for the election of this affliction, but—in all the cases cited—we have the phenomenon of a man whose emotional conflicts could tolerate neither a normal sexual life nor abstinence, and whose attempts at sexuality seem to have masked destructive impulses which were then reflected back upon him, first in the form of impotence (i.e., functional inhibition) and then, as if by replacement, with a more focal and autonomous self-destruction in the form of urethral and prostatic infection. If we may judge from these few cases, either staphylococci or gonococci may be utilized in the production of the lesions. For without invoking mystery or theories of bacterial transmutation, we can probably assume with justification that a man who acquires gonorrhœa from his first and only contact with a woman, a woman whose supply of gonococci is so slight or non-virulent as to give no clinical evidence, must have had a biological susceptibility (if not an actual chemotaxis) far beyond the ordinary or average. This corresponds precisely with the demonstrated psychological

needs of the same individual which may, of course, have been merely a coincidence.

That bugbear, coincidence, hangs over our head constantly in psychoanalytic observations, because our material is, after all, so scanty in comparison to the millions of cases seen and treated by the urologists. We cannot *prove* that these two factors have a causal connection—we can only indicate that they *appear* to have, and that this apparent relationship occurs in repeated—albeit numerically few—instances.

Coincidence is probably less serious an objection than one which arises upon a purely deductive basis. It may be, specifically, that these few cases come about as we have proposed, through some expression of unconscious intent, but only through an unusual and irregular psychosomatic structure. They may, in other words, be simply exceptions like those rare individuals who retain the ability to accelerate or retard the heart voluntarily, or possess other manifestations of conscious control of autonomic functions. But this, too, is only a hypothesis.

Again, there is the fact that of thousands of patients undergoing psychoanalysis, these mechanisms and results have been observed (at least *reported*) in but few—which lends support to the previous objections.

Finally, there is still the possibility—I submit it only as a possibility—that these cases, whether exceptional or not, are fortunate illustrations of a phenomenon about which we are as yet too ill-informed to be dogmatic but too oft reminded to be completely skeptical.

It is a phenomenon which falls in direct line with a more general hypothesis, so that in conjunction with this hypothesis we may perhaps venture a prediction without the fullness of conviction of the astronomer predicting a planet, but with the same technique. The hypothesis is that there is a self-destructive impulse in every individual which, hindered or fortified by other elements in the personality, achieves its purpose to varying degrees and in various ways. Its conflict with the life instinct, with the demands of reality and with the exigencies

of the conscience result in compromises which may be regarded as *partial suicides* or *focal self-destruction* (bearing in mind that this partial suicide is for the sake of personality preservation). These focal suicides may be carried out in a conscious deliberate way, as in self-mutilation, or in ways which seem accidental or extrinsically necessary, as in certain accidents and operations. There is nothing in the theory to make us doubt but that these self-destructive tendencies lying, as they do, deep within the fabric of the instinctual life may also express themselves without the assistance of the voluntary nervous system and the striated musculature, and are to be seen as well in the death or injury of organs not directly connected with consciousness. The physiologists have supported such a hypothesis from experimental work to the extent that we know that nervous pathways for the effecting of these purposes exist. Clinicians from their side offer the evidence that emotional factors seem to affect physical illness although in just what way they cannot be sure.

The step that remains is to indicate that the self-destructive purposes for which we are able to find these clinical examples, on the one hand, and these psychological trends, on the other, are in some intimate and purposive way related. This we have pitifully small data to support but, such as it is, we have submitted it. It would seem as if the self-destructive tendency were such that it thrusts one arm into consciousness, and one arm into the somatic structure of the body, with sometimes the one, sometimes the other, more active. It is only occasionally and with difficulty that we are able to let "the right hand know what the left hand doeth". *Practically,* in the majority of cases, it probably does not matter but *theoretically* this remains the task and the opporounity of psychoanalysis: to identify and relate specifically the emotional factors contributing to somatic disease.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Analysis of a Case of Neurosis with Diabetes Mellitus

George E. Daniels

To cite this article: George E. Daniels (1936) Analysis of a Case of Neurosis with Diabetes Mellitus, The Psychoanalytic Quarterly, 5:4, 513-547, DOI: 10.1080/21674086.1936.11925298

To link to this article: https://doi.org/10.1080/21674086.1936.11925298

ANALYSIS OF A CASE OF NEUROSIS WITH DIABETES MELLITUS

BY GEORGE E. DANIELS (NEW YORK)

Analysts agree that a more basic understanding of anxiety is essential for the solution of the problem of neurosis. From the physiologist they receive important information on the physiology and biochemistry of anxiety. Their own studies reveal the manifold forms of clinical anxiety from the outspoken anxiety neurosis with massive discharges of anxiety, often based on direct sexual frustration, to the subtler manifestations of anxiety as a warning signal in anxiety hysteria, and the marked anxiety which lies hidden under an hysterical conversion symptom or which may be transmuted into spasmodic tic-like compulsions. And all these varied forms of anxiety, as in the present instance, may appear in the same case. Freud refers to anxiety as the common coin into which all other neurotic symptoms can be changed. Furthermore, a characteristic common to all forms of anxiety, as to all neurotic symptoms, is its utilization for pleasurable ends, its "erotization". In searching for the matrix from which these physiological and psychological manifestations emanate, I should like to present the record of an analysis which may possibly throw light on the metabolic changes underlying one form of anxiety and its erotization, with a suggestion as to further investigation of the problem.

A married business man of thirty-three was referred by his physician for a severe neurosis associated with diabetes. He was seen an aggregate of two hundred eighteen hours distributed over a fifteen-month period. The case is of particular interest because of the diabetes which is, I believe, an integral part of the neurosis. In presenting this case it will be our thesis that there is a marked resemblance between the symptoms of hyperinsulinism and the clinical picture of anxiety

Read at the New York Psychoanalytic Society, February 25, 1936.

neurosis while the hysterical symptoms representing a conversion of anxiety are closely associated with hyperglycæmia shown by glycosuria.

Dr. H. Rawle Geyelin[1] who has been familiar with the medical condition of the patient from the first informs me that it is not a typical case of diabetes but one which belongs to a small group which is characterized by the prominence of autonomic nervous phenomena; and that the case is further unique in that hyperinsulinism preceded the frank appearance of sugar by many months. Obviously it is impossible therefore directly to apply our conclusions to diabetes in general, without further investigation.

The patient's first symptoms appeared three and a half years before he came under analytic investigation in the form of attacks of shaking and hunger with a feeling of hollowness, or emptiness, occurring at four in the afternoon several times a week. At the same time, he developed the habit of turning his head to the right. Two months later a trace of sugar was discovered accidentally when he was being examined for life insurance. Several weeks later he consulted an internist. An abnormally low blood sugar was found on several examinations. A glucose tolerance test was suggestive of disturbed metabolism found in diabetes. One of these low readings was made during circumstances which closely paralleled a series of reactions which later occurred during the analysis.

After a time he was allowed to test his urine, but he became careless about this, and it was not until twenty-two months later that he discovered large amounts of sugar in his urine. His blood sugar was up to 233. Thereupon the patient was given insulin which he continued to receive three times a day thereafter. The amount of insulin required fluctuated widely, at times reaching fifty units daily, whereas during two summer vacations, the sugar almost disappeared. On one such occasion he was advised to omit the insulin altogether but did not

[1] For further account of the medical status of this case see H. Rawle Geyelin, *Symposium: Endocrine Glands, Problem of Therapeusis in Diabetes,* N. Y. State Journal of Medicine, Vol. 36, 1936. Pp. 1605–1606.

do so. Even a long weekend in the country often was sufficient to clear the sugar rapidly and bring on a state of insulin shock.

To the earlier symptoms of tremor, gnawing hunger, and a feeling of hollowness were added excessive salivation, hyperhydrosis, and flushing, i.e., waves of heat which passed over the surface of the body usually from below upward. He came to associate these attacks with insulin shock, though they were not always accompanied by low blood sugar. They were often initiated by an inability to focus images except at distant objects, and by annoyance at sharp color contrasts. He feared he would suddenly go into a coma, and made it a point to carry identification papers with him.

With the habit of turning his head to the right in order "to feel his neck snap" was later combined a jerking of his foot when sitting down. He explained these as a method of proving to himself that he was not entirely "numb". One day he noticed that the habit was particularly exaggerated when he was anxious and uncomfortable in a barber's chair. A few months before beginning the analysis he began to have jerking movements of his lower back as well. The compulsive tic-like quality of these movements was evident. He also developed frequent attacks of yawning.

A distinct change in the clinical picture occurred a year after the appearance of glycosuria, and ten months before the analysis. While under observation in the hospital he developed severe attacks of choking with sensations of suffocation, accompanied by fear of being smothered to death. These followed closely on nose and throat instrumentation which occurred as a part of the examination, but he had had several intimations of this reaction shortly before. The attacks were typical of a globus hystericus. He would feel as though his neck were stiff and had the inclination to shake it. He had the feeling that something was sticking in his throat which he was unable to dislodge. After the attacks, he would be concerned about long strands of mucus which he could discharge, and which he called "worms". Between attacks he was attempting constantly to bring up material that seemed to him to be irritating his

throat. Attacks often were precipitated by eating or drinking. The symptoms appeared coincidentally with his loss of sexual desire. Exhaustive analysis of these attacks revealed the typical nature of the relevant unconscious material. Lack of space makes its detailed description unwarranted here.

Subsequently attacks appeared that combined elements of insulinism and globus hystericus and which at first he mistook for the insulin shocks proper. These attacks usually occurred in a restaurant, theater, barber shop, or subway; and led him to avoid these localities when possible. "Dizziness" was the outstanding complaint. He described this as a "seasick" feeling, during which the floor, a chair he was sitting on, or other objects in the environment would seem to be going up and down; or if he were sitting in his car, he could not tell whether it or other objects were moving. The best description he could give was that it was like the sensation that one has in trying to keep a half-filled canoe upright. A fear of falling over was prominent. This "dizziness" was often accompanied by waves of heat, perspiration, and hollow feeling, as in the status of true hyperinsulinism; or feelings of pressure in the lower chest, with fear of suffocation, shortness of breath, and a weak pulse characteristic of the choking spells. Eye symptoms were often present in this intermediate variety. A fear of impending disaster was frequent "as though some serious circumstance would occur during the attack". Often a mild feeling of unreality accompanied the attack. These attacks he later came to relate to the appearance of sugar in the urine.

Several features of his medical history must be mentioned. In boyhood he had had a series of accidents, such as breaking bones, wrenching himself, cutting himself or being cut. These predominated on the left side of the body and seemed to exceed in number the lot of the average youngster. Further evidence for the existence of feminine masochistic components is illustrated by his interest in and attitude toward syringes. As a boy, he used to study advertisements of these in mail-order catalogues and remembered the particular interest which he had in the large syringes that were used to impregnate mares.

During a period when he was taking a series of injections of cold vaccine, the doctor allowed him to give himself his own injections after a few preliminary treatments. He remembers what satisfaction he took in this. Later when he was found to have diabetes, although he was sorry to have the disease, he confessed to himself that he looked forward to taking the injections of insulin as a compensation.

During puberty, he showed albuminuria which at the time was treated as nephritis. Later this disappeared spontaneously with no residual traces of kidney disorder. During adolescence he suffered from juvenile acne, periodic headaches, attacks of hay fever in spring and fall, and periodic asthma. At least two attacks of this respiratory disturbance were conditioned by emotional factors. None of these symptoms were prominent during the analysis. The last severe respiratory difficulty had occurred a year before his marriage.

The patient was the oldest of three children. He was born after a difficult dry labor, and had been nursed at the breast for a prolonged period. The second child was a girl, four years younger, followed by a brother, four years later. Neither of the siblings occupied a prominent place in the analysis.

The father was a successful business man who had attained his position of responsibility through hard work. Toward his family he was indulgent though arbitrary. He was inclined to be demonstrative toward his children to a degree that embarrassed them in later life. Both he and his wife resented the marriages of their children. Because the patient had not succeeded in emancipating himself as well as the two younger children, circumstances enabled the father to keep him under his thumb. The patient admired and loved his father and was not aware, until well into the analysis, of the repressed hostility which he felt. The infantile situation was constantly being reënacted, with sustained conflict, because the patient had given up his original ambition to study law in order to go into his father's business. His father, though promising to advance him, failed to do this and always belittled contributions which the son made, so that at times he felt he could not stand his

father in his executive capacity. This became the object of constant controversy. In the office the patient's repressed hostility came out toward another official who was close to his father and whose privileged rôle as an intimate of the head of the family and firm he resented.

From an early age the patient had become the protector and consoler of his mother. He distinctly recalled having decided to give up standing up for his own rights in arguments that occurred at the dining table because these were upsetting to his mother. The table had become the scene of bickering, because the father had the habit of bringing up unpleasant subjects at this time and of being unusually critical and severe. If the patient had guests at table, his father seemed to delight in embarrassing him. Later during his illness his most constant reactions were in a restaurant where his father and other members of the firm took their meals. After occasional quarrels between the parents, the patient would be sent by his father, after his mother's withdrawal, to patch things up, or he would go as a self-appointed envoy to comfort her. The family learned to recognize that the patient, more than any other member, had a soothing influence on her. One of his constant differences with his father was because of what he considered his father's lack of consideration for his mother. He was particularly upset when his father appeared at all intoxicated, and in one of his dreams he was shaking his father, saying: "You will kill her if you don't stop."

The patient's attitude toward alcohol is noteworthy. He had formed the habit of taking a couple of highballs after he came home in the evening, and this always seemed to quiet him and to put him in a good humor. He never got drunk and was unable to get these exhilarating effects from social drinking. He had a strong feeling of guilt about his use of alcohol and constantly spoke of it as one of his vices. On numerous occasions he was on the point of giving it up altogether, which however he had never been able to do.

A number of incidents in the conscious memory of the patient are of interest in relation to the establishment and

accentuation of a severe castration complex. At five or six years of age, he was caught by his mother exposing himself with some other children. As a punishment, the genital area was painted with iodine, and he was told that if he played further with his penis it would be cut off. He recalled having observed a boy older and a girl younger than himself mutually exposing themselves three years later, but it was not until in the analysis he had worked through the material relating to his own fear of erections that he recovered the additional memory that the boy's penis was erect.

One of the occurrences which was most telling in convincing him of the reality of his castration fear came when he was ten years old. It had been explained to him by the family and the physician that his adenoids should be removed. He readily agreed. The parental bedroom was turned into an operating room with the help of a kitchen table. It was difficult to get him under the anæsthetic because he choked a great deal. On coming out of ether, in addition to a very sore throat, his penis felt uncomfortable, and when he put his hand down there he found it swathed in bloody bandages. When he demanded an explanation, he was told that he had needed an operation there as well, but for fear of upsetting him it had been decided to do it first and tell him later. As a present with which to mollify him, the father produced a flashlight in the shape of a pistol, showing his unconscious understanding of the situation. The patient recalled vividly his terrible anger that such a liberty had been taken, an anger which remained for days before it subsided. The trauma was accentuated by the sleeping arrangements during convalescence from the operation; he was required to occupy his mother's bed, his father sleeping in his own twin bed to nurse him. Associations with this experience occurred frequently throughout the analysis and were prominent in connection with the initiation of his attacks of globus hystericus.

Shortly after this experience, a definite character change took place in the patient. Whereas formerly he had been a very active, mischievous child, up to all sorts of pranks, and a con-

siderable annoyance to his family and others, he now not only became quiet and unusually well behaved, but he began to criticize and exhort the younger children when they in their turn were annoying. The most definite change set in after his return from a summer camp which he attended the following summer. At this camp there was a minister who acted as one of the councillors. This man used to take walks with the boys and talked with them considerably. He also gave them their instruction in sex, and among other things stressed the evils of masturbation, which the patient subsequently gave up. The patient developed an avoidance of vulgar talk, risqué stories, showed embarrassment easily, and became prudish and religious. He was a model of behavior in school and hated above all things to be suspected of any wrong doing. He was known to the other boys as "the preacher", but despite all this was well liked because he was generally agreeable and sociable, enjoyed sports, and mixed well with his fellows.

During another summer at camp, he was worried about nocturnal emissions and frequent erections. At one point in the analysis, ostensibly to give the analyst a picture of him at that time, he brought in a number of letters which various camp councillors had written to his father. Later it developed that his unconscious motive in showing the analyst these letters had been to determine whether the councillors had written to his father to report on his erections. One breach of camp discipline about which he felt particularly guilty was at having been caught off bounds by an instructor while he and another boy were watching a bull. He was much relieved when later he learned in school that "wet dreams" were normal. There was a brief return of masturbation at nineteen, with a quick suppression.

He was bashful with girls and hated mixed parties and dancing until, at seventeen, he fell in love with his future wife. Then he began going out with her and enjoyed dancing. He failed to make a good enough scholastic record to encourage him to go on with schooling after finishing the equivalent of high school. This was partly due to his many illnesses and

partly from failure to apply himself to anything except what interested him at the time. He then decided to give up his idea of studying law and entered his father's business. Another important factor in this decision was his desire to get married. His preparatory training for the particular business which he entered was very thorough. In addition to a prolonged apprenticeship at home, he was sent to spend a year abroad in special study. While abroad he had his first heterosexual experience, but this was associated with a great deal of conflict and was followed by a severe bronchitis, which at the time was diagnosed as tuberculosis. Later this was disproved and after his return to this country a final check disclosed râles typical of a post-asthmatic condition.

After his return he became engaged, but his financée thereupon developed a severe neurosis from which she was still suffering when they were married a year later. Consummation of the marriage was postponed for several weeks, and the infrequent and unsatisfactory relations were attributed to his wife's poor health. After a year she was put under the care of a psychiatrist, and as she began to recover, the patient became ill. In spite of his wife's poor health and the demands which this made upon him, he was able to throw himself into his new work in the firm with a great deal of enthusiasm and to accomplish a great deal. With this his life seemed tolerable, and he was able to remain free from symptoms. As time went on, however, there was a continued failure to recognize his contributions to the business, and repeated criticisms by his father made him feel that hope of real advancement was slight. The matter was discussed on numerous occasions and was made the subject of family councils, but with no result. He remembered feeling that frustrated as he was both in marriage and work, it would be a relief to be ill. It was about at this time that the early symptoms both of his metabolic disturbance and of his neurosis made their appearance.

The patient was observed for a month before the analysis was determined upon. During this time he showed a return of sexual desire which had been greatly reduced during the

preceding year. He had intercourse for the first time in six months; the preceding occasion had been spaced at about the same interval.

The patient adapted himself readily to the analytic approach, and a positive transference made its appearance promptly. A good illustration is a dream which occurred during the third week of the analysis proper. In this dream he seemed to be driving a high-powered motor car with someone sitting in the seat beside him. He could not make out who the person was. It seemed to be more a presence than an actual person. The car struck an obstruction in the middle of the road and swerved to the left, heading for a picket fence. The patient at first seemed powerless to make any move to control the car. Just before the car struck the fence, however, he seemed to gain strength and turned the wheel just in time. He woke up before knowing the outcome. In his associations he recalled a motor trip which he and his family had taken during which a serious accident had been avoided by the patient's discovering that the chauffeur had fallen asleep while driving on the wrong side of the road. Only his quick presence of mind in grabbing and turning the wheel had saved them. The left side of this patient, as is common, represented his weaker, and thus female, side. On the same night he had a second dream in which running a temperature was the explanation for sugar in the urine.

After two and one-half months of analysis, he brought in a dream in which, as in the automobile dream, he had the feeling of another person's presence. There was an oval swimming pool that seemed to be frozen over. He went out on the ice which held him. A voice told him that if he went to the other end, he would see where someone had broken through the ice. He went forward and underneath the ice in a deeper pocket of the pool was the crouched figure of a body. The figure seemed cold and dead. The patient thought to himself that it was too bad they could not have gotten the body out before the ice froze over. Later in the analysis, this figure was definitely identified as himself and the swimming pool was associated with a room with a sunken floor in a house in which the

family had formerly lived. This room had a toilet and wash-bowl in it. Because of its tight tile floor, it was used to keep the Great Dane in, and it was often the patient's job to clean up quantities of urine after the dog had spent the night there. This same dog pulled out a large fence post, to which he had been fastened, and dragged it down the street after him. Two other associations with this sunken room were that in this room he had formed the resolve never to masturbate again, a decision to which he had held throughout his school years. He also thought of another occasion when after choking on a fish bone, he had run into this room to look into the glass. This group of associations brought together his suppression of masturbation, polyuria, and the choking sensations which were related to his later globus hystericus.

In the third month of analysis the patient reported persistent epigastric pain of a type unusual for him. This pain occurred during a period when he was receiving dental treatment. When examined by a physician for possible physical causes, tenderness was found in the region of the pancreas. Over this area of skin a slight rash appeared. The patient at first resented the inference that the pain might be of psychogenic origin. He had developed considerable anxiety about its cause and was visiting various general physicians. A dream which he had at this time represented an old friend of his father's dancing and holding a saxophone in his mouth as he danced. In another dream the same figure appeared on a boat. In one section of this boat there was an altar and the figure of a woman with a child. The figure became alive and he fell down in adoration. The man represented in the dream had a large family and used to tease the patient about not having children. In another dream he went into a theater in which all the people in the audience had thermometers in their mouths. He went in and sat down and was given a thermometer, which he did not put in his mouth, but placed it on his thigh, which seemed to be bare. It went up around 107. In his associations to this dream he thought of the flashes of heat which he had as being in some way connected with his

father. The abdominal pain disappeared entirely after a few days of analysis, ending in a shower of his usual anxiety symptoms. Following this, he was able to talk to his father and to clear up a number of things that had been rankling in his mind. His sugar also cleared and he had a true insulin shock, the first one in some time.

During the next two months of analysis, considerable material was worked through in relation to death wishes which were directed primarily toward his father, and for the first time he began to realize his ambivalence toward him. On several occasions when there was discussion of his hostility toward his father, or towards another member of the company who served as a father-substitute, the patient experienced severe symptoms of anxiety on the couch, and on one occasion, following such a discussion, he had a severe attack and almost lost consciousness immediately after leaving the office. He thus began to study his reactions in his father's presence and made the following interesting observation:

One day he went into his father's office to discuss a business matter with him and another man. He had carefully gone over the question to be presented with one of the other employees and wished to make definite recommendations. Before he was able to do this, however, the patient's father made some introductory remarks which, in the patient's estimation, had the effect of nullifying his recommendations before he had made them. His father seemed always to go out of his way to reject the patient's ideas. On this particular occasion, the patient became very angry and felt that he did not want to have anything more to do with the matter. The conference went on, however, and during it he found his mind straying from the business at hand to a careful scrutiny of his father's face. He noticed the way in which color came and went and in his thoughts he contrasted this with the healthier appearance of some other men. He thought of his father's energetic bearing and of his ability to handle a great many matters, and of the contrast between this and an occasion a year or more before when, for the first time, he had seen his father intoxicated.

The next idea was of how his father would look in a coffin lying pale and dead.

It was pointed out by the analyst that the clear emergence of such hostile fantasies might be a safeguard against symptoms, and he was asked whether he had been conscious of any. He stated that there had not been any symptoms on this occasion but that on the day previous, also when in conference with his father and some others, he had several surges of dizziness and trembling. At that time, however, none of the hostile fantasies had come through. He recalled further that one of his worst attacks had occurred in his father's office the year before. While in his presence, he was suddenly struck with a wave of emotion, first affecting his head and making him dizzy, followed by trembling, sweating, and his other usual symptoms. He was afraid that he was going to faint and excused himself. This reaction continued all that day and the next. The patient had gone to the internist's office shortly after the attack started, and low blood sugar had been found. He stated that already in the analysis he had had the experience of having some of his symptoms start and then clear up when some of the underlying ideas became conscious, but it had never before been so clearly correlated as in the situation of the conscious death wishes just described.

The patient stated that he had had opportunity to make frequent observations which had led him to the conclusion that excitement usually caused sugar to appear in the urine rather than to produce an insulin shock. He had also come to correlate the mixed attacks, which were characterized chiefly by dizziness, with the appearance of sugar. Previously he had not been able to differentiate the two and had always thought he was having an insulin reaction. His ability to recognize which was happening depended upon the degree of intensity of the reaction, the more intense being from hyperinsulinism. As an example of what usually would have caused sugar to appear, the patient reported an outburst he had had in connection with a situation at the bank when one of the subordinate officials had discussed with him the matter of a payment on a mortgage.

He became more excited than the situation warranted. Later he talked with the head of the bank and was able to accomplish what he desired. Nevertheless, the apparent injustice of the situation seemed to continue in his mind, and he talked with several people about it, apparently in this way working off some of his affect. He remembered that whereas such a situation would usually have led to the appearance of sugar, it had not done so in this instance. This situation had come up during the period in the analysis which we have just described, and the overdetermination of his affect clearly arose from his activated hostility.

The rôle of direct sexual frustration in relation to the neurosis was mentioned in the description of the onset. It is of interest that after five months of analysis, when the autonomic nervous symptoms had already improved greatly, during a period of one and a half months' abstinence which was enforced by the acute illness of his wife, the patient had a return of attacks of hot flushes, marked sweating, and an exacerbation of his anxiety symptoms and of the impulse to turn his head to the right.

Toward the end of the first year considerable material began to appear in the analysis in reference to condoms. In one set of associations he related the act of giving himself insulin injections to a feeling which he had had two years previous when condoms had become particularly unsatisfactory. He stated that both seemed to represent a turning of the penis against himself. In one dream he was sitting on a couch. At one end was his wife, and at the other, other members of his family. He had a condom in his hand and was tossing it up in the air before their eyes. In association with this dream, he remembered that on a previous day on leaving the analysis he had felt that he had made progress in the understanding of the onset of his symptoms and of his diabetes in relation to frustrations which he experienced when first married. Shortly after this dream, intercourse on one occasion was particularly gratifying. He discovered afterward that the condom he was using had broken. In association with this incident he made

the slip of speaking of secretion as excretion; thought of diapers being washed, and then made the association of condoms and diapers.

In a dream which occurred at the time of the further conversion symptoms about to be described and on the same night that he had the dream of a man in a coffin, he had another dream in which a girl and her brother appeared. The patient was in love with this girl and was going to marry her. Just as he stepped up to talk with her, a condom fell out of his clothes. Although a deeper, earlier significance of the condom was hinted at in the analysis, no actual memory was recovered.

Seven months after the appearance of the abdominal symptoms already referred to, he complained of a severe pain in his left shoulder which had appeared after leaving an analytic hour, and of a feeling of numbness in his hand. In association with this, he brought up the many injuries which he had experienced, and mentioned that certain of these accidents had occurred in connection with definite situations. On two occasions he sprained his ankle just before dances. The day before his wife announced their engagement, he had dropped a huge log on his foot, crushing it so that it needed bandages. He also recalled a serious accident his father had had in falling from a tree, and his own delight in climbing trees and carving his name and that of girls at the top.

Further associations to the affected arm indicated its phallic significance and his concern over erections. He thought of the affected arm as though it were straight out in the air like an erect penis. He recalled an incident which had appeared earlier in the analysis when as a boy he had reached out to touch a metal chain attached to an electric light and had received a severe shock from a contact made through his parents' brass bed. He recalled also the story of an incident when, as his mother bent down to kiss him while he was asleep in bed, he had flung out one of his arms and struck her across the face in his sleep. He mentioned recent symptoms of dizziness that had occurred on reading in the newspaper of a scientist who had been bitten by a snake which he had thought

to be doped, of how this scientist had taken anti-venom and was then awaiting the result.

Two dreams of this period are of interest. In one, his sister, by heating two flasks of blood, was preparing some drug which was going to have a marvelous effect. He associated the dream with tests for pregnancy. In another dream he brought out the relation of alcohol to sexuality and his idea that drinking was the father's exclusive prerogative. With his immediate family and some other relatives he was sitting at the table. Some one made the remark, on looking at the empty wine glasses, "I thought we were going to have brandy". His father became very angry and wanted to know why they didn't have brandy and shoved everyone out of the room. This seemed to be so he could get an extra drink before the family came in. The patient's mother seemed to suspect this and hurried back into the room. The father was wiping his lips, confirming the suspicion that he wanted to get at the bottle by himself. To this the patient associated his own conflict over alcohol and his inability to stop his nightly drink. He recalled outbursts of anger which his father sometimes had at the table. In the dream, while driving the family out of the room, his father's face seemed to change color. This brought up the thought of the appearance of a man when intoxicated, and, as will be seen, this flushing of the face held considerable importance later in the analysis. At the thought of his father's features, he also thought of his dentist, although the two men did not resemble each other.

Four days after their appearance the symptoms in the left shoulder and hand disappeared suddenly after an analytic hour. A few days later, the patient reported a hyperæsthesia of the skin over the abdomen, which he associated with the idea of pregnancy. Also he reported that his attitude toward shocks was changing, in that he welcomed them and felt happy about their appearance, as though they represented a good sign.

Two months later he brought in a dream in which he was lying on the analytic couch. He took out a check which he was going to give to the analyst. While he had the check in

his hand, the name seemed to change place with the figures. The analyst apparently became very much upset and leaned forward to talk to the patient, "as though trying to impress something on him". As the light struck the analyst's face, he noticed that it had a deep purple flush and that the analyst's teeth were bared. In his associations he thought of changes of color in his father's face. When the interpretation was made that the flushed face thrust forward might represent a penis, he was incredulous, but further associations to the flush elicited its similarity to the appearance of a finger which has turned purple after a rubber band has constricted it.

Three weeks later, and six weeks before terminating the analysis, the patient announced that he was finally severing his relations with his father's firm by applying for a leave of absence. The situation in the company at the time made this advisable; but he felt a great relief because for a long time he had wanted to leave and strike out for himself. In the preceding weeks he had noticed that his relationship with his father had improved greatly. Instead of trying to block his father and differ with him constantly he had been anxious to help him in any way possible. To some degree his resignation was on his father's advice.

His wife's health was poor at this time and he was under pressure from her physicians to take her South as soon as possible. A few weeks after terminating his relation with the company, he decided to leave the city but was persuaded to remain another month because of the crucial situation in the analysis.

The sensual transference became much heightened at this point, and the patient began to evidence renewed conflict over erections. More insulin was necessary to control his diabetes than at any period in the analysis. The patient brought in a dream in which his father-in-law was lying in a coffin. While he watched the body, it began to stir and sat bolt upright. The figure got out of the coffin. Then it became a woman dressed in clothes of thirty years ago. He began to dance with the figure. After a while he turned her over to his father to dance

with. He thought it was a shame to turn her over while they were both enjoying the dance so much. The figure sitting up was interpreted to him as the process of erection.

Another dream at this time was related to fingering an automatic pistol in his pocket. Later it fell on the floor and broke into two pieces. To this he associated the flashlight which had been given him after his circumcision and which did open up into two parts.

Although the relations between the diabetes and the neurosis had come out in numerous associations throughout the analysis, it was only in the six last weeks of the analysis, immediately after his resignation from the company, that the transference neurosis showed unmistakable diabetic trappings. The patient's most frequent and regular anxiety attacks occurred at lunch-time. He was in the habit of eating with other members of the firm in a nearby restaurant. Not only was there always anxiety about having his meals on time in order to avoid difficulty, but before the analysis and during the earlier part, he found it necessary to take his insulin immediately before lunch in order to avoid a reaction, presumably a shock. Thus, he had to give himself a hypodermic injection in the toilet of the restaurant and then immediately begin his meal. Nevertheless, he would frequently have symptoms of dizziness and sweating on sitting down at the table. Drinking or eating often would initiate the choking and suffocating sensations. As the analysis progressed, however, he found it possible to allow a longer interval between giving himself the insulin and eating his lunch, so that he could take the injection before leaving his office. This seemed to cut down some of the reactions which he would have while giving himself the insulin.

A few days after the dream of the figure in the coffin, he came one day complaining of pain in his right shoulder and in two teeth. He had first noticed this on awaking from a dream that morning. The pain in the teeth had disappeared, but the shoulder symptom persisted and was accentuated during the hour. In the dream he had been sitting on a low stool in the toilet giving himself an injection. An erection had occurred

simultaneously. Just at this moment one of the men in the office, toward whom he felt a grudge, came in. The patient stooped over in an effort to hide the erection. Further associations to the pain reminded him of electric shocks which he had received, particularly the one which had occurred in his parents' bedroom. He thought of his having been afraid at school of doing anything for which he would be reprimanded. He recalled particularly the time that he was caught out of bounds when he and another boy had gone to observe a bull in a neighboring pasture. This same feeling of guilt seemed to persist throughout his schooling after his suppression of masturbation. In further association to the dream of taking insulin, he thought of his fear of having an erection when under ether, his fear of operations, and his fear the first time he went to a barber shop.

In a dream a few days later, the patient's penis was encased in a glass tube resembling a test tube. This tube seemed to exert considerable pressure on the penis and when it was withdrawn he noticed a hole on the side of the penis. In this hole was a long, small brush, like one used to brush suede shoes. After this was withdrawn, the wound healed up, leaving a small scab. The wound was the result of the pressure of the tube. The crowded feeling in the test tube made him think of fæces pressed against the body and held there with a diaper. The association between condom and diapers has already been noted. The episode in which he had exposed himself with other children and had been painted with iodine also came up. Three days later the pain in the right shoulder disappeared.

In association to a dream in which he seemed to be having an erection with numerous people observing him, he spoke of the fear that he used to have that his erection would be observed, and thought this was why he had not liked dancing. He recalled times in which he would have erections when driving a car or riding on a train, and he thought that this might be the reason he had dreamt so much of accidents in automobiles and trains during the first part of the analysis. Fear of erection did not seem to trouble him after his mar-

riage. He wondered if this were actually true, as he thought, or whether it had not been working in a subterranean fashion and causing his diabetes. At this stage in the analysis he had a definite feeling that something had cleared up. Recently he had caught himself noticing women and wondering how it would be to have intercourse with them. He also wondered if he could get an erection if another person were looking at him; or how it would be if his family saw an erection. He then realized for the first time why he had brought the camp letters to the analyst earlier in the analysis; and also for the first time recalled that the boy who had exposed himself in front of him with the little girl had had an erection.

The following dreams were brought in a month before the termination of the analysis. He was in a room with the analyst and two other persons. The patient was kneeling by a table in the middle of the room and someone seemed to be on the couch, but he was not sure who it was. As the patient was talking and saying something about eyes, a men with dark glasses passed by in the corridor outside and went into a room directly opposite. He seemed to be offended by what had been said. (The patient was often forced to wear dark glasses on account of photophobia.) Later in the dream the patient seemed to be talking with a nurse and explaining to her that he had put so many injections into his leg that it had become hard and that he had decided to put them into his abdomen instead. He explained that this was not low down in the abdomen but up over the diaphragm. He showed her a mound-like place on his leg which resembled an island sticking up out of the water that was covered with green shrubbery. She told him she would show him how to fix this and took her hands and squeezed and rubbed it. It went down and he had a feeling of relief. Later a small tree with branches appeared there. On the branches strawberries hung. She again offered to treat it. With scissors she cut off the branches bearing the strawberries and later cut off the trunk of the tree.

In association he thought of strawberries as being heads of penises; and of the mound also as a penis. He stated that the

skin of his leg had actually become hard from the many injections. The man with the dark glasses seemed to interrupt the treatment going on in the room where the patient was. There were no associations to this man except that he could not see well. He made the further statement that the man "could not help looking in as he went by". The patient became very restless at this point and complained of a constricted feeling in the throat. To further questioning with regard to the injection in his abdomen, he pointed out just where it was supposed to be given directly over the pancreas, and recalled that this was exactly the spot where he had had his pain the year before.

During one of the hours at this time the patient made the statement that he was having frequent erections at night and also that he was again able to reduce his insulin. He also reported that he kept imagining the odor of fæces. At the time he reported these changes, he brought in a dream which identified the analytic hour with the midday injection of insulin, which had been the most frequent cause of accessory anxiety symptoms. In this dream he was looking at his watch and found that it was a few moments after one. He suddenly remembered that he had missed an appointment with the analyst at noon, which was the hour for his insulin—but never the hour for his analysis. It was thus too late to go. His first association was to another dream which he had had on a preceding night. In this dream a man was going to buy some insulin which a doctor had prescribed for some digestive difficulty, not diabetes. In the dream the patient told this man that inasmuch as he would not have to use insulin for much longer he would let him draw it from his own bottle. The man accepted the patient's offer and produced an enormous syringe. It was blue and graduated like an ordinary hypodermic but had no needle on it. The patient decided that it would take a whole bottle to fill the syringe even once, and withdrew his offer. It was pointed out to the patient that in the dream of missing his appointment he had substituted the analysis for his midday insulin injection and the meal which he always feared to miss. At this the patient began to breathe

in a labored manner, fidgeted violently on the couch, and suddenly sat bolt upright. When questioned, his first thought was of having a movement. When it was pointed out to him that this probably represented a symbolic erection, the patient felt much disturbed to think that this might be possible. He stated that he had just experienced the same sensation that he used to have in the middle of the night when he would waken out of a sound sleep and sit up, apparently a pavor nocturnus as a substitute for erection during sleep. He thought again of choking feelings in connection with the sensations which he had experienced on riding on trains where also he had had to fidget a great deal. During the hour the patient recalled having broken off a needle a few days before, and associated this with the item in the dream that the big syringe had no needle on it. Associations which kept returning to him in a subsequent hour were of the big syringe and the previous dream of missing the twelve o'clock appointment, both of which again were associated to a brass crib which stood in the parental bedroom, and which presumably at one time he had occupied.

At this point in the analysis, two weeks before its termination, he brought in the following dream: He was in a restaurant which he associated to the one where he usually eats lunch. The waitress was the same. Three men were sitting at the table, two of whom he recognized as from the office. The first man announced that he was going to have an erection. The second said something about showing him how he could have one as well. Some sort of struggle ensued. The first man had an erection which he took out of his trousers and put under the table so that only those around could see it. The second man had one which was larger than the first. The third man then had an erection that was enormous and larger than those of the others, which he proudly displayed in his lap. The waitress came over to see it and expressed astonishment. Then the character of the penis changed. The lower part acquired something like a curved decoration and the top took on the form of a mushroom until finally the whole thing resembled a large wedding cake with tiers built up one upon

the other and covered with decorations. It was yellowish in color like the walls of the analyst's office. The man then detached it and put the whole thing inside his vest. The patient seemed to be a detached onlooker at this whole proceeding.

During his associations he was asked where he kept his hypodermic syringe. He indicated the same spot that he had referred to in showing where the man had put his cake-penis; but when this was pointed out to him, he explained that it was not the same because this was inside the man's vest and not in his coat pocket. He stated that he had had an insulin shock which he believed was related to the dream. He had awakened that morning with the empty feeling which usually preceded such shocks, and had an intimation that he would have one later, and that it would be related to the dream. The shock occurred about noon. He thought again of the large syringe and of the dream of missing the twelve o'clock appointment.

Two days before the termination, he brought in two dreams which had the quality of nightmares. In one of them he was bringing a bottle of whiskey to his business office. It was in a cardboard box and he took it out and looked at the patent stopper. Just at this time some people came in and he tried to put it together and conceal it. Among those who entered was his father. Later, after they had left, the bottle was gone. He suspected that his father might have taken it and later saw him outside and found that his surmise was correct. His father asked if this belonged to him and returned it. He found, however, that part of the contents had been removed and he accused his father of having taken the whiskey.

In another dream he and his father were together in a way which was reminiscent of times when they took a surreptitious drink together before dinner. On awaking, he opened his eyes and looked toward the figure of his wife, lying beside him. He seemed to see a red haze in her place. Then in the position where his wife had been, he saw very clearly and distinctly the head and face of his father. It was very red and animated and

extremely vivid. He was awake and could not believe his eyes. When he closed them the image disappeared but whenever they were open, no matter at what part of the room he looked, he clearly saw the head and face. The vividness of the hallucination then began to fade to a dead whitish tone, and the figure became blurred and distorted. The patient was in terror for fear it would assume some more fantastic shape. He got up and went to the toilet. Subsequent tests showed marked glycosuria. In another dream the patient took himself to task for drinking, and decided that he would give it up and pay more attention to his wife.

At the last analytic session he reported that he had had a dream the previous night in which he seemed to be in snow. He associated this dream with two lewd stories that he had heard when he was ten years of age, which had made a great impression on him, and which, although he rarely was able to remember stories of this sort, he had never forgotten. In the first story, a woman at a dinner party, whose name was Snow, got up and left the table. She was gone a long time when a man got up to look for her. He also remained away, so a third guest continued the search and found the man "buried so many inches in Snow". This reminded him of another story of a man who had an erection while at the table and was so embarrassed to know what to do with it that he put it through his button hole. In his associations he brought up his own conflicts at table and the insulin shocks at the restaurant. He reported what he felt to be a satisfactory working through of his passive homosexual tendencies, of which he had become aware during the analysis.

He reported further that in the preceding two weeks his sugar reaction had been different. Instead of a gradual rise over several days in the amount of sugar in the urine, to reach a peak, followed by a series of insulin shocks which lowered the sugar level, he would find heavy traces of sugar in the morning followed by insulin shocks and a rapid clearing of the urine sugar. This up-and-down reaction had never before occurred

in this way, and he did not know how the account for it, unless it was due to the analysis.

The analytic material of the last two months of analysis pointed to a strong unconscious resistance as the chief reason for its termination, though the patient repeatedly denied this, and presented practical reasons which were impossible to ignore. The analysis seemed to be rapidly approaching the recovery of memories of a primal scene; but it was impossible to verify this before he left. One would also suspect that the diabetes represented the last stand of the neurosis, and that this he had very strong resistances to giving up. The dream in which all his insulin was in danger of being used up would seem to indicate this.

The autonomic nervous symptoms of which he complained improved definitely during the analysis; and he was able to resume activities which he had had to give up, such as riding on subways and trains. He had resumed his interest in work, and felt in a hopeful mood at the time the analysis was discontinued. His plan was to resume it after a few months' interval, but this was indefinitely prolonged.

On his return from the South the patient reported four months later that, in spite of many external difficulties, he had never felt better in his life. However, immediately after his return, he had suffered another serious injury to his foot. After six months he reported that he was free from his nervous symptoms, but that his diabetes had not shown any marked change. No further word has been heard, except that he had accepted a good position with another firm, and that he still intends to continue his analysis at some time.

It is a matter of conjecture whether the analysis he has received or further analysis will succeed in curing the diabetes. The fact that his diabetes practically cleared up during prolonged rest away from the city, even without analysis, would lead to the conclusion that this is a reversible reaction, and that with the final resolution of his neurosis, his diabetes would

disappear as well, if they are as definitely correlated as the analysis would lead one to suppose.

In an attempt to classify this case, it is necessary to bear in mind the patient's early tendency to develop symptoms of organic illness which, in view of his history, would seem to have had a relationship to his instinctual conflicts. His immediate illness followed the same lines. In its initial form it resembled an anxiety neurosis with a metabolic disturbance. A tic supervened; and some of the later anxiety attacks took on an hysterical coloring.

The question arises whether the entire neurosis would be amenable to analysis or whether a portion would continue always to discharge at the physiological level. The trend of the disease both spontaneously and in the analysis was for the original physioneurosis to evolve into a psychoneurosis. The reason why this did not take place more readily would seem to have been the intensity of the castration fears with the resultant repression of any genital expression either direct, or even in the usual form of hysterical conversions.

The patient has strong oral character traits and his conversion symptoms tend to follow this path, but meet with a strong prohibition. He has characteristics that might easily lead to drug addiction and it is a question why alcohol is not the drug of choice. In another communication, I have presented a case in which alcoholism was a substitute for masturbation. In this case the relation of the insulin to masturbation comes out clearly. I believe the alcoholism did not develop further because of the same strong oral and genital inhibitions and because the conflict was acted out largely at the metabolic level, and stabilized at this level by the erotization of the anxiety.

Depletion of his native stores of insulin through constant expression of anxiety called for its artificial administration.[1] The insulin has the value of a habit forming drug, with its peculiar method of administration playing an important rôle.

[1] This statement depends on an *insulinogenic* theory of diabetes which some observers (Loeb, for instance) reject.

Treatment, therefore, must be directed not only to a psychoneurosis, but to a drug addiction.

In this communication I have been content merely to indicate changes in the insulin requirements and the urine sugar levels as they were related to emotional expression or conflict. I realize that this may be somewhat disappointing, but exact relationships could be established only by regular and carefully controlled studies of the urine and blood sugar, which were impossible in this case. Should such an opportunity arise, it would be important to consider the feasibility of studying corresponding variations of the sexual hormone in blood and urine. By so doing, it might be possible to establish a relationship between the amount and character of the hormone, male or female, and the nature of the conversion symptoms. A physiological index to the degree of erotization might thus be developed, and in making such an investigation the measurement of the metabolic products of neurotic anxiety would appear to be the best starting point.

DISCUSSION

1. Remarks by Dr. Bertram D. Lewin:

It is eminently fitting that Dr. Daniels should have addressed this Society on the psychological problems in diabetes and insulin therapy; for in a sense the whole experimental work on diabetes and insulin began with an observation of a psychopathological phenomenon in dogs. A certain dog, from whom Minkowski had removed the pancreas during a research on digestion, suddenly showed a remarkable character change. Hitherto well-behaved, he began to eat his fæces and drink his urine; he became a "problem dog". Minkowski investigating these symptoms found that he had diabetes, and out of this initial observation developed the studies of the pancreas which later culminated in the discovery of insulin. Dr. Daniels' paper in a sense too stems from this initial observation, for it takes up again the problem of the interrelation between the physiology of diabetes and psychological facts.

2. Remarks by Dr. Earl Engle:

Dr. Daniels' approach, in an attempt to correlate psychoneuroses with such measurable physiological functions as sugar metabolism, is extremely interesting. We are all aware that the diabetes problem was not closed with the discovery of insulin. Indeed it has become an experimental problem of very great interest since the discovery (by Houssay) that the removal of the anterior pituitary before the extirpation of the pancreas enables the animal to utilize sugar without

administration of insulin. The relation of the anterior pituitary to the gonads makes doubly interesting the problem of sex disturbance in these cases.

Dr. Daniels has mentioned the possibility of assaying the sex hormones as well as studying sugar levels in this particular group of cases. The techniques for such assays are now quite dependable. Koch has a satisfactory method for extracting estrin, a female sex hormone, and also a male sex hormone from the urine of men and women. Actual standards as to the amount of each hormone which is normally excreted day by day by either sex are not available for any number of individuals.

While the work will be done by someone, I personally have two mental reservations. First, I do not understand the significance of a sex hormone which is excreted in the urine. Is it eliminated because it can not be used, or because it represents an excess amount in the organism? If it represents the water through the flume which has already turned the turbine, then the measurement of its excretion is important. The second reservation is more fundamental. The sex hormones are essential to the functional maintenance of the genital systems. It is not clearly demonstrated that the sex hormones have much to do with sexuality, as Dr. Daniels and his colleagues use the term. The interaction between "mental" processes and the more accurately measurable physiological processes should and will receive more attention as projects of group research.

3. Remarks by Dr. Robert Fliess:

In a neurotic who has diabetes we face a person who has two ailments. In order to obtain clarity in this clinical picture it might be valuable to start naïvely from the nosological entities to which we are accustomed, and to adhere to the old-fashioned conception that there are such things as purely organic, and purely psychic conditions,—at least in the abstract. We then can attempt to establish order in the symptomatology, trying to put the symptoms under the two respective captions, neurotic, and diabetic. In so doing we seem to succeed in establishing two discrete groups:

A. *Purely diabetic symptoms:* glycosuria; diabetic blood sugar curve; low blood sugar level (this latter possibly being an artificial symptom, a side-effect of the administered insulin).

C. *Purely psychic symptoms:* the various tics relative to head, foot, lower part of body, etc.; eye symptoms; globus hystericus; choking sensations.

But we then find a number of symptoms remaining, the classification of which remains doubtful. Putting them under the separate caption *B—Ambiguous symptoms,* we easily recognize that each of them *a priori* might be looked upon as a psychic symptom as well as a physical one. They are: cessation of libido sexualis; flushes; attacks of ravenous hunger; anxiety.

A discussion attempting to decide upon the classification of these symptoms in group B encounters the particular difficulty that the alternative is not only: psychic origin (=conversion) vs. organic origin (=diabetes), but that the group organic in itself contains the alternative: diabetic vs. experimental (=insulin effect) vs. anxiety-neurotic.

The question then arises, do we have sufficient methodological means to

carry through the analysis of the symptom group B to the point of conclusively deciding about the respective origin of its symptoms? In order to answer this question we have to take up the single issues separately: conversion vs. anxiety neurosis, and conversion vs. insulin effect.

While he considers anxiety neurosis as an organic condition in a person who is a victim of a toxic effect of sexual substances which his improper sex activities do not permit him to expel, Freud gives as the criterion for the clinical differentiation of the symptoms only the impossibility of analyzing them. This criterion cannot be applied here because the analysis has been broken off prematurely by the patient. (I may be allowed to mention a personal opinion regarding the phenomenological identity of actual neurotic and conversion symptoms: I do not feel them to be identical, but similar. After having had enough opportunity for observation I found that actual neurotic symptoms resemble conversion symptoms only in their cruder features, deviating in some finer accompanying traits. But though impressing the eye of an observer, it does not stand exact description, and cannot therefore also be used for our analysis of the symptom group in question.)

The next issue to be considered would be: conversion vs. insulin effect (respectively diabetes). Here we seem to have a criterion in as much as we expect the insulin effect (respectively the state of diabetic decompensation) to be accompanied by a low blood sugar level. But this is a false criterion, and it shows Dr. Daniels' keen sense of differentiation that he did not use it. Not necessarily does the hyper-insulinism go hand in hand with a low blood sugar level. Long before that could be verified by detailed clinical observation, two American physiologists, Mann and Macgath (*Arch. of Internat. Med.* XXI, 797, 1923) made a series of experiments, the significance of which justifies a brief summary here. They removed the pancreas making the dog diabetic, and then removed the liver, with the result of getting the typical clinical picture of insulin shock. They then varied the interval between the two operations, recording the blood sugar content. It was in the course of those registrations that they found, for instance, that the shock following the removal of the liver performed 92 hours after the removal of the pancreas was accompanied by a blood sugar content of 200 mg%. Further physiological investigations during the last decade resulted in the present conception of the theory of "insulin shock" according to which it is not the sugar content of the blood but the probably indigestible physico-chemical state of this sugar that causes the shock. Thus we find ourselves deprived also of this criterion.

So we see that as the result of our methodological investigation we find it impossible to reach a decision regarding the classification of the ambiguous symptoms.

As far as the relation in general of an organic disease to a neurosis is concerned, it is valuable to remind ourselves of the fact that Freud declares that even the mere question of the *"Neurosenwahl"* is a problem of organic medicine. Libido fixation at a particular stage of the libidinal development which creates the disposition for the selection of a particular type of neurosis according to him, contains a constitutional, i.e., an organic factor. Thus the question of when and why an organic ailment is chosen to take over the rôle of neurotic

symptomatology may be considered certainly as a problem of organic medicine. But the means which medicine has at its disposal for the study of the nature of dispositions are by far not sufficient to throw light upon the conditions which enable a neurotic to use his organs proper instead of limiting the shifting of the libido to the *"Organrepräsentanzen"*, as one does in conversion.

4. Remarks by Dr. Abraham Kardiner:

Dr. Daniels' paper affords the analyst and internist a rare opportunity of finding a common interest in a case. In this particular instance the internist is at a great advantage in that he has a working definition of organic disease, backed by centuries of tradition, a clinical orientation rooted in a pragmatic attitude to organs and their functional interrelationships. The analyst has no such working definition. He cannot take over the weapons of the internist, because they are couched in concepts which cannot be translated into terms of motive, wish, desire, or instinctive drive or their vicissitudes. Though the internist and analyst both know that the organ is an executive weapon of the ego and at the same time the creator of certain tensions, no way has been found to connect them with the outer world, or to establish their connections with the executive ego.

The gentlemen who preceded me in the discussion have indicated however that an attempt to breach the gap is on the way. Dr. Fliess gave us a very daring conception of organic disease: that in an organic disease the patient acquires a *"Gelegenheitsapparat"*, which expresses in this somatic way tensions which are the equivalents of affect. Dr. Engles spoke of the "wisdom of the body" and the remarkable precision with which functional balance is maintained; Dr. Jelliffe spoke of organs as "fixed precipitates of experience". Now all these views are interesting and stimulating; scientific ideas cannot however be evaluated by their suggestiveness, but by what working tools they place in our hands. Those mentioned do not give us tools with which to bridge the gap between disturbances of instinct life and disturbance of organ function. Our knowledge of organ function is continually increasing, but our knowledge of the tensions they create and to which they respond, are not known in terms of instinctual needs.

Psychoanalytic work on organic disease has proceeded largely on the basis of our knowledge of conversion hysteria and hypochondria, both dealing with specific methods of reproducing regressive pleasure tensions (or preventing them). This discovery led to a definite way of thinking of organic changes in terms of the content of dreams and fantasies associated with them. How the ego mobilized the soma to this distortion of function is not known; but from the point of view of methodology, it introduced some crucial errors. Between the psychic content and an existing organic condition there is not only no direct connection, but it was entirely overlooked that the organic disease is not the product of this wish concealed in the content, but that the content may be a reaction to the organic condition. In other words, does a pregnancy fantasy produce a neoplasm, or is the content "pregnancy" a clumsy effort secondarily to bind the devastating tensions created by the tumor and put it to some good use?

Alexander recognized this error and observed that the connection between organic disease and the wish tensions found in connection with them was not a direct one, but was preceded, in the case of gastro-intestinal lesions, by disturbances in innervation, circulation and secretion, the disease itself being something of an accident. Alexander uses a very special case, the gastro-intestinal tract, but he fails to establish a specific etiology. Specific wish tensions, like those described in connection with gastric ulcer, exist in persons who have never had any gastric symptoms and can indeed be recovered in phobias, and in cases of asthma. We cannot further pursue Alexander's stimulating work but to say that the gastro-intestinal tract has a very direct connection with the sensorium, and its activities form prototypes of certain primary attitudes of the ego. What Alexander fails to do is to tell us how these basic ego attitudes usurp the utility function of the organ.

The case discussed by Dr. Daniels cannot be evaluated on any of these above mentioned criteria. The disease has no locus. There is no pain, there is no organ that is the carrier of specific attitudes, no conscious knowledge of any disturbance of internal economy. If the pancreas is the diseased organ what stimuli came from pancreas to sensorium? It takes no direct part in erogenous development, and is not directly a carrier of pleasure tensions. It is just such a condition which is most likely to have a disrupting influence on the ego, because no organized defense is possible.

In studying this case we have the choice of seeing the effects of the illness as aggravating preëxisting psychosexual conflicts, or seeing the illness as a product of these and other conflicts, and one can view the course of the analysis as indicating that the incapacities, anxieties and helplessness, the oscillation between aggressive attitudes and dependent ones are reflections of an injured ego, and therefore not to be evaluated in the same way as hysteria.

There are several indications that we ought to follow. The internists in the case agree that this case had a preponderance of autonomic disturbances, moreover that these disturbances preceded the diabetes by several years. These symptoms are tremors, sweating, globus, albuminia, asthma, eye symptoms, spastic phenomena, dizziness, fainting, etc. These Dr. Daniels identified as the basic physioneurosis. These symptoms are certainly not specific, are not the product of toxins, and are usually indications that certain ego functions, which may escape our recognition, have been contracted and withdrawn and their channels of discharge blocked. The autonomic symptoms themselves are the result of the stasis produced by the pressure of *"Bedürfnisspannungen"* on a defective executive apparatus. An additional proof of this is a fact not included in Dr. Daniels' presentation, the dream-life of the patient which is filled with violent sado-masochistic extremes, with aggression to love objects. If we could only identify the ego inhibitions of which these stasis phenomena are symptoms! It has been my good fortune to be able to observe in conjunction with these phenomena severe thyroid disturbances, gastric disorders, even gastric hemorrhage. Whether albuminuria, asthma and even glycosuria can follow from it I would not venture to guess. It cannot be devoid of significance though when this patient's aggression was discharged the sugar disappeared from the urine.

At all events, the existence of these phenomena should qualify our attitude to the content of the patient's productions. I hold it to be an error to view them all as expressions of psychosexual conflicts. I believe the material tells us also of the disorganized state of the ego. The very first dream is an indication of the collapse of the ego, be it due to old conflicts of psychosexual character aggravated by a new insult to the integrity of the executive apparatus. I see this conflict even in the dream of the penis turning into cake. The lability of his assertive attitudes and the speed with which they turn to dependent ones are to me definite indications of this deeper conflict. Throughout we find constant efforts to secondarily bind and erotize the disturbed situation.

I have ventured on a dangerous hypothesis for it is not one capable of ready proof, namely, that the illness may be the end-result of a series of inhibitions whose nature we do not yet recognize, but whose effect is detectable in stasis phenomena with efforts of ego regressions. This hypothesis may turn out to be all wrong; but I prefer to work with it rather than with philosophical judgments having no clinical applicability.

At all events there are three places where this hypothesis has proven workable: in the traumatic neurosis, where it was shown that ego functions that have direct connection with the sensorium can be inhibited. These inhibitions themselves are silent; all the noise is made by the stasis created by them and by the disorganized character of all executive efforts. There is, in addition, a very difficult problem. What is the relation of these internal organs to the instinctual purposes they further by maintaining an internal economy? There must be some connection, for a failure in some aspects of adaptation disturbs this internal harmony.

We lack the knowledge to answer this question. Perhaps the answer lies in the study of infant adaptation, where the contact with the outer world is less complicated. We do know that in infants mass inhibitions can be instituted, involving circulatory and metabolic functions, in syndromes well known to pediatricians. These cases show no morphological changes other than *cessation of function.* Dr. Simmel has reported a case in which kidney function became inhibited with resultant uremic condition. This is a signal case.

Perhaps the discussion leads to no immediate positive results. We learn, however, that in pursuing this problem we cannot fruitfully use the criteria employed in studying conversion hysteria. By pursuing psychosexuality alone in these cases we can only succeed in telling ourselves what we already know. If we take the stasis phenomena as our starting point and learn to identify the contraction of function other than sexual which they represent, we may get somewhere. At all events it is a tool to work with, right or wrong.

5. Remarks by Dr. Smith Ely Jelliffe:

Dr. Jelliffe said that some thirty years or so ago his curiosity regarding the significance of psychological factors in diabetes had been aroused by hearing Dr. Douglas Singer—he thought it was he—detail the history of a manic-depressive psychotic who had a series of depression attacks during which she showed no involvement of any particular organ function, but who in the well

periods had a definite diabetes mellitus which strangely cleared up *pari-passu* with the onset of the depression. He had met this selfsame situation on several occasions.

Psychoanalytic psychiatry has established the profound relationships of sadism to the depressions and hence he had begun a systematic search for sadistic quanta in the unconscious of a few diabetes mellitus cases which had come to him more or less by accident. In all there was profound sadistic cathexis of the father hostility—all having been males. Inasmuch, however, as in every deep analysis sadistic material always turns up, he had for many years tried to formulate some ideas as to the quantitative estimation of the energy quanta of these investments. He had asked Freud about this, also other analysts, and had frequently brought the matter up in this Society, since he was of the opinion that one of the important criteria that separated the reversible conversion displacements of the hysterias, the organ neuroses so-called, from the irreversible malignant conversions, lay in this generalization. That such cathexis would cause irreversible molecular rearrangements—i.e., organic disease when massive in intensity (analogous to high voltage and/or great amperage) or when if not so heavily loaded but operated over a number of years, i.e., classically by forty. He had said this frequently in this and other Societies for years before Bergmann, speaking of gastric neuroses, made a somewhat similar generalization. It was, he felt, a valid general principle and it applied to many disease situations. It was, however, to be borne in mind that it was necessary to do more than analyze the unresolved œdipus components in their quantitative aspects. It became important to study other factors in the ecological "interrelations of the wisdom of the body"—i.e., the homeokinesis, as he preferred to call Cannon's terms, and its derangements.

Speaking in general terms and not entering into all of the links of the diabetic chain, especially the pituitary ones, as Dr. Engles has so nicely shown, he would stop for a moment and suggest where some insight into the complicated problems might be obtained. He would begin with the pancreas, and especially that aspect of the pancreas that was interested in carbohydrates. Ever since he had read Maudsley's definition of an "organ as a bit of structuralized experience" he had always asked himself the question just what has any particular organ specialized in. Here the answer was mostly experience in handling carbohydrate energy transformations. Thus one of the first questions he deemed of service in a deep analysis was to learn more what through identification, through displacement, through symbolization was the nursing baby's attitude towards the carbohydrates with which he came in contact early in his career. To him, conditioned or unconditioned reflex conceptions, while of service as an intellectual challenge, were not enough. He would like to have learned if possible what were the initial phases of the nursling's identifications especially to lactose and other carbohydrates as they were added to the diet. Where were the resistances, avidities, greeds and aversions? There are hosts of these to be traced not through taste alone but, even possibly of more significance, through olfactory and other sensory sources. Here was a field he missed entirely in Dr. Daniels' more than admirable paper.

Then to pass abruptly to the opposite end of the chain namely the effector demands of the carbohydrate store he first would emphasize the significance of "thought" as "muscular action", which has never been measured in calories. He recalled many discussions in 1895 with Professor Atwater of the Man in the Box on this type of problem. This immediately ties up with sadistic impulses and the adrenals. Here Cannon's apt antithesis fight and flight is relevant. Large amounts of actual muscular attack call for increased adrenal supply. He believed the same situation arose and even more so in the activity of unconscious sadism. Cannon's "rage" reactions of cats and dogs are imperfect registers, but they show the validity of the hypothesis which Singer's depressed patient originally suggested. Then to complete a part of the cycle, it may be said that continuous action of the muscle—and/or thought-hostility demanded more sympathetic impulses to the pancreas for more carbohydrate for the greater effector craving of the sadistic satisfaction of annihilation of the hated object. Here is where the pancreas does or does not respond to the demand on the ground of specific greeds or aversions of the early carbohydrate identification values.

In a more carefully presented sketch, he felt he could intercalate figures of experimental value at many points in the cycle, even though the physiologist admitted gaps here and there—lactic acid production as a measure of muscle use for instance; liver metabolites also—but the physiologist was impotent in the face of the *"purpose"* demand and its energy investment. The psychoanalyst was hunting for quantitative criteria more significant than basal metabolism to measure the energy of craving needs and satisfactions behind the numerous symbolizations of the unconscious where subjective affect was being translated into objective data. Claude Bernard, who as we all know stands out as a monumental figure in the search for an answer to the diabetes problem, must have meant something like this when he said, "Some day the poet, the philosopher and the physiologist will talk the same language and understand each other; then a true science of medicine will arrive."

6. Further Discussion and Summary:

Dr. Binger raised the question whether this was a case of true diabetes mellitus. Dr. Kelman cited several cases of amenorrhea in which such simple maneuvers as arranging for a urine test for pregnancy had been sufficient to bring on a period.

Dr. Daniels, in answering Dr. Binger, referred to Dr. Geyelin's summary as quoted in the text. Drs. Geyelin and Elliott Joslin, who had also seen the patient, had come to the conclusion that it should be diagnosed a diabetes mellitus. Dr. Geyelin had classified it as among a group of diabetics, in whom autonomic nervous symptoms are predominant.

In replying to Dr. Fliess, Dr. Daniels asked whether those instances of anxiety with complaints of ravenous hunger described by Freud might not show characteristics of hyperinsulinism. In replying to Dr. Fliess's discussion of the definition of insulin shock, Dr. Daniels mentioned the custom in some clinics of calling autonomic nervous symptoms "insulin shock", even with blood sugars as

high as 140. The idea behind this is that the symptoms associated with insulin shock are due to the antagonistic action of the adrenals after the blood sugar has dropped a certain amount from the sudden out-pouring of insulin.

In reply to Dr. Jelliffe's remarks Dr. Daniels pointed out that it would be possible to supplement the paper with a great deal more aggressive material which had come out in the analysis. These trends were further brought out in the patient's phobias. The case also illustrated many actual frustrations as causative factors in the manner emphasized by Dr. Kardiner.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Addenda to "The Medical Value of Psychoanalysis"

Franz Alexander

To cite this article: Franz Alexander (1936) Addenda to "The Medical Value of Psychoanalysis", The Psychoanalytic Quarterly, 5:4, 548-559, DOI: 10.1080/21674086.1936.11925299

To link to this article: https://doi.org/10.1080/21674086.1936.11925299

Published online: 11 Dec 2017.

ADDENDA TO "THE MEDICAL VALUE OF PSYCHOANALYSIS"

BY FRANZ ALEXANDER (CHICAGO)

1.

The Contribution of Psychoanalysis to the Knowledge of Psycho-Somatic Relations

The first beginnings of psychoanalysis go back to the concept of "conversion hysteria", in which psychological factors cause bodily symptoms; in fact, one of the first psychoanalytic case histories of Freud, the case of Dora, is devoted to the explanation of somatic symptoms from unconscious psychic influences.

Freud's original view of hysterical conversion has been already described in the second chapter of this book.[1] The essence of this theory is that every psychic tendency seeks adequate bodily expression. The normal way of such expression goes through the system which is called the conscious ego, which is probably localized anatomically and physiologically in the cortex. The conscious ego has control over those muscle innervations which serve to relieve psychic tensions that originate from our biological needs. All our voluntary innervations serve to satisfy these needs by appropriate activity. There is also a series of automatic psychomotor phenomena which serves to express emotional excitation such as weeping, laughing or blushing. If the passage through these normal channels is blocked, i.e., an emotional tendency is repressed, an unusual relief comparable to a short circuit takes place in the form of an unconscious innervation. This is the hysterical symptom. It gives symbolic expression to the repressed wish or wishful fantasy, and thus serves as a substitute for a volun-

---

These and other new chapters will appear in the new and revised edition of Dr. Alexander's *The Medical Value of Psychoanalysis*, published by W. W. Norton & Co., New York.—Unless otherwise stated all page numbers in the footnotes refer to this book in preparation.

[1] See pp. 53 to 62.

tary action, which the patient cannot carry out because of its objectionable content.

The main difference between conscious and unconscious innervations is that the latter do not go through the conscious ego. If it is really desired to give an anatomical-physiological explanation for this difference between conscious and unconscious innervation, it could be assumed that the conduction of the sensory stimuli to the motor fibres takes place in hysterical processes through subcortical centers, and not, like voluntary innervation, through the motor centers in the cortex. However, so far, knowledge of the anatomical-physiological basis of these processes is lacking, and even methods of investigating it do not exist. The psychoanalytic technique, on the other hand, makes it possible to reconstruct at least the psychic side of the psychomotor processes and to make conscious the unconscious content of them. The therapeutic significance of this procedure is that the unconscious psychic stimulus, after having become conscious, has the possibility of finding relief in the normal ways of expressing emotions which destroys the dynamic foundation of the neurotic symptoms.

Thus every emotionally conditioned disturbance of an organic function is essentially similar to such normal psychophysiological processes as weeping, laughing, or blushing. They differ from those normal reactions, however, in three important points: 1. In the case of a psychogenic disturbance of an organ the emotion which seeks expression is unconscious, that is to say, repressed. Normally the individual who laughs or weeps is able to some degree, at least, to define the psychological reason that impelled him to laugh or to weep. This is not the case with patients who are suffering from a stomach neurosis. Such a patient is not able to describe those emotions which are responsible for his stomach symptoms; he is not even aware of the psychic origin of his symptoms; he will deny it and try to find some somatic basis for his ailment, and in so doing is, in most cases, supported by his physician. 2. The psychogenic disturbance is an unusual or, one should say, an incomplete expression of a psychic tension. It does not give full relief to

the causative emotional tension in the same way as laughing or weeping do. 3. The symptom not being able to relieve the psychic tention in the same way as normal psychomotor reflexes do, a permanent tension is sustained which is the cause of the chronic dysfunction.

2.

Critical Discussion of the Extension of the Theory of Conversion Hysteria to the Field of Organic Diseases

In the writings of the pioneers of this field who first dealt analytically with organic diseases (especially in the writings of Georg Groddeck, S. Ferenczi and Ernst Simmel, but also in the earlier writings of Felix Deutsch) there was a great tendency to interpret even somatic phenomena that take place in the visceral organs as the direct expression of a definite and highly specific psychological content, such as an emotionally charged idea or fantasy in the same way as Freud has originally interpreted the psychological significance of a hysterical paresis of an extremity or a hysterical paræsthesia. In approaching the field of organic diseases most of these authors simply applied the theory of hysterical conversion without any modification. They overlooked the fact that Freud's view of hysterical conversion was based on observation of phenomena in organs which are under voluntary nervous control and in the organs of sense-perception. An important distinction obviously escaped their attention, namely, that in the vegetative organs the possibility of expressing details of a psychological content is much more limited than in those organs which are voluntarily controlled and in the organs of sense-perception. They applied in a somewhat uncritical fashion the suggestive idea that speech is not the only function by which emotion or ideas can find a motor expression. It is unquestionably true that facial expressions and gestures come near to words in expressing even fine details of a psychic content, and that there exist also involuntary organic processes such as blushing, palpitation

or diarrhœa, which are precipitated by different emotional impulses. It is obvious, however, that in contradistinction to words, mimicry and gestures, the vegetative organs are limited in the variety of their response to psychic stimuli. The function of these organs is circumscribed and restricted to certain definite physiological accomplishments. One must consider that for the symbolic expression of ideas through speech a most complex and specifically adjusted organ is at our disposal, and it is hardly possible that any other organ can fully substitute for expressing detailed ideas which we express through those extremely complex innervations that constitute speaking. The heart can only beat, the stomach and intestinal tract have a limited variety of motor accomplishments and secretory functions, and the lungs can only perform within certain quantitative limitations their physiologically prescribed activity. To fear, as well as to sexual excitement and also to pleasurable expectations, the heart will respond always with palpitation.

These general considerations alone show that the theory, which attributes to changes in visceral functions certain specific symbolic (ideational) significance is extremely unconvincing. It is hard to believe that such a detailed psychological content as a hostile fantasy directed against a definite individual can be symbolically expressed by the functions of the stomach. To what the stomach may react is not a specific idea such as revenge against a definite person, but probably only an emotional tonus or tendency, which, of course, may have a very specific nature.[1]

This extension of the theory of conversion hysteria is a typical example of an error, so common in the history of

[1] This type of causal interpretation of visceral disturbances, for example, the heart symbolizing the male genital, is found even in Ferenczi's writings. Fenichel interprets a case of heart neurosis on the basis of the patient's identification of his heart with his superego! This type of causal symbolic interpretation is even then fully unjustified if the dream life of the patient contains symbolic references of a similar nature. The patient's secondary knowledge of his heart ailment may supply material ("day remnants") that appears in the dream with a symbolic meaning. This, however, does not justify the assumption that such a fantasy plays a rôle in the causation of the organic symptom.

science, namely, of the uncritical application to another essentially different field of concepts that have been derived from definite observations.

Another fundamental difficulty of the unmodified application of the theory of conversion hysteria to the disturbances of vegetative organs lies in the fact that in contradistinction to the voluntarily controlled and sensory organs most vegetative organs have no direct psychological (certainly no ideational) representation in the mind, probably not even in the unconscious. Their relation to psychic life, particularly to ideation, is much less intimate than that of those organs in which hysterical conversion symptoms are observed: in the voluntary and sensory systems. If we had not learned of the existence of the liver from anatomy, through personal experience we would never know of it, but we have an immediate knowledge of the existence of our extremities, skin or eyes. There is no evidence whatsoever that we have even an unconscious knowledge of the existence and functioning of many of our visceral organs.

In a recent discussion Ernst Simmel emphasized the fact that in organ neuroses in contrast to conversion hysteria psychological factors are involved which belong to the earliest phases of child development (pregenital period), namely, psychological tendencies connected with nutrition and excretion.[1] This fact accounts for the important difference between conversion hysteria and organ neurosis which Simmel in his earlier writings would not recognize. As I have pointed out before, in this early phase the child's psychic life does not contain highly specified ideational elements, but consists mainly of general emotional trends connected with the vegetative functions. The emotional sources of conversion hysteria, on the other hand, belong to later stages of development (phallic and genital phases) in which the child has already learned to speak and can verbalize his feelings, is capable of ideation and fantasy

[1] In the Los Angeles Psychoanalytic Study Group. See also, Fenichel, Otto: *Hysterien und Zwangsneurosen.* Int. Psa. Verlag, Wien, 1931, pp. 72 and 73 *(praegenitale Konversionsneurosen),* and Wilson, George W.: *The Transition from Organ Neurosis to Conversion Hysteria: A Case Report,* to be published in Int. J. Ps-A.

formation and becomes emotionally involved in the problems of specific human relations, of love, hate and jealousy. This fact explains why in organ neuroses only general emotional tendencies come to expression in contrast to conversion hysterias, in which the symptoms are based on specific fantasies and have a specific symbolic significance.

The greatest mistake of the previous analytical attempts to interpret psychosomatic relations consists, however, in the fact that it was hardly ever fully taken into account that organic symptoms are usually the final result of a chain of intermediary organic processes. Whereas in conversion hysteria the unconscious tendency finds a direct expression in the physical disturbances, in organic processes controlled by the vegetative nervous system often a longer chain of intermediary physiological processes is interpolated between psychological stimulus and organic end-result.[1]

3.

A General Etiological Scheme of Psychogenic Organ Disturbances

The combination of clinical, physiological and psychoanalytic approaches in the study of peptic ulcer formation gives us an etiological formula which can be considered as a general pattern of many organ neuroses and psychogenic organic diseases. In the long chain of causative factors the following links can be distinguished:

1. Chronic psychic (cortical) stimulus (repressed tendency).
2. Excitation of subcortical centers through psychic stimulation.

[1] In the next section the author discusses his view in more detail according to which organic disturbances, even though they may be the end-results of an emotional disturbance, may not necessarily have a symbolic meaning. Only the original functional disturbance can be interpreted psychologically; its organic end-result must be explained on a physiological basis. We omit this section because it follows closely the ideas which the author has already published in this QUARTERLY in his paper, *The Influence of Psychologic Factors upon Gastro-Intestinal Disturbances: A Symposium—1. General Principles, Objectives, and preliminary results.* EDITORS' NOTE.

3. Conduction of the excitation of the subcortical centers to different vegetative organs through the vegetative nervous system (parasympathetic and sympathetic pathways) producing local changes in the vegetative functions.
4. Morphological tissue changes under the influence of the chronic functional disturbance.

In cases which do not progress to the last link (4) we speak of organ neurosis or of a functional disturbance; in cases in which the pathological processes progress as far as the end phase (4), that is to say, in cases in which eventually permanent structural changes in the tissues appear, we speak of an organic disease. This etiological scheme follows up in continuity the pathological process step by step through its different phases and eliminates all the obscurity and mystery about psychologically conditioned organic processes. The rough morphological changes in the tissues are not direct effects of psychological forces but are conditioned by a chronic, probably quantitative disturbance of the physiological function of the organ. That such a functional disturbance may have a central (psychological) origin is common knowledge; psychoanalysis adds to this knowledge the precise description of the psychological factors.

According to this view the difference between organ neurosis and conversion hysteria lies mainly in the localization of the symptoms and in the difference of the pathways through which the original psychological tension (stimulus) finds its somatic expression. In conversion hysteria the psychological tension finds direct expression in voluntarily controlled organs and in the organs of sense-perception, i.e., in organs, which execute the interaction of individual and environment, and which consequently are in permanent contact with mental life in general and with ideation in special. In organ neuroses the emotional tension influences via the vegetative nervous system the function of vegetative organs, which have no direct relation to ideation. This may explain why in organ neuroses the symptoms do not express specific ideational content, as for example, fantasies as they do in conversion hysteria, but only general

emotional trends. Common, however, for both disturbances—for conversion hysteria and organ neuroses—is the fact that they are the last results of the patient's disturbed emotional relation to his environment. They are unconsciously conditioned innervations, and are substitutes for voluntary actions, which the patient cannot carry out because their motivation is rejected by the conscious ego and consequently repressed. In the organ neuroses, however, also the division of labor between the functions of the cerebro-spinal and the vegetative nervous system is disturbed. As has been already discussed in Chapter V the structure of the nervous system manifests a certain division of labor in that the relation to the environment, on the one hand, and the regulation of the inner processes, on the other hand, are divided between the cerebro-spinal and the vegetative nervous system. The voluntary innervations, which are subject to the control of the cerebro-spinal system, regulate the attitude to the environment; the inner vegetative processes are controlled by the automatic functions of the vegetative centers. An organ neurosis represents a confusion in the division of labor of the nervous system: the dividing line between the inner and foreign politics of the organism is mixed up. If a psychodynamic quantity which under normal conditions would lead to an external action becomes repressed, it takes a wrong pathway and instead of a voluntary or genital innervation it leads to innervations in the vegetative systems. Thus, for example, in the place of the normal expression of love or hate, an inner process is influenced. This pathological deviation of a psychodynamic quantity from external action, that is to say, from voluntary innervation to the innervation of a vegetative organ, can be compared with a social phenomenon which so often takes place in the politics of the nations. Ambitions in the field of foreign politics which become frustrated by a military defeat usually lead to an overheated atmosphere in the inner politics of the nation. This is best shown by the fact that revolutions start usually after lost wars and that the method which has proved to be the best to check revolutionary movements is to start military action against a foreign

nation. Inner social tensions can be best relieved by diverting the energies that are engaged in inner affairs outward in conducting them into the channels of foreign politics. And, *vice versa,* the decrease of the possibilities of active foreign politics enhances the danger of inner social difficulties.

Every neurosis, no matter whether it is expressed merely by psychic processes or by bodily disturbances of functional nature, is the result of a defeat of the individual in his psychic relation to the environment, in his foreign politics. Every hysterical organ disturbance is the dynamic substitute for omitted actions. In organ neuroses, however, the emotions and wishes to which the individual cannot give expression and relief in social or sexual activities find expression in the unintelligible tacit language of inner vegetative processes.

4.
Vector Analysis of Psychological and Biological Forces

It has been pointed out before that in studying the influence of psychological factors upon vegetative functions, in the first place the patient's general emotional attitudes and the dynamic direction of his impulses must be considered rather than the specific ideational content of the psychological material.

These general attitudes can be described in dynamic terms expressing, as it were, the direction of the patient's major tendencies. We could differentiate three major dynamic directions or "vectors", characteristic of emotional tendencies—the wish to incorporate (to take in), to eliminate, and to retain. These are abstractions which correspond, however, to very well-defined emotional attitudes. The vector tendency to *incorporate* is common in many different psychological attitudes, such as the wish to receive a gift, the wish for a child, or love, attention, to be fed, or to take away something from another person. Similarly many attitudes possess the common quality of *elimination;* to give in a constructive way, for example, a gift, love, attention, to make an effort for the sake

of another, to create something of value; and also destructively by attacking or soiling another person, especially by throwing something at him. The wish to *retain* is also a common characteristic of many different psychological attitudes in which holding on to a possession is the major vector quality.

During the analysis of organ neuroses we observed that very different psychological impulses with quite different specific content may lead to the disturbance of the same organic function provided that they possess the same vector quality: incorporation or elimination or retention. At first sight it seems that the different psychogenic factors which are apt to influence the same organic functions are not at all specific, or in other words, that the same disturbance can be caused by a great variety of psychological contents, seemingly unrelated to each other. Further analysis of these apparently unrelated psychic factors showed, however, that they had one important feature in common, i.e., the direction of the general dynamic tendency which we call their *vector* quality. So, for example, organs which have the function of incorporation, such as the stomach in its digestive or the lungs in their inspiratory activity, are apt to be disturbed by very different repressed tendencies. These tendencies, however, have one dynamic feature in common, i.e., they all express receiving or taking something *(incorporation).* It has been observed that this general dynamic direction of a psychological content is related to the kind of organ function which will be disturbed by it. The stomach functions can be disturbed, for example, by any one of the following heterogeneous group of repressed wishes: the wish to receive help, love, money, a gift, or the wish for a child; or the wish to castrate, to steal, to take away something. The same group of wishes may also disturb other organic functions which involve incorporation, for example, the inspiratory phase of the respiratory act, or swallowing. The common feature in all these different tendencies is their centripetal direction: they express receiving or taking something. Thus our first category is *incorporation.*

Also the second dynamic category, that of *elimination* tendencies, includes an enormous variety of psychological contents:

on the one hand to give love, to make an effort, to help to produce something, to give a gift, to give birth to a child; on the other hand, the wish to attack someone (especially by throwing something at him). Any of these impulses, if repressed and excluded from voluntary expression, are apt to influence eliminating organic functions such as urination, defæcation, ejaculation, perspiration, or the expiratory phase of respiration.

The third dynamic quality, the significance of which became apparent during the analysis of gastro-intestinal neuroses, that of *retention,* again includes a great variety of different psychological contents. These all share the one common dynamic quality—that of retaining or possessing. For example, collecting different objects, putting them in order and classifying them (as a sign of the mastery of them), also the fear of losing something, the rejection of the obligation to give something, the impulse to hide things to prevent their being taken away or to protect them from deterioration, and the mother's protective attitude towards the fœtus—all these frequently find expression in retentive physiological innervations. The best known of these is constipation, but it seems also that the retention of urine, retarded ejaculation, and certain features of the respiratory act, can express the same tendencies.

Thus we differentiate three large categories of psychological tendencies representing the three vector qualities: *incorporation, elimination* and *retention.*

It seems to us that in the concept of psychological and biological vectors we have found the common denominator of psychological and biological processes. The organism can indeed be considered a mechanism the fundamental functioning of which (metabolism) can be well understood and described in the terms of the three vectors of incorporation, retention and elimination. The analysis of the psychological attitudes leads us to elementary tendencies that can be described in terms of the same vectors. Thus the assumption seems to be justified that these psychological tendencies or vectors are nothing but the subjective perception on the part of the organism of its fundamental biological processes; or, in

other words, the psychological dynamics is the subjective reflection of the biological dynamics of life.

The same point of view is applicable not only to the function of the whole organism, but also to the function of many specific organ systems, for example, the gastro-intestinal tract with its three-fold function of incorporation, elimination and absorption (retention); or to the three-fold function of the lungs which consists also of an inspiratory (incorporating) and expiratory (eliminating) function, and the absorption of oxygen as a retentive function.

As yet the vector analysis has proven its usefulness mainly in the study of those organ systems which have an opening on the body surface and whose function consists in an exchange of substances with the environment and whose physiological activity consists in incorporation, elimination and retention (the gastro-intestinal tract, respiratory system, genito-urinary system, and to a certain degree, the skin). The psychologically conditioned disturbances in the function of these organs (organ neuroses) can be understood as the result of a disturbed emotional balance between incorporating, eliminating and retaining tendencies. These tendencies or vector qualities determine the type of vegetative organ functions which will be disturbed by them in the case of an organ neurosis.

Such a disturbance of the emotional balance takes place if these major attitudes or tendencies cannot, because of psychoneurotic conflicts, find a normal expression in the individual's social and sexual relationship.[1]

[1] The general theory of such organ neuroses in the light of vector analysis is discussed more fully in my article *The Logic of Emotions and Its Dynamic Background.* Int. J. Ps-A. XVI, 1935.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

An Abnormal Child

Editha Sterba

To cite this article: Editha Sterba (1936) An Abnormal Child, The Psychoanalytic Quarterly, 5:4, 560-600, DOI: 10.1080/21674086.1936.11925300

To link to this article: https://doi.org/10.1080/21674086.1936.11925300

AN ABNORMAL CHILD

BY EDITHA STERBA (VIENNA)

"I like to be afraid!"

Subsequent treatment was characterized by a change in Herbert's behavior in the analysis. He had up to this point agreed that his fear should be "conjured away", was wonderfully willing to aid the analyst's efforts in dissolving his anxieties, and he frequently commented, "Today the Sorcerer and I have had a good tussle with the fear." When all day long he had wept, and suffered the torments of fear until he had made up his mind to look at the keyhole, he grew happy and gay when finally he had managed to look at it. Such fortunate changes as had brought him a release from his chief anxieties he had learned to value and he would often say, "Now I'm only slightly afraid, and can do anything at all." The striking improvement in his behavior brought with it great outward advantages for him. During this time he had attended daily a private kindergarten. In the summer he was placed in a home for children, and in the following autumn could be sent to the Montessori public school. That winter another three months were spent in a children's home, and the following summer, a month in the country with the Montessori school. Finally he was placed with a family for the entire summer under the charge of an analytically trained school teacher who was chiefly occupied with him during this part of the treatment.

It became known during a conversation about his fear of the analyst's spray that he liked to be frightened. At first he tried subterfuges: "I do pass by the perfume shop. That ought to be enough for you." Then he asserted, "I'm always so afraid that you'll squirt my *Klufterierpfuffi*", and when this excuse did not suffice, there appeared the first great resistance

---

Continuation and final instalment of the article published in the July issue.

which expressed itself in two ways. The first was expressed as follows: "The whole thing is just the *Pruicht's* invention.[1] The Sorcerer has sprays, gets angry on account of the fear, and then fetches the spray, and I have to look at it." He was denying reality by characterizing everything which had to do with the unpleasant fear of the spray as an invention of the analyst. *Pruicht* meant bad, or stupid, an expression not infrequently used in addressing the analyst, but used also to designate objects which angered him. It was a word to conjure with, and in the kindergarten when some child had annoyed him, he would run about calling out *Pruicht,* "to do him harm". He continued to believe in the magical effect of his words.

The second form which his resistance took consisted in his assuring me, "I like very much to be afraid and don't want to give it up because I don't want to be examined" or, "because I don't want to go to the dentist". He suspected not without cause, that when he no longer feared the spray, all the other real dangers which he had feared might some time befall him. Thus he retained his anxiety of the spray as a protection against being exposed to greater dangers should he yield in this lesser anxiety. Exhibitions of the spraying apparatus, and explanations from the analyst were met by him with abuse: "You dumb fresh Sorcerer, I won't give up my fear! I'll keep it!" He no longer called her *Pruicht* because she knew its meaning. Occasionally he would rush at her and try to pinch her.

Coincident with these resistances his interest in the difference between the sexes took on added importance. Although his fears of the keyholes and of the *Foche* and *Floda* left no doubt that on this subject there was no lack of clarity in his mind, the problem was acutely revived because in the kindergarten during sun-baths and elsewhere he had the chance to see little girls naked. He addressed the girls as colleague

[1] In this period of the treatment, all unintelligible words had the meaning of expletives which were to express his aggression. He thus abused the children in the home by calling *Toche, Foche,* etc.

(Kollegin), chum *(Hauptfreundin),* or companion *(Nebenfreundin),* to avoid using the word *girl.* With an idiotic expression, he asked each stranger, "Are you a man or a woman?" The kindergarten teacher observed that whenever he happened to touch a girl, he would stand stock still as if transfixed. Once she asked him what had happened with the girl and he had answered, "But it was a boy." The argument that it could not be a boy since the child in question had on a dress and apron, was answered: "A boy can also be dressed in such a way. One must say that and nothing else; otherwise you'll become a girl." "I know all about it", the analyst ventured. "You're afraid to say *girl* because you're scared about your *Klufterierpfuffi.*" He fell into a towering rage: "Don't talk like that! Don't say that! Those have their *Klufterierpfuffi* all snarled and crumpled. One can become like that. Don't say it. You fresh, stupid Sorcerer! Don't talk about it. I'm mad. I want to go away." She made no reply while cutting out little "carpets" with keyholes in them. It did not disturb him at all. "*Jejuju* are allowed", he said. "You don't have to cut them out. I'm not afraid of them. But you mustn't ever ask me questions. If you do, you're no longer a nice Sorcerer."

It had previously been interpreted to him that he feared he might get a *Foche* instead of his *Klufterierpfuffi,* but the danger again became real for him at the sight of the little girls' genitals. He stated, "I saw the *Klufterierpfuffi* on one of my little colleagues when she did number one. It was all snarled and crumpled. I won't be like that!" It was only the consequences of uttering the word *girl* which he feared: "One can say mamma and daughter and woman, but not *that;* else you'll be like that." He made this sharp distinction between the genitals of little girls and those of full-grown women, probably with reference to the presence of hair. He termed the genitals of a little girl "an altered *Klufterierpfuffi",* but a woman's genitals he called *Floda.* He attempted on numerous occasions to look under women's dresses. Asked why he did it, he would

say: "You stupid, fresh Sorcerer! I only want to see how it really looks."

His fear of the girls' crumpled *Klufterierpfuffi* had a connection with his eating difficulties. "At home", he said, "I can't eat anything. The food there's so crumbly and crumpled. It reminds me of disagreeable things." Explanation of his fear of crumpled food together with the consequence of forbidding him all other nourishment when he declined the food given him, took rapid effect. Although his feeding difficulties at home were extraordinary, at the kindergarten he was soon induced to eat soup, meat, and vegetables. He had always liked starches. His objections were now limited to milk and to certain fruits and vegetables.

His fear during this period, as everything proves, was of getting a "snarled *Klufterierpfuffi*". To rid himself of this anxiety, he altered reality by simply denying his masculinity. His mother had reported before, that often he had rushed to little children in the park, saying that he loved little babies and when they fell asleep he would touch their eyes till they awoke. He would then shout, "Lovely little babies, lovely little babies." At an earlier time, he had said, "I'll take the queens from the chess set. From the prettiest queen I'll take pieces and make dolls out of them." There was a very pretty little boy of two and a half whom Herbert particularly loved, and about whom he used to say, "He's my *Tuju* (darling) boy." When he had been with this boy in the summer home, he stated: "He's my darling child. He used to be in my belly." For a while during the treatment he had anxiously avoided any contact with furniture, saying, "Nothing must touch me for a *tuju-child* is just about to come out of me, and I'll give it to you." When asked with astonishment how that was possible for a boy, he had said, "No, I haven't got a *Klufterierpfuffi*; I'm a girl." His readiness to admit on this occasion that he was a girl, made it possible for him to use the dreaded word. Harassed during this time with fear of the spray, he would say, "I'll give you as many children as you want if you'll only keep quiet" or "How many *Tujus* do you

want? Well then, I'll make you a present of them." Sometimes he would tell about what his babies were doing: "David and I have two little kids. They're our children. I'm the mamma and have borne them and David's the papa. I put diapers on them because they're always doing something in their trousers. They won't eat anything. They always spit it out. Just the same, I have to give them something hard to eat, so that they get holes in their mouths, or else they'll have to go to the doctor. In spite of that they eat nothing." Thus in fantasy his weaning traumata and his painful early experiences with doctors, were inflicted on the child. Coincidentally, it was clearly to be seen from his hostile conduct towards his brother, that his exaggerated love for little children was an overcompensation for the hatred and envy which he had borne this younger brother from his birth. When attempts were made to explain this to him he maintained, "No, when David was a baby I loved him; how could I know that he would become so bad as he is at the present time." However, the fundamental destructive impulse broke through the repression in a fantasy about twins whom he claimed to have seen in a baby carriage: "They were the kind with hoods. They've got to be cut up in little tiny pieces, and then you have little *Foche dolls* to play with." Another time he suddenly interrupted a serious conversation with the analyst to say, "But you won't mind my killing your babies if you ever have any."

In the kindergarten in which he had been first placed his behavior was not altogether abnormal. He did not have to use unintelligible words the entire time. He busied himself with things which had an intellectual content, and if one gave him a book he would stay quiet for hours poring over it. With the exception of his "darling child", his "colleague", his "chum" and his "companion", he had showed no interest in any of the children. It was noteworthy that he always avoided boys of his own age. But it was considered a sign of real progress that the other children even tolerated the presence of this strange child. The nagging questions by means of which he was continually trying to extend his knowledge,

made him a bore and a nuisance. Everywhere and on all occasions the mention of a child, aroused his combative feelings. He had refused at first to enter a kindergarten because, as he stoutly maintained, "I am a big boy. I can only go to a boys' home." If the person who was taking him to school should by mistake utter the word kindergarten it was nearly impossible on that day to induce him to enter. He would demand: "Take that back, and say that it's a home for boys; otherwise I can't go." With the mistress of the kindergarten he got along very well, for he was not asked to do things of which he was incapable. As he did not wish to utter a name, he simply called her "dear lady".

The improvement in his condition became clearer the following summer in the children's home. At first he had run about the entire place until he was quite familiar with everything. He did not want to be washed in the shower-room because he had found some tubing there, but eventually he had permitted it. He had refused to undress for the bathing pool, but later had done so when permitted to wear bath shoes. To be sure he did not go into the water, but one could splash water on him, and he had been driven to the baths in a bus without making any disturbance.

There had been struggles when his nails had had to be cut or his ears cleaned, but when the kindergarten teacher became angry, he had allowed everything to be done without showing any anxiety. He gave the impression of clinging to his ceremonials, without needing to observe them. Prohibitions against certain foods were less conspicuous. With few exceptions he ate all kinds of meats, vegetables, starches, and fruits, but refused to drink milk, saying, "Only children drink milk; not boys and grown-ups." For a long time he could not be dissuaded although one of the younger men teachers in the home, whom he liked, was always showing him that adults drink milk. He was not convinced: "It isn't true that he's drunk it." Since at the summer home he was very dependent on the kindergarten teacher who had previously looked after him, and since she insisted that he drink milk or else she would be

annoyed, after much hesitation he finally consented, though for weeks he contested each swallow, and if none observed him he would take only a few. "You mustn't look! That makes me a child." After he had drunk a few times, he triumphantly announced it to the other children who were not in the least understanding, and laughed at him. Once when something was being distributed, he made the unprecedented demand, "Me first! Not always the last." Often he refused to eat, saying that the food was too bitter or sour. "Dogs," he had once stated, "love to eat bitter, sour things. That's why they like to eat a piece of sour filth like David."

In his relation to the outside world there was a considerable change. He began to address certain people by their names and continued to do so. With those who understood him better and tried to gratify his whims or appease his thirst for knowledge, as for example the young teacher at the summer home, he made friends. Except for his "darling child", the little boy of two and a half years, he made no contact with the other children. He wanted to associate with the group of older children ranging from eleven to fourteen years who found him troublesome and rejected him because of his nagging questioning. However, he managed to create for himself a certain position among them due to his quickness in reading maps when expeditions were made. These children often said of him: "How can he be so clever when at other times he is so stupid?" Now, isolation seemed to oppress him. Whenever the kindergarten teacher became cross with him, he tried at once to conciliate her, and, indeed, this was often the only means by which he could be induced to coöperate. "Please be good", he pleaded, "there's absolutely no one here I can love. Don't go away. You've got to love me, every bit of me." These were the first expressions of the fear of loss of love. Fear of the analyst's anger had been rather with reference to her magical power which he wished to keep benevolent: "It's not right to make a famous sorcerer angry." Separation from his parents and his brother he quite ignored. He never inquired about them. When his father paid him a visit he

was greatly pleased, but he refused the entire time to write to his mother who was then in the country with the smaller boy. His jealousy was frankly expressed: "I won't write to her. I'd be glad if she weren't there and I didn't have to bother about naughty David."

His "darling child" was the other person to whom he had developed an attachment, although, to be sure, a very ambivalent one. He wished to take care of him, and tormented him unceasingly with his solicitude, never allowing himself to be separated from him, and often calling out his name while asleep. He often asserted: "I must look after him and feed him. He only arrived in the world today. I bore him myself", a very clear identification with his mother. This identification became still clearer when he disclosed whom the youngster was to replace. For one day he said, "Little Heini is the same kind of child as David". Thus his attitude towards the boy was an overcompensatory reaction which sprang from his hatred of the younger brother. It was also striking that he called this child by his first name which up to that time he had never done with any other person excepting his brother. When this was called to his attention he had replied: "You can't use first names, for if you do, you'll be rechristened, and you'll become the person whose name you speak. Last names aren't so dangerous to use, and you can speak the first names of your own children and relatives without being changed into them because they are part of the same person. Heini really is my child." However this did not seem entirely right to him for he continued: "I was in Mamma's belly and I ought to have the same first name and the last name as she does because it's the same person, but the first name is different. Maybe someone will take away my child because its first name is different from mine." During the period when his fear about names was being discussed, he was tricked into speaking one. He was reading aloud from *Wonderboat,* a story in which appeared the word "Marikken", a first name which was unfamiliar to him. As soon as he had uttered it, his attention was drawn to the fact that he had read a first name aloud. He

was enraged, and demanded that he be allowed to reread the entire book from the beginning in order to undo the fact that he had uttered the name: "I want to keep my fear. I'll take it all into myself, and I won't read to you out loud any more!" Nevertheless his anxiety about pronouncing names was visibly diminished.

Once he ran a thorn into his finger. Although one could see that it was painful, he would let no one look at it, and even while the splinter was sloughing out, he ignored it completely. It was impossible to get him to gargle because, "a doctor prescribed that". On one occasion it had seemed necessary to take his temperature by force. He had cried for hours: "The doctors have come back from the devil. They've stuck me behind with the nail. It'll get inflamed there the way it did from the thorn." It was clear that he perceived the wound made by the thorn as an injury to his ego, and that he wished to deny every real injury, so that it should not have to be treated by a doctor.

His contact with reality was much improved. He showed sporadically towards his surroundings the interest of an average child, but when he was absorbed by some book or deep in reflection, it was difficult to draw him from his seclusion. His interests were, to be sure, different from those of an average child both in content and manner of pursuit. When he became interested in an event, it was always to inquire exactly how and why it had thus occurred. Although his questions were never senseless, he exhausted everyone with them, and as no one could ever answer him with sufficient thoroughness, he always remained unsatisfied. One could not mention a natural phenomenon without his breaking into the conversation. Should, for example, one mention the fact that it was raining and that one could not go out, he would ask, "Why does it rain today? Does it always rain this time of year? Does it always rain here at this time? Is this a region where it rains a great deal during August? Are there many such regions where it rains much during August?" This might continue half an

hour, and if the answer were indefinite to the slightest degree, he reproached one with it all day long. The analyst one day had with her a camera which had a complicated shutter that he had never before seen. In addition to Herbert, a twelve and a fourteen year old boy had simultaneously shown an interest in it. The older boys had listened a couple of minutes to her explanations, and then growing bored, had busied themselves elsewhere. But Herbert teased for an hour and a half until she had told him everything she knew, and until he was really able to grasp in detail the function and mechanics of the shutter. During such technical expositions he would often catch one in a mistake, and then he would grow angry and say: "Again, you don't know exactly how it really works!"

One seldom heard his neologisms in the summer home. When scolding, he used the familiar *"Toche", "Foche",* etc., and when one got angry with him, he would run about shouting *Pruicht.* Thunderstorms of which the other children were frightened, delighted him: *"Fix, Pruicht,* thunderstorm! Let the lightning come! Let it strike! Let the *Pruicht* flash and thunder and carry off the doctors! Then I'll be glad!" *Pruicht,* therefore, was not only evil, but the evil one, the devil, who could magically injure all the adversaries which Herbert was too weak to do.

Although the children at the home often employed expletives, word inventions, which were then adopted by the others, or playful word distortions, Herbert never imitated such playing with words, just as likewise he never adopted the curse words of others. When once he was challenged in fun to do so, he replied angrily, "You haven't any idea what might happen!" He might only make use of his own words whose magical operation he could absolutely understand and control. Likewise, the other children never employed his word combinations and distortions. He was too strange to them, and they wished to avoid disputes with him. One or two attempts of the bigger boys to imitate him had so enraged him that the other children had been intimidated. Only Heini,

his favorite child, was permitted to use his words and to mispronounce them. That was not dangerous for Herbert believed that they were identical.

In contrast to his intellectual precocity, Herbert used to relate stories which showed a striking poverty of creative imagination. That he would tell stories at all was explained by the fact that he did not wish to let himself be outdone by the older children.

Three of his stories were as follows:

I. "There was once a child who was always alone till he was three years old. Then he got a brother and they both grew up and were washed and became adults, and they both found a wife and a child and they stayed adult."

II. "Once there was a house which at first was quite empty. Then the carpenter came and made furniture, and the people had everything else they could think of made. And there were a great many wives there and they had children and many people lived inside."

III. "There was once a very old man, eighty-two years old. He lived all alone and he had no children and no wife. Then he got a wife and many children, and they built a house and moved into it. And then the house tumbled down and all the children were killed. One day another child was born, and he came to his parents and they lived all alone, and they built a new house which didn't fall down." He refused to give any explanation for these stories, and was, when asked, angry because he perceived every question as casting doubt on his knowledge.

What was the meaning of the old man could never be discovered. As the stories originated at a time when the older boys in the home were teasing him, one may suspect from them what he wished might befall them and, also, of course, his brother.

He was often observed to masturbate before going to sleep at night or during the afternoon rest period. His masturbation consisted mostly of squeezing the penis and pulling it about to produce an erection, but he appeared unconcerned

and not particularly excited by it. He showed a great deal of interest in the bathing of the older girls, and always wished to be present, but in the little girls at this time, he showed no particular interest; moreover he was permitted to watch them while they were being bathed.

He continued to enjoy his anxiety, he often informed one. He had written to the analyst, "I hardly have any anxiety any more", but he still averred, "I want to keep my fear", particularly on those occasions when some food against which one of his prohibitions was directed was offered him.

In the autumn, shortly after his return from the summer home, he was sent to a Montessori grammar school. The return to his own home was without particular incident. He paid no attention to his surroundings, and was indifferent to his mother and brother. Soon he developed a curious conflict with his mother, and towards his brother he became more aggressive than ever. He got along well with his father, and used often to call him affectionately, "Darling Pappa *(Vatju)*".[1]

The first crisis occurred at school when, like all the other children, he was given a green overcoat to wear: "I can't do it. I tell you, I'm a big boy. I don't want to be a frog. I won't put it on." Moreover as he affirmed that he wished to keep his anxiety in order not to put on the green overcoat, it was most difficult to influence him in the analysis although of course the various reasons for his refusal were explained to him. But once he had said "I will become a frog", he could not be dissuaded. An accident came to the rescue. He had graciously consented to don a blue coat since the teacher, an adult, was wearing one. Shortly thereafter, the kindergarten teacher whom he loved so much, and fear of whose disapproval among other reasons was partly responsible for his consent to wear a blue coat, wore a green blouse. That seemed very important to him: "Have you noticed that your blouse is green? Perhaps I shall also be able to put on the green overcoat." This was soon followed by: "It'll be all right about

[1] *Tuju* meant darling, as already mentioned. *Ju* appended to words betokened unusual tenderness.

the overcoat. The material isn't as shiny as the frog's skin which is always wet. That's why I've been so afraid." One sees how being drawn to an individual helped him in twofold manner to subdue his anxiety. He first feared the loss of love,—"If the kindergarten teacher should become angry,"—more than he feared "becoming a frog", which now seemed a little less actually possible than at first. Secondly there was the possibility of identification with this beloved person which afforded him assurance that if nothing happened to her, nothing would happen to him, and that if she could wear a garment of green material, that is to say wear something which seemed dangerous to him, he also could do so.

His fear of the spray which had been difficult to broach since he had begun to cherish his fear, again made its appearance and could be discussed. In school he refused to write. The kindergarten teacher had induced him to try it, however, and was able to observe that every time he made a loop he would shake all over, while with up and down strokes this was not the case. During this performance he was very refractory and kept objecting, "It takes too long to dip the pen in the ink." Recalling in this connection his fear of the keyhole and the spray, it was thought that perhaps he would manage better with a fountain-pen, since the owner of a spray (fountain-pen) need have no fear of loops (keyholes). This proved to be the case. He was extremely happy over the fountain-pen, and ready to write with it, "because it is a spray". His fear of sprays had diminished. During the summer he had allowed himself to be sprayed, and he no longer avoided his father's spray which the latter used every day while shaving. The fear of enemas was unaltered. The enema he called *schluju* or *flaudele,* "the tube which one gets inserted from behind". He was in a state of continual apprehension that someone might touch him on the back, and thereby make *flaudele.* He confessed this, and explained why it had become so bad. Once or twice in the school, he had wet himself and had defæcated in his trousers because he said that the closet stank too much and he did not want to use it. His mother had been shocked

when she heard about it, and threatened him as punishment with an enema because she knew he was greatly frightened of it. Herbert reported this in the following manner: *"Flaudele* is a word for things which make one terribly afraid. Mamma warned me that if I made a mess in my pants she'd make *flau."* His mother had also told him that she would tie up his *Klufterierpfuffi* in order to stop him from wetting himself. Shown the spray during this time in order that he might see that it was no *flaudele,* he confided, "I'm so afraid that if mamma does it to me again, I'll become a little two-year-old child like the time before when she first did it." He was afraid that all those terrible things which had befallen him might once more occur,—the birth of his brother, the treatment of his ear. Now it had been reported that he had played the part of aggressor in making *flaudele* during the summer, whenever he wished to be particularly affectionate with little Heini. He would rush at him from behind, seize hold of his buttocks, and shout *flaudele.* His sexual excitement at such times was plainly to be seen. He often declared, "Heini also needs a *flaudele,* the same as David. I have to do a *schluju* to him." The analyst put a paper doll in front of him and reminded him about this episode of the summer home. She said that he probably was so afraid of his mother's threat because he so much wanted to do the same thing himself, as with Heini whom he had been prevented from tormenting in this way. He made no answer, but with evident excitement did *schluju* and *flaudele* to all the paper dolls. A difference was at once noted. He did *schluju* to the girls, and *flaudele* to the boys. It was then suggested that surely he must have done *flaudele* to his brother, for he wished to inflict on David everything which he himself found unpleasant, and that his mother had undoubtedly been very angry about it. He confirmed this at once. "I've often done *flaudele* to David, and stuck my finger up him behind when he was still small. He cried a great deal at it and mamma was very angry." A few days later *schluju* was again mentioned, and the analyst told him that she understood the difference between *schluju* and *flaudele,* and that

perhaps he had wanted to do *schluju* with women, perhaps with his mother. At first he ignored her remarks, but suddenly rushed at her in great excitement and crying *schluju,* he repeatedly grasped with his hand in the region of her genitals. Subsiding, he confessed: "Once in May I wanted to do that with Mother. She was very angry, and she said, 'You'll find out! I'll do that to you, too!' " While he was being told that boys did not do *schluju* with adult women, which fact in his delusion of grandeur he did not seem to comprehend, he interrupted to say: "You see, I'm governed by my fear. I must do everything that it tells me. If it says, 'You must do *schluju* to a woman so that she won't do it to you', I've got to do it. But only with you and Mummy." With his mother because she had threatened him, and with the analyst because she had so often shown him the atomizer. It was learned from his mother that she frequently did not permit Herbert to go to the toilet, but made him use a chamber-pot, and that after his bowels had moved, she cleaned him like a little child, which frightened him greatly. She related that on these occasions he had often talked about *flaudele,* but she was less angry about it than one would expect. He attempted no activity of this kind with others for only with his mother and the analyst was he compelled actively to ward off the passive suffering which threatened him.

It was soon apparent that he knew quite well the difference between *schluju* and that which a man did with a woman. Once he rushed to the kindergarten teacher and pressed closely to her. When asked if he would like to be squeezed in this way by someone, he replied, "That's not right to do. Only when boys are going to marry can they do it. I want to marry her (the kindergarten teacher)." He knew this because, he said, "I've seen it in the park. A man and a woman did it there." A few months later when lying in bed in the children's home, he said to the young school teacher who occupied herself especially with him, "Dearest, come closer to me. Do *fluju* with me. Come closer. You can't do it from a distance. Lie

down. You can only do it if we lie together." He never repeated this proposal.

At school, he still had "friends" and "colleagues", but used these terms only in order to avoid his fear of mentioning names. A delicate little weakling of a girl was his "baby". With his "colleagues" he had friendly relations, but with the "friends" he desired to have children. This became apparent when his "best friend" was absent from school for a considerable time. He would run to the door of the school-room, in order to look and see if she might not still be coming. Annoying at this time likewise was his habit of frequently stamping for a long time on the floor, both at school and at the analyst's office. She was particularly struck by the fact that in her room he always left the carpet in order to stamp on the bare floor. She asked him why. As if it were the most natural thing in the world, he said, "Why don't you know? I'm making children. I stamp on the ground, and from the hole I pull out a child." In answer to her astonishment, he stamped hard again, then bent down, stretched his hands toward the floor as though he were about to loosen something cautiously from it, and presented both hands saying, "Look at it. The darling *Tuju-child!* I'll give it to you to bring up." When asked further why at present he was stamping so much at school, he gave as the reason, "At other times I do that with my girl, but now she's sick, and so I've got to make babies by myself." And the facts indeed supported his words, for during the illness of his little friend whom he loved tenderly (he had, of course, never made any sexual attack upon her) he carried on his stamping, and left off when she reappeared in school.

It was disturbing that the little girl to whom he cautionsly referred as his baby, he tormented with his attention exactly as he had little Heini. Repeated interpretations to him why he preferred having a daughter to a son, and confronting him emphatically with reality when he maintained, "She is really my child" (for the nature of the resistance in this assertion now became evident) had no effect on him. It was not until

he was told that because he made this assertion he must be crazy, and could not be permitted to go to school any longer, that he grew reflective. Soon afterwards he said to the little girl whom he had always before addressed as baby, "I can't go with you any more because I'm not your father. Unfortunately it is not so!" From that time on he had no other child in the school, but there always remained the tendency to mother children who were small and weakly.

Herbert's greatest progress was shown in his conduct toward doctors. When he had grown to understand that he had found the ear treatments so intolerable because just at that time he had had every reason to fear the destruction of his ego, that for long all the doctors and other dangers had been kept away from him, and that, furthermore, his terror lest all these terrors should return was unfounded, he grew little by little more confident until one day he said, "If you tell me that doctors are nice, I will believe you." He kept his word. Soon after he had a severe earache, and was sent with his teacher to an ear specialist. The latter talked to him as if he were grown up, and took great precautions with the examination, so that Herbert was aware of no discomfort.[1] He did not fuss about going, and although he was frightened, behaved bravely and quietly. When it was over, he received as a reward a much wished-for dictionary with which he was greatly pleased.

A few weeks later he caught a bad cold, and a pediatrician was called to examine him. He was described as behaving on this occasion like a madman, and it took two hours to examine him. Afterwards, he acknowledged his bad behavior, saying, "Yesterday I was very insulting to someone. But you've got to be insulting to doctors, when they bring along all their things, the way he did. Do you know what you ought to do with doctors when they want to get in? You've got to hold the door shut so that they have to stay out. The doctor fell on me with everything he had, and he hurt me very badly too."

[1] A chronic bilateral middle-ear inflammation was discovered, with a very widespread scar-formation of earlier origin.

That was of course not true. The doctor had scarcely been able to auscultate, and look in his throat; more than that he would not permit. The next time he came to the analytic treatment, he sat in the waiting-room, and ignored the analyst completely, which he had not done since the beginning of his treatment. When he had been urged several times to come into the treatment room, he said, turning to the kindergarten teacher, "Did you hear someone speak to me? I have heard nothing." Having succeeded in getting him to go with her, he then poured out his bitter complaints: "It was just like an attack! I thought at once that Doctor X and Y had come back from the devil. You promised never to let a doctor see me without asking me first!" As a result of this experience it was observed that he showed fear when he happened to see a speculum which the analyst's husband kept in an instrument case. For weeks after this he refused to enter his office although at this period he was on the best of terms with him. A few months later, he denied that he had had any sickness for which he had had to be examined. He maintained that he had been entirely well, obviously for the purpose of abolishing the anxiety connected with the doctor's visit. During the two and a half months which he spent in a children's home, he again developed a bilateral middle-ear infection with a high fever. He allowed himself to be treated with astonishing composure, and although he was very fearful and trembled all over, he did not try to defend himself. Both his ear-drums had to be punctured, and this was done under ether. Nevertheless, he had grasped what had been done to him, for a month later he said, "Of course I know that Doctor N. stuck a needle way into my ear, but that wasn't like it was with the doctor at the clinic, for I didn't feel anything, and only knew about it afterwards."

When he returned from his summer vacation with the Montessori school his nose was operated upon by the same physician of whom he was very fond. While under ether, growths were extracted from his nose, and at the same time his tonsils were removed. During this performance he was

remarkably composed. He was accompanied by the school teacher and was taken care of by her afterwards in her home. He offered no resistance and made few remarks about the operation, since he had had no chance to see either blood or instruments. Following the operation he was unable to speak for a few days, but this troubled him relatively little. The railroad, which he received as a reward for his bravery, delighted him beyond all measure, and for the first time he played like a normal child. As he could not speak, he invented a sign language and in this he was very ingenious, and derived a great deal of fun from it. This medical intervention, which was by no means slight, was followed by no relapse, nor in any disturbance in his relationship to the analyst nor to his two teachers.

The analytic problem now devolved upon finding a means of overcoming the resistances expressed as his wish to be afraid. On one occasion after declining something out of fear of being injured, he had said, "I want to keep my fear. It comes from Doctor X's speculum. I love it, and have to keep it as a safeguard against being killed. That can happen whenever one is held tight. I want to be a doctor too but one who doesn't have a speculum." He clung to his fear as a protection against possible greater dangers; he wished to retain it as an amulet; that is to say, its function was of relatively secondary importance. His fear now was chiefly of speaking aloud proper names of individuals and names of the various parts of the body. He clung tenaciously to this fear while others could be suppressed through firmness and persistence, such as his fear of a salve with which he had to be rubbed, of oil to be dropped into his nose, or of particular foods. The phobias and rituals too well supported the illusion of his omnipotence to be completely relinquished.

He talked of the *Pruicht,* the representative of evil and stupidity, identical at times with the analyst, and whose function grew better defined. He fantasied: "The *Pruicht* will let you know all right that I want to keep my fear. He is a great sorcerer. He lives between heaven and earth, and he does

everything that I want him to. The Pruicht can conjure away all the months in which something has happened that I don't like—May, June, July, when one has to go in swimming. I just say, 'Silly May', and at that moment he conjures it away." The fairy story of Anderson, *Twelve With The Post,* which he used to read over and over with delight, played a part in his game. In this, all the months appear in order at the beginning of the new year, and in his fantasy he changed it about so that the *Pruicht* made all the months disappear. Everything he had learned from his instruction in religion, came to be transferred onto the *Pruicht. "Pruicht* is a god. If there is no *Pruicht,* there is no God either. The *Pruicht* is more than a sorcerer, and you have to do whatever he says." Analysis of these fantasies, and analyst's refusal to be impressed or intimidated, led him to threaten her with real personages: "The President of the Diet forbids you to talk about the fear. He is the highest person in Austria and you have to obey him."

A considerable reduction in his delusion of grandeur was expressed in one of his remarks about school: "Do you know, they say I'm the second smallest? That hurts me a lot." To console him, it was suggested that he was best in arithmetic. To this he answered, "Don't you think that the best in arithmetic ought also to be the best in writing?" This remark was significant because he had persistently refused to write in school. After this achievement of insight the analyst was never again threatened with the *Pruicht* nor with any other authority. A crucial change was initiated following the admonition that if he wished to preserve his fear for the rest of his life his continuation with the analysis was without purpose. That made him very reflective, and one day as he was leaving the analytic room he took the analyst and the kindergarten teacher by the hand and said very earnestly, "Will you both always love me?" This was correctly understood to mean that he was prepared to forego his last fears, if only he could be certain that he would suffer no such loss of love as he had previously suffered when his mother turned from him to her new son, and he had felt forsaken. He was afraid of being abandoned again should he

become well and thereby lose the analyst. After frequent reassurances he declared, "On June 16th I will speak out loud names and the parts of the body."

He had refused the entire winter to write, and the principal of his school had to insist on an examination to determine whether he was capable of writing. This examination was to take place before the 16th of June, as the school had planned a holiday in the country for the entire month. The analyst had promised to be present at the examination in order to "make magic" against his fear of writing proper names or parts of the body, and she proposed therefore to him, that since he would give up his fear of naming things in a few days anyway, he might just as well move forward the date to the day of the test, but he laughed ironically saying, "What are you talking about! Of course I can't do that. If I could, my fear would have to be quite gone. Then I wouldn't need the 16th of June." In the examination he surprised everyone by an acquisition of knowledge which seemed incredible. He could suddenly write, could repeat the content of a little story, and his ability to calculate was phenomenal. Unfortunately this served to increase his overestimation of himself very considerably. We had fought his delusion of grandeur by showing him how much more others could accomplish; now without practice, he had succeeded in writing, and, what is more, quite correctly. He was triumphant: "I always told you that I didn't have to practice writing. It's too dull. I do everything without effort. That's why now I'm going to put my fears in a machine, and it will seize the doctors. I'll do it all without you. I don't need a sorcerer any more against fear."

On the 16th of June his prohibition against speaking first names and parts of the body really disappeared. He made a great fuss about it, informed everybody at home, and without any help or suggestion wrote to tell me that his fear had vanished. To be sure, he did not always speak the names aloud but would often say them in a low tone for which he gave the following reason: "When my fear took leave of me on the morning of June 16th it said, 'When someone has been

afraid for so long, it takes a long time to grow accustomed to speak out loud names and parts of the body. This can last two or three months or even longer. With you it will take a long time for your fear has been great, and has lasted long'."

When Herbert returned from his holiday in the country, he had become much freer and more aggressive; if one tried to detain him about something, he simply pushed one out of his way laughing loudly and heartily, whereas formerly this had happened only when he was laughing at someone whom he was criticizing. After his tonsillectomy, one had many opportunities to watch him. He busied himself with his railroad, built a house for the engineer and the machinist, and played like a normal child. Characteristically, however, he also studied a time-table, and in a short time he knew all the chief connections between Vienna and foreign countries by heart. With eating, he now had hardly any difficulties at all. The analysis was to him a haven of refuge from everything unpleasant which occurred at home, and this was why he did not particularly wish to surrender his fear, for then he would be forced to give up this place of safety. When he came again, subsequently to his return home, where they had found him much improved, his attitude towards the analyst was hostile. "Why have you done that to me?" he asked repeatedly, "David is just as naughty as ever." He had expected that David would be just as much improved as he was. He had been fearful for a few days that for real reasons he might not be sent to the country with the rest of the school. This had caused him to worry greatly. "Nothing matters", he had said. "At home they are only angry with me."

The return to his parents' house, which took place about a month after his vacation with the school, brought him disappointment once more. Although apparently his stay at the Home and the separation from his family had produced as usual no impression on him, he nevertheless understood that they had sent him from home for a while, because no one could get along with him. His intentions were good, for he would often say, "When I come back home I will be very good to

Mummy." At this time, his favorite toy was a large drum which he loved and guarded jealously. It afforded him an outlet for his hostility and aggression, for his interest in drums had arisen in connection with his interest in trumpets (ear-specula have the appearance of little trumpets). Of the drum, which he had kept for months at the analyst's house, he said, "I'll take it home now if I see that David has become good; otherwise I'll bring it back here." Gradually, David had discovered all of Herbert's peculiarities, and he steadily tormented him by opposition, or by giving utterance to a stream of gibberish, which Herbert for the most part had now abandoned. The latter felt a deep resentment, particularly because his mother made no attempt to keep David in bounds, in fact she paid little attention to his pranks. Herbert had attempted a stratagem against his brother, which had been effective with himself, but was unsuccessful with David—whose formula was, "Let him be seized by fear!" He employed against him all the threatening words used to frighten little children, and which his mother had employed, though in vain, to suppress the impudent and disobedient Herbert. Thus, for instance, "The gypsy, the nigger, the chimney-sweep, the cannibal will catch you and eat you." David had laughed at him, and it usually ended in a violent quarrel between the equally matched competitors, for Herbert was still extremely clumsy physically. His wish for his brother's death was openly expressed: "I'll have to go to bed with David soon, not because I love him, as I used to, but in order to hurt him so that he will die. I don't want a wicked brother like that. He ought to be destroyed." Although he fought violently, it was never he who started a quarrel, and he was always surprisingly willing to quit; his interest in his brother never persisted very long.

Towards his mother his attitude was very ambivalent. He would say to her in the same breath, "My adorable Mummy", and "Dumb, stupid woman". The latter, of course, did not contribute towards the improvement of their relationship. To her credit, be it said, that it would have been very difficult for any mother to maintain a good relation with this abnormal

child. When he was with his mother he still often displayed distressing eccentricities which otherwise he had discarded, such as talking in a loud voice, gesticulating, or screaming *Pruicht* on the street, and his malicious delight at her irritation was plainly to be seen.

His attitude towards the analyst was likewise ambivalent. In the waiting-room, in front of strangers, he said in a very affectionate tone of voice, "That is my darlingest Sorcerer", whereas a few minutes before he had declared that she was stupid, impudent, and understood nothing about magic. Or when she had visited him at the children's home, and he had not recognized her at once because he was so absorbed in his work: "What a lovely lady that is. Ah! my darling Sorcerer—— You *Kruichen!* You dummy!" His hostility towards her was a result of the attack made by the analysis on his fears. He tried to ward off the suffering he had endured by inflicting it actively on others. He announced that he would not allow his nails to be cut, and upon her making an attempt, he tried suddenly to pull her hair. But her good will was still of great importance to him, and he worked hard to preserve it. When he was sick with nasal catarrh, he at first refused to let his nose be greased; then out of fear that she would become angry, he yielded with the remark, "Now we'll have to use a lot of grease so that the Sorcerer will be nice once more."

One day the analyst visited the school accompanied by a small girl whom he knew to be a patient. He pretended not to see them, became excited, and ran aimlessly about. Later he was asked if he knew that he had been jealous. He burst out, "Of course. You're not even her mother. But you came with her, and left with her, and that's not right. And I'm glad", he continued, "that I can get away from the idiots at home. You promised that Mummy would love me, but it's not true. When she used to call me *Putju* and *Bubilu* she wasn't angry then on account of my fear. At that time she still used to love me." His mother confirmed the fact that she had often used these words when he was an infant. The analyst had been a surrogate for the good mother of the time

before the birth of his brother. During this period, he took more than the usual interest in everything that went on around her. He now resented her having to leave the room to answer the telephone, although this had often occurred before. He asked where she had been, and being told that she had been telephoning to someone who wished to visit her at nine o'clock in the evening, he grew furious, saying, "That's not right. Nine o'clock in the evening is no time for magic. I'll be sleeping by then, and you oughtn't to work. It's too much. At the most sorcerers ought to work from eight in the morning till eight in the evening, not longer. If you do that I'll notify the Department of Labor about it." Apart from the fact that this was the first time that he had ever been observed to take any interest in the welfare of a human being, the remark was also characteristic of his real understanding and correct use of such difficult concepts as working-hours and Department of Labor. He was also interested at this time in her husband's work, and made an exact differentiation between them: "One goes to the husband, if one wants to *talk* about magic, but to you, because you really practise magic."

Herbert had never during the treatment played in the proper sense of the word. In the first period of the treatment he had drawn, and later, when not actually busy with conversation, he would usually turn over the pages of a book. To contend with his inclination to foster his fear, it seemed desirable to devise some means of preventing him from withdrawing into books. Given playing-cards, which on account of his passion for estimating and calculating, it had been surmised would hold his interest, he was in an ecstasy of delight, recognized each card as it appeared, invented new games, and would not be separated from them. "Darling, dearest Mr. Sorcerer", he cried, "you know best of all what I like." He quickly learned to play Rummy according to the rules. Surprisingly, however, instead of naming the suits, clubs, diamonds, hearts, spades, he had invented, *Puiben, Foitika, Buim* and *Hovendinacht*. These bizarre names had originated in events which happened when he was scarcely two and a half years old, and

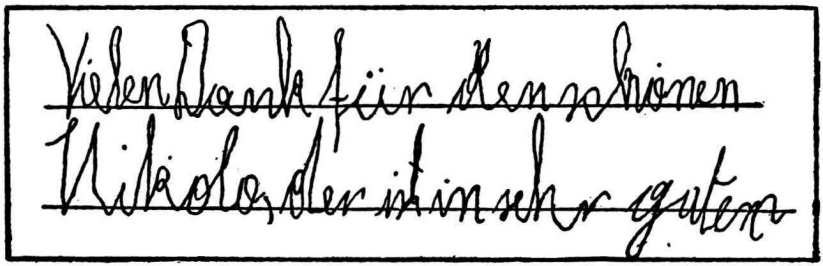
had called his father's attention to all the people in the park who played cards. Once, four boys who as they played, were shouting loudly in Viennese dialect, *Buam* (slang for *Buben* which means "boy") from which he derived *Buim,* and in addition, *hau ihm den nach!* ("Give it to him!" or "Give him a crack!") from which he had constructed *Hovendinacht. Foitka,* the name he gave to diamonds, recalls *Foche,* and suggests that the lozenge-shape of the diamond reminded him of the female genital. "I have to speak in this manner", Herbert insisted, "because my fear of the cover was so great at that time", that is, when he had first become acquainted with cards. Once in the excitement of a game he made a mistake, and discarded more cards than is permitted by the rules. Nothing was said, but the next day he volunteered, "In playing we must always avoid a situation where it gets to such a point that I discard too many, for otherwise something might happen which would be unpleasant for me."

During the holidays he had told a boy of his own age about his fear of the keyhole and of the spray. It was impossible to discover how much he had told the boy of the meaning to him of both these objects. At any rate they played for a long time a game to counteract the cover fright, and the squirt fright, as they called it. It consisted of stuffing the keyholes with plasticene, or of shoving every imaginable pointed object such as pens, pocket-knives, paint-brushes, violently in and out, and during one of these performances,—it was after the incision of his ear-drums—Herbert said, "It must go in deep. You have to stick it in, and squirt fluid into it." The other youngster was particularly fond of this game, and was not to be dissuaded from it, although all of the keyholes were ruined by the two boys.

His thirst for knowledge at the end of this period of treatment, was unsatisfied. He no longer questioned one with such exigent impetuosity as formerly, and his zest for printed matter of all kinds was more normal and better arranged. He did not plunge indiscriminately into books whose contents must have been totally lacking in interest for him. They were

now carefully selected. He asked for novels or plays, because, he said, he wished to write these himself. His method of absorbing the content of a book was most unusual. He was never observed to read a book slowly, page by page. He skimmed through it, dallied a little over several of the pages, always giving the impression that he had merely glanced through hurriedly from cover to cover. Then in an extraordinary fashion, he could reproduce the content exactly, and never err in a single detail.

He had by this time given up the use of all unintelligible words; nevertheless his trick of repeating certain words again and again in order to produce a certain effect, persisted. Thus,



instead of attacking other boys of his own age he would cry out *Tetschen, Watschen, Fotzen,*—Viennese slang for a box on the ear—increasingly since he had become more aggressive. He explained, "There will come a time when they [the boys] will get what's coming to them." Occasionally, he again lost his sense of the meaning of words. For instance: "Why does one say *hervorragend* (predominating) and not *frauvorragend?*" On being served cocoa with whipped cream, he said, "I really can't eat that. If I do I'll get whipped. I can't eat any *Schmarrn* (a Viennese dish), because it's nothing." *Schmarrn* in a transferred sense also means something without any value. If one answers *Ja, ein Schmarrn,* in Viennese slang it has the meaning of a negation. All the more remarkable does it then appear, that he understood the exact difference between stratosphere, atmosphere, and troposphere, in which he had become interested in connection with Piccard's flight.

Summary

That Herbert surpassed the average mental development of children of a like age is an incontestable fact. According to the Binet-Simon test, the child was on the average three and a half to four years ahead of his age. The justification for considering his early intellectual development, at least tentatively, in a separate category from his mental illness, is based on the fact that this early intellectual development occurred first without a sign of his illness.

An insatiable thirst for knowledge such as appeared in this child simultaneously with his mastery of speech, has been observed with otherwise normal infant prodigies.[1] Like Herbert, these children also, at least in whatever came within the scope of their unusual talent, exhibited an inordinate self overestimation.[2] Although in all the biographies of early geniuses, traits and qualities are found which are identical with many of those which were observable in this case, nevertheless, there seems to be an essential difference between the talent of the infant prodigy and Herbert's intellectual precocity. The performance of all infant prodigies has occurred in a specific easily demarcated sphere. Many of them showed childish traits and retardations in development. Herbert's early intellectual development appears to have had a different character. There was no special field where his precocity appeared as extraordinary as it does in the case of infant prodigies whose performance is exceptional and far surpasses the average level of the adult. Herbert's development in the intellectual sphere was of a general nature. It appeared as if, at twenty-two months of age, he had endeavored to be an adult. His mathematical talent although far above the average, was not to be compared with that of a chess genius. Some quite extraordinary talent in some specific field in spite of his illness would have to be demonstrated to consider him a child prodigy. His literary production may be considered merely as a product

[1] Pestalozza, A. Graf. v.: *Das Wunderkind*. Leipzig, 1923.

[2] Baumgarten, Franziska: *Wunderkinder. Psychologische Untersuchungen*. Bern, 1930.

of his universal mental precocity rather than as the first sign of a literary talent, although of course all prognostication over the further development of his talents must remain very uncertain. Between the quality of his intellectual maturity, and the type of his illness there is a very far-reaching connection, at which one can merely hint. Perhaps the proofs may be deduced from the summary of his libidinal development as it appeared in the frame-work of the analytical treatment.

His linguistic talent does not fall, perhaps, quite within the scope of general intellectual precocity, because properly speaking, Herbert never acquired the language of a child but began at once to speak correctly. In other respects, his intellectual development was parallel. He walked without first learning to creep; he could read without any observable effort to learn; he could write without having had to practice it. There emerges here a new problem. How was Herbert able directly to achieve all these purely intellectual feats? The unusual quality of his genius may lie, perhaps, in just this faculty of acquiring mental knowledge without preliminary training, which may have to be accounted for by the fact that he possessed a peculiar propensity in this direction which is incapable of further explanation. There appears to be present in his speech, a faculty for formal presentation which is far above the average. Everything he said was in a sense verbally perfect, and it could not be said that the form of his sentences was borrowed from books, for his reading which was confined mostly to dictionaries and calendars, could not possibly have helped to form his style. It is difficult to procure comparative material from unusually speech-talented children, or from the biographies of poets at the same age level. There is little such material available, and when one comes across childhood sayings in a poet's biography, one is never certain that such sayings are cited literally.

As already mentioned, when Herbert was brought to the analysis, he used only the infinitive of verbs, avoiding the pronouns *I* and *you*. C. and W. Stern in their book, *Die Kindersprache,* have reported that their little daughter, at the

age of twenty months, employed the infinitive only, and the use of *I* and *you* first developed at the age of twenty-five months. One might venture to suppose that Herbert had regressed to an earlier stage of speech development. His parents, if we may believe what they say, had never observed such a stage in his development. Perhaps the period of normal speech acquisition passed so quickly that no such observation was possible. In contrast to the speech development of other children, which begins with the imitation of sounds, Herbert showed always a disinclination to onomatopœia. When he had been asked to copy a story about a fire company in which the expression *trara* appeared, he had objected strongly to this word. "I can't write that. That is childish. You can't copy sounds. Sounds are really not words." For a time he could not be brought to read names of certain animals such as lion, tiger, dog, "because they make sounds which are not words".

Some of his peculiarities of speech which may be observed in the speech development of average children, appeared in his speech at a different time level. Such remarkable combinations as, "That is the water-door because one goes through it to the water-main"; or "the workshop (occupational therapy) is thursdayish because it occurs on Thursday",[1] are very reminiscent of C. and W. Stern's collected word-combinations of their children, which, however, fall within the period of from two and a half to five years of age. Such word-combinations of other children all originated at a time when the speech development was not yet ended. They are, therefore, a constituent part of their speech development, whereas with Herbert these verbal combinations belong to a period long after he had completed his speech development. Considering his unintelligible expressions as original word-formations one discovers that a connection with colloquial speech may always be established.[2] There are to be found in his history, no

[1] Stern, C. and W.: *Die Kindersprache.* P. 347 and ff.

[2] C. and W. Stern characterize "original word-formations" as words which have been constructed without any connection with existing roots. Cf. *Die Kindersprache,* chap. 21.

authentic original creations. Stern and other investigators of children's speech have proved that during the period of speech development these are never observed. Herbert's first unintelligible words, *lan, len, lin, lün, lein,* are etymologically only to be taken as a stringing together of syllables with different vowels, which is so popular among children. What is remarkable, is that these words were used to characterize objects during a period in which speech was already fully developed. The word *floda* might have had its origin in the exclamation *ein Floh ist da! Flau* may have originated by analogy, and the same is true of *flaudele.* The etymologies of *Roche, Toche, Foche,* appear to be sufficiently covered by the word *Toches* (Yiddish for buttocks), and the Viennese expression *Fotz* (female genitals). All other neologisms contain a preponderance of *u* and *i* sounds, always employed in the same sequence. They are constructed in the same way as *Potju* and *Bubilu.* From *Potju,* in an analogous manner, might have been constructed *Jejuju* (keyhole), *futju* (being excited), *tuju* (darling or loving), *schluju* (to administer an enema), *Kindju* and *Vatju.* Similarly formed from *Bubilu,* would be *Klufterierpfuffi* (penis), *Bluftili, Wuftili, Fudili* (nipples), *Wudi* (orange seeds), *Pruicht* (the evil one), and *Kruich* (female genitals). Although Herbert as a rule rejected onomatopœia because "sounds are not words", with certain words one has to presuppose that there is a reminiscence of onomatopœia. For example, *Klufterierpfuffi* suggests *pf, pf,* and *Schluju* (an enema).[1]

Such punning as "I can't eat whipped cream, for then I will be whipped", is frequently encountered in children. Stern observed a similar tendency in his daughter. She would ask, "Do nightingales make night?" At that time she was three years and nine months old, and obviously did not yet understand the meaning of the word nightingale. Herbert knew the meaning of all the words he used. At times he chose to ignore their meaning for a specific reason. There are some

[1] It is a great pity that Stumpf, in his report *Eigenartige sprachliche Entwicklung eines Kindes,* could discover no reason why this child clung so long to this remarkable speech. (Zschr. f. pädagogische Psychologie II, 1900.)

important parallels to the speech disturbances of schizophrenics, which cannot be gone into in this article.

This child had been brought for treatment with the diagnosis of an infantile psychosis, and the recommendation that he be sent to an institution. He was completely subject to numerous phobias, rituals and prohibitions which he had explicitly to observe, defensive measures against every kind of medical attention, he showed an insupportable restlessness, attitudes approaching delusions of grandeur, a total lack of contact with surroundings with absence of any feeling, and completely unintelligible speech, all of which made living with him at this period very nearly impossible.

The first step in the treatment was the establishment of a contact with the analyst. Next to be observed, was a certain interest in his environment. For the first time, he spoke normal sentences, he began to use personal pronouns, it became possible to give him medical attention, and the delusions of grandeur were reduced. He no longer had to preserve the illusion that he was an adult practicing a profession to be able to exist.

During the next phase of the treatment two very widespread phobias disappeared, the fear of keyholes, and the fear of the "squirting lattice". His fundamental attitudes towards his parents and his brother emerged, he developed an increasing attachment for the analyst and for his kindergarten teacher, his self overestimation was further reduced, but his fear of speaking proper names, and of naming parts of the body remained.

The latest period of the analysis here reported attacked the problem presented by his expressed wish to remain fearful. He managed finally to speak proper names and names of the parts of the body, and in general he was changed so much for the better that he could go to school, and be placed in a children's home. Physically, he was much stronger, and his appearance had become significantly more normal. He underwent operations on the ear, nose, and throat, without the slightest relapse to the original condition of his illness. His

behavior at home was a little improved although his earnest endeavors to establish a more cordial relationship with his mother and his brothers met only with disappointment. Consequently, he was all the more attached both to his teachers and to the analyst, and his behavior in the family which lodged him during a summer was entirely normal. With children of his own age he now formed some sort of a superficial relationship. He succeeded in his studies at school, in spite of his refusal to adapt himself to the curriculum. His quest for knowledge remained totally unchanged, with the exception that he was no longer so querulous and disturbing, and he was much more reasonably selective in his interests. He was less awkward, but any instruction requiring manual dexterity he rejected as "a stupid imitation". He had given up the use of all unintelligible words. His talent for expressing himself in words and for calculating endured, although they were no longer so striking and abnormal as formerly. In spite of this great progress Herbert could not be said to be a normal child; he was still too conspicuously introverted from time to time. When he was buried in a book or lost in his thoughts, one found it difficult to engage his attention. But very often he was interested in everything, laughed and played as would an ordinary child, or else he was ironic and witty in the manner of an adult. This last began to develop in the most recent period of the treatment and steadily increased. Thus when he had been reproached for the long time which he took to dress, saying, "You need five minutes for each overshoe", he had replied with a laugh, "What are five minutes to eternity?" He could now, like other children his age, take care of his needs, wash, and dress himself. But at times his tendency to introversion prevented him from accomplishing this. Similarly, for a while, he would make no objection to eating the food given him, but then again he would refuse certain dishes. He took longer to eat than other children because of his bad teeth and because, especially while eating, he became greatly self-absorbed. One might say that he was able to forego all his fears, prohibitions, and rituals when he was not exploiting them to obtain something.

In tracing his libidinal development, one is first impressed by the extraordinary difficulty encountered in his weaning. The violence with which he rejected all other forms of nourishment which were placed before him, allows one to assume the presence of an unusually strong oral constitution. Taking into consideration the extent to which the younger brother was utterly spoiled by his mother, one may safely infer that during Herbert's infancy, his mother had done everything imaginable to indulge him orally. Everything known of his development after weaning, is in accord with a tenacious clinging to his oral pleasure. The feeding problem began immediately, and increased as time went on. Furthermore, one finds in him from the earliest age all the characteristics of the oral type.[1] He began to talk extremely early, and his speech development was accomplished in an unusually short time. He showed an abnormal urge to know, would have liked impatiently to swallow up everything which furnished him with knowledge, to suck in everything in his environment. He was insatiable in this demand; his craving for knowledge knew no limitation. It seemed as if the restlessness with which he pursued his intellectual interests were a proof that his abnormal mental development had absorbed all the available energy, so that nothing was left over for the creation of normal object-relationships, displaying no feelings, and never demanding affection, indicating a marked fixation at the autoreotic level. He had kissed and caressed himself. His strong autoerotism, on the other hand, may have intensified the effect of the frustration which the retarded weaning had occasioned, and thus have checked the establishment of object-relationships.

It may certainly be said that Herbert exhibited a special fixation to the second stage of oral erotism, the level of pleasure in biting. One will recall in this connection the importance to him of nipples, his anxiety of being bitten by the *Wudis* (orange seeds, nipples), with the consequence that he could only suck out the orange, an anxiety that was a defense against

[1] Abraham, Karl: *The Influence of Oral Erotism on Character-Formation.* In: Selected Papers on Psychoanalysis. London: Hogarth Press and The Inst. of Ps-A., 1927.

his desire to bite. His oral sadism was distinctly expressed in his very first words in the analysis, "Everyone is choked".[1]

In the period in which Herbert should have begun to develop normal attachments, he experienced three severe traumata: the birth of his brother, painful treatment for otitis media which he was forced to endure for months, and an attempted seduction by a maid servant. His parents made the observation that his mental illness steadily increased following this period. There is a connection between these traumatic events and the character of his illness. All of his symptoms,—his unintelligible words, the compulsions, his delusions of grandeur, his refusal of every kind of medical attention, his fear of speaking names and parts of the body, his anxiety about keyholes and the "squirting lattice",—serve the one purpose of protecting him against the repetition of these three frightful experiences. The fantasy that he was an adult with a profession also had the purpose of avoiding the dangers which threatened him as a child. He kept all doctors away, in order to prevent them from hurting him as they had done when they treated his ear. His refusal to eat was a repetition of his reaction to the trauma of weaning. His disinclination for everything that was new sprang from a desire to stick to whatever had been proven safe. His desire to know and understand everything concealed behind the oral greed an apprehension that whatever was unknown might constitute a menace.

His peculiarities of speech were defensive measures against the anxiety aroused by his traumatic experiences, and they originated as a protection against their repetition. He did not give the strap in the trolley car its proper name because he could not admit that he was a child unable, on account of his small stature, to reach it. Sequences of unintelligible words all of which represented things taboo, were found for the greater part to have originated through analogy to two pet names which his mother had called him, when he was still the only child. The use of these unintelligible words signified a

[1] Sterba, Richard: *Spinne, Erhängen und Oralsadismus.* Psa. Bewegung IV, 1932. A connection between hanging (choking) and being bitten is shown.

retreat to a period preceding the terrifying traumas, a period in which no injury had as yet befallen him. Many of the other peculiarities of his speech, such as the exclusive use of the infinitive, the avoidance of certain personal pronouns, odd combinations, which in his case, in contrast to other children, were found only after the developmental period of speech had come to an end, are to be viewed as a flight to the happy time in which he was a suckling, beloved and spoiled by his mother. He had begun to talk when he was nine months old, and at fourteen months the developmental period of his speech may be regarded as having come to an end. At eleven months he had been weaned. Through the revival of certain peculiarities belonging to the developmental period of his speech, he repeatedly experienced the pleasure belonging to the period in which these imperfections first made their appearance. No one had observed them because he had learned so quickly to talk.

Deriving also from the influence of his strong oral fixation was his firm conviction in the magical power of the spoken word to alter reality. Simply to state that he was a shopkeeper, made him one. Naming a part of his body would make it vulnerable; to speak a person's name might cause him to become transformed into that person; if he were to speak the word, girl, he might become castrated like a girl. Similarly, he could not walk by a perfume shop, because of his conviction that it had squirted at him. His inner realities had for him greater force than external reality, and he strove to impose this inner reality of his upon those with whom he came into contact.

It is known that primitive peoples have prohibitions which forbid the speaking of a certain name because, if it were uttered, some inauspicious event fraught with danger would follow. With children, also, there is a period in which they believe in the omnipotence of their wishes, gestures, and words. Following its birth, there is an attempt on the part of those who take care of the infant to approximate the condition prior to birth where it was in need of nothing, and this

is done by anticipating the infant's every need. Every expression of a need is followed by its immediate fulfilment. The child soon recognizes this sequence and deems the utterance of its wishes to be invested with sufficient power to bring about their satisfaction. It has sufficient cause to believe in its omnipotence. When it learns to talk, the feeling of omnipotence is transferred from the previous physical expressions of its needs, to words. Ferenczi has described this phase of the period of magic omnipotence of words.[1]

The beginning of this period of the magical omnipotence of words, must fall naturally in Herbert's development in the period of his speech development. He had, moreover, particular reason for being convinced of the omnipotence of his words, for through words he had succeeded in attaining the continuation of the suckling's almost completely satisfied condition. He had begun to talk at nine months, and nursing was continued at his demand until he was eleven months old. One might for this reason assume a special fixation to the period of omnipotence of his words which was in turn strengthened by virtue of his oral fixation.[2]

The form of his aggression also showed his fixation to the stage of magical omnipotence of words. He seldom attacked physically his brother whom he threatened verbally with cutting off his *Roche*. His strongest, affect-laden aggressions were imprecations. By crying out a hundred times, *Tetschen, Fotzen, Watschen,* he inflicted all these blows through the mere power of his cries. His mother had, in fact, threatened that he would be turned into a sewer-cleaner if he used the word for filth. There is no doubt that his continuous efforts to be grown-up and big and to have a profession, his rejection of everything childish and his opposition to the very use of the word "child", are all results of the severe disappointments which as child he had really endured.

Another sign of his imperfect adaptation to external reality

[1] Ferenczi, Sándor: *Entwicklungstufen des Wirklichkeitssinnes.* In: Bausteine zur Psychoanalyse I, p. 76. Wien: Int. Psa. Verlag, 1927.

[2] With regard to the importance of weaning in the development of the sense of reality, compare also Siegfried Bernfeld's *The Psychology of the Infant.*

was the lack of his connection of the meaning of a word, to the thing itself, which was conspicuous at times when he had reason to deny reality, in situations in which he felt himself endangered or which were preceded by events which incurred the threat of danger. Also the abundant symbolism in his speech and actions seems to be further proof of his failure to achieve object relationships. When he had handed an object to a teacher who was in a receptive, passive position, it had had for him the meaning of an act of sexual intercourse (the test material for touching, in the Montessori school); when he had stamped on the floor, it had meant producing children. The foot was the symbolic penis with which he stamped a hole in the earth out of which the children were drawn (his stamping on the ground during the illness of his little friend).

It seems justifiable to conclude that there is an essential difference between a childhood neurosis and Herbert's illness. However, as the theoretic considerations from the analysis of this case will be deferred to a subsequent paper, the author will here summarize the difference briefly. Despite his unusual intellectual maturity, Herbert's illness consists in his adhering to an extremely early stage of ego development in his relation to reality. To be sure, certain constituents of his ego have developed a relation to reality, but they are in the minority, and the chief components of his personality have remained retarded partly as a consequence of the severe traumata, and partly also on account of his pathological self-love and his strong oral fixation. Because of this defective reality testing, his conviction that reality consists in what he asserts and imagines, make it justifiable to conclude that his illness was a psychosis rather than a neurosis. This distinction lies in the fact that with a neurotic child, one who has a dog phobia, for example, the symptoms are expressed in such a way that the fear of dogs is found to develop from inner conflicts, whereas with Herbert, in consequence of the frustrations and injuries which he had suffered, the picture of reality itself had undergone alteration in such a way as to protect him against all dangers.

The difference between his illness and the psychosis of an

adult may be formulated in the following manner. The essential characteristic of an adult psychosis is the loss of contact with reality, whereas in this child one finds rather a failure to acquire any such relationships at all. That is to say, it is primarily the factor of regression which distinguishes Herbert's illness from the psychosis of an adult.

There is an objection which the reader might be prompted to raise. One might be inclined to regard the protective mechanisms, which are compulsive in character, as symptoms of a compulsion neurosis. This is supported by abundant evidence of a strong anal sadism. He wanted to stick his finger into his brother's anus, to give him an enema, and then, on account of his own libidinal wishes was in turn himself afraid of enemas. But apart from the general weakness of his object relationships and the fact that most of his sadistic aggressions were encountered on the oral level, there is another essential difference from a compulsion neurosis, and that is the fact that he devised all his protective measures consciously, employed substitute words in order to escape the dangers which his verbal expressions might involve, and did not speak other words because he knew exactly the dangers which would beset him, and was firmly convinced that these dangers would materialize; so firmly convinced, in fact, that he altered the outer world to suit himself in order to escape a repetition of these dangers. The compulsive neurotic, on the contrary, is not conscious of the reasons for which he carries out his compulsive act. It is true that he believes that something dreadful might happen, but he is not aware of all the antecedent events which have set this compulsion in motion. It is only during analysis that all this can be made conscious to him and brought into its proper connections.

On all occasions his fears of an injury to his entire person was much greater than the fear of an injury to his genitals. Even though he was afraid of losing his *Klufterierpfuffi* (his penis) and of becoming a girl, that is to say he showed what one commonly calls castration anxiety, the author attributes a secondary importance to this anxiety, because the fear of injury to his

entire person was ever present. When he was masturbating in the children's home without any sense of shame he still continued to defend himself against all medical treatment. Likewise the anxiety of the "squirting lattice" disappeared completely only when it had been brought into proper connection with his experiences at the children's clinic, with the crib and its railing and the enforced douching which recalled to his mind the ear treatments. Attention is called to how crude, direct, and uninhibited by shame were the expressions of his sexual activities, and that this is an argument against his fear of being punished for these activities to any unusual degree. This fact falls into the category of his remarkable precocity and desire for universal knowledge. He knew everything, requested the school teacher to have coitus with him, was familiar with how a penis functions, but the next moment on seeing a new book, he was completely indifferent to such things. His attitude towards sexual knowledge was charged with no greater affect than to any other topic, and he never became so excited when masturbating or being *futju,* as on those occasions when he was able to learn something new.

Corresponding to the difference in form of his illness from that of the ordinary neurosis of childhood, the treatment had to have a different aim. It was not a question here of discovering and making conscious and intelligible the unconscious, but rather of permitting him *to make up for his deficient contact with reality,* to educate him, so to speak, to a normal sense of reality. The analyst succeeded first by participating in his delusional ideas, and by understanding them, came to occupy a position in his omnipotent magic world corresponding to his demand for a protector equipped with magical power. From this position of advantage, which for him betokened the most important relationship to an object in the outer world, she began gradually to confront him with reality, and, while affording him protection by her enchantment, to show him again and again, and to prove to him the unreality of his affirmations. It is unnecessary to emphasize that such a procedure was possible only on the basis of an acquired understanding of the

protective function of his delusional ideas, and that it required the most careful dosage in order to maintain his attachment to her in spite of her encroachments. At the same time she gave him as far as possible the opportunity actively to work off the sufferings he had passively endured, as for instance, by drawings in which the devil made off with the doctors. It can not be said that the explanations given him were interpretations in the narrower sense of the word. He needed usually only a hint which he elaborated at once into an exhaustive and penetrating explanation of the psychological situation that was under discussion, so that it was not necessary to interpret.

The changes which were accomplished in this treatment together with the displacements in energy which brought them about, were realized through the acquisition of a sense of reality, and by the extension and deepening of the child's relationship to the outer world, and to human beings. This furnished him with the further possibility, based on an identification with the analyst, and protected through the belief in her magical power, of assuring himself of the relative harmlessness of the outer world. In the beginning his attachment to the analyst could still not be characterized as normal on account of the position which she had occupied from the start in his reality-denying system. It was only in the last phase of the treatment described, that one finds traces of object-libido, such for instance as his jealousy, and his interest in her private life.

With the strengthening of his object-relationships his libidinal orientation also underwent an alteration. He was freed in part from his oral fixation. One sees from the persistent strong urge to know, from the overemphasis of everything verbal, and from his continual difficulties in eating, that the oral component still remains in the foreground. How far he will still be able to overcome this fixation, the future will disclose.

Translated by SYDNEY G. BIDDLE

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Horace Westlake Frink, M.D. 1883-1936

C. P. Oberndorf, M. A. Meyer & A. Kardiner

To cite this article: C. P. Oberndorf, M. A. Meyer & A. Kardiner (1936) Horace Westlake Frink, M.D. 1883-1936, The Psychoanalytic Quarterly, 5:4, 601-603, DOI: 10.1080/21674086.1936.11925301

To link to this article: https://doi.org/10.1080/21674086.1936.11925301

Published online: 11 Dec 2017.

IN MEMORIAM

Horace Westlake Frink, M.D.
1883-1936

It was with profound sorrow that those associated with psychoanalysis in America learned of the death on April 18, 1936, at Chapel Hill, North Carolina, of Dr. Horace Westlake Frink. Dr. Frink was one of the first physicians in America to engage in psychoanalysis as a specialty and from the time when he first became interested until he was forced to relinquish practice through illness, he was one of its most effective and ardent supporters.

Horace Westlake Frink was born on February 7, 1883, at Millerton, New York, the son of George Sherman and Henrietta Foster Frink. His family on both sides had resided in this beautiful territory at the foothills of the Berkshires since prerevolutionary days. As a child he went to live with his uncle, Dr. Horace Goodwin Westlake, of Hillsdale, New York, for whom he was a namesake, and grew up in this medical atmosphere. Dr. Westlake was widely known as a practitioner in the Hillsdale district where he practiced for sixty years after his graduation from New York University in 1850.

Dr. Frink received his early education in the common schools of Hillsdale but later transferred to the Norfolk, Connecticut, school which he attended from 1899 to 1901 to prepare for college. In 1901 he entered Cornell Medical School from which he graduated in 1905 and thereupon served an internship on the Second Surgical Division of Bellevue Hospital from 1906 to 1908. Although he showed considerable promise as a surgeon, this specialty never attracted him and during the two years in which he was in general practice after leaving Bellevue Hospital, he devoted himself to extensive reading and to the study of neurotic conditions. This work led him to the investigation of hypnosis which in turn accounted for his drift to psychoanalysis which in 1909 was beginning to make itself known in American psychiatry. In that year he became an

assistant in the outpatient neurological clinic of Cornell University Medical School, at the time under the directorship of Professor Charles L. Dana. Dr. Dana, notwithstanding many deep prejudices against psychoanalysis, showed great tolerance in the clinic and before long permitted Dr. Frink to devote himself exclusively to the treatment of neuroses and allied conditions. This work at the Cornell clinic was perhaps the first time in the world that ambulatory patients were treated by psychoanalysis, which at that period was still at times combined with mental catharsis under hypnosis.

From 1914 Dr. Frink served as Assistant Professor of Neurology at the Cornell University Medical School and as Adjunct Neurologist to Bellevue Hospital. His positions entailed the instruction of the Cornell medical students in psychopathology. Dr. Frink inevitably presented hysteria and neuroses from the analytic approach and his capable and lucid explanations found a favorable acceptance by the students whose general training had not prepared them to consider the psychological basis for conversion symptoms. By this time his absorption in psychoanalysis had quite superseded every other medical endeavor and he resigned in order to devote himself exclusively to psychoanalysis.

In 1912 Dr. Frink married Doris Best. In 1922 he was wedded to Angelica Wertheim and in 1935 to Ruth Frey who survive him. There are also two children, by his first wife, John Westlake and Doris, who survive him.

Dr. Frink was one of the most active of the initial New York group in popularizing the knowledge of psychoanalysis in New York, appearing before many of the local medical societies with presentations of cases illustrating the clinical application of psychoanalysis. In 1918 he published "Morbid Fears and Compulsions" dedicated to Professor Dana to whom he felt he owed a great debt for the liberal attitude which Dr. Dana maintained toward a theory of which he was not convinced. The book remains today one of the clearest and most readable on neuroses in English.

The idea that an analyst should himself be analyzed as a part

of his technical training did not gain general acceptance in Europe until 1913. The Great War then intervened, but at its close Dr. Frink was one of the first of the Americans to go abroad for this purpose. In Vienna he achieved the great respect and confidence of Professor Freud.

A series of tragic events after 1922 so affected him that for many years he withdrew from practice almost entirely. Some years before his death he moved to Chapel Hill, North Carolina, where with the return of health he began to resume contact with psychological and psychiatric problems.

Dr. Frink was a charter member of the New York Psychoanalytic Society, its first secretary from 1911 to 1913 and its president from 1913 to 1915. He was an early member of the American Psychoanalytic Association and during the critical years when its existence was threatened, from 1917 to 1920, one of its staunchest supporters. He was a member of the American Psychopathological Association, the American Neurological Association and numerous other medical societies, as well as the New York Academy of Medicine up until 1931.

There are few physicians in New York who became interested in psychoanalysis from 1911 to 1922 who are not indebted to Dr. Frink for an ardent enthusiasm for any efforts they showed to become acquainted with the subject. There was a warmth and zeal in his coöperation which did not take into consideration the time and energy he so willingly devoted to explanation and instruction. His expositions of psychoanalytic principles were marked by a clarity which was always enlivened by laconic comment and quaint phraseology and by homely but incisive illustrative examples. As a friend he endeared himself to many of his colleagues, for they could rely on his loyalty and sincerity. To them particularly, but to psychoanalysis in general, his premature withdrawal from the movement and his death have been a great bereavement and loss.

C. P. OBERNDORF
M. A. MEYER
A. KARDINER

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Research in Dementia Præcox (Past Attainments, Present Trends, and Future Possibilities.) By Nolan D. C. Lewis. Acknowledgment by Dr. Arthur Ruggles. Copyright by the Supreme Council of the Northern Masonic Jurisdiction of the Scottish Rite, released by the National Committee for Mental Hygiene. 1936. 280 pp.

Ives Hendrick

To cite this article: Ives Hendrick (1936) Research in Dementia Præcox (Past Attainments, Present Trends, and Future Possibilities.) By Nolan D. C. Lewis. Acknowledgment by Dr. Arthur Ruggles. Copyright by the Supreme Council of the Northern Masonic Jurisdiction of the Scottish Rite, released by the National Committee for Mental Hygiene. 1936. 280 pp., The Psychoanalytic Quarterly, 5:4, 604-610, DOI: 10.1080/21674086.1936.11925302

To link to this article: https://doi.org/10.1080/21674086.1936.11925302

Published online: 11 Dec 2017.

BOOK REVIEWS

RESEARCH IN DEMENTIA PRÆCOX. (PAST ATTAINMENTS, PRESENT TRENDS, AND FUTURE POSSIBILITIES.) By Nolan D. C. Lewis. Acknowledgment by Dr. Arthur Ruggles. Copyright by the Supreme Council of the Northern Masonic Jurisdiction of the Scottish Rite, released by the National Committee for Mental Hygiene. 1936. 280 pp.

This exhaustive review of research in dementia præcox during the last fifteen years is a part of the coördinated study of this psychosis sponsored by the Northern Jurisdiction of the Scottish Rite. The author has tried to adjust his presentation to both lay and scientific readers. He has achieved a readable style, punctuated by an abundance of sage quotations from students of the philosophy of science. But most of the subject matter is highly technical.

The bibliography comprises 1,778 scientific titles, published between 1920 and 1934 in ten European languages (with "miscellaneous" and "Oriental" references as well.) These are classified according to topics, subtopics, and the publication years. The text is primarily a discussion of this bibliography, under the following headings: Research Trends in Mental Disorder, Clinical Features, Etiological Aspects, Alterations in Structure and Structure Function, Differential Diagnosis, Therapeutic Modifications and Experimental Therapy. There is a brief chapter of conclusions, and a supplementary bibliography of books on dementia præcox (1920–1934) and a four and one-half page bibliography of publications prior to 1920. The author fortunately digresses here and there from his discussion of the bibliography to present cases and opinions of his own, and the latter chapters include a treatise on differential diagnosis. A table comparing in parallel columns the diagnostic criteria of psychoneurosis and psychosis is especially worthwhile (pp. 270–1). A composite of the separate bibliographies, alphabetically arranged, and an index to the discussion would add to its unusual value.

Dr. Lewis' discussion of the literature of research in dementia præcox represents a modern and progressive viewpoint, and a full appreciation of the primary importance of psychologically oriented clinical observation. His general impressions are that "schizo-

phrenic research is in a state of chaos", and "there is too great a tendency . . . to consider mental disorders as due to influences penetrating from without, or due to something dissolving or disintegrating within the individual" (p. 1). His deliberate subordination of personal views and conclusions achieves its purpose of closing no scientific doors. But more pointed criticism and weighting, even a dash of personal bias, would have made the pudding gel.

For Dr. Lewis has promised in his preface "to offer some general principles as well as a few specific leads for future procedures". As we accompanied him on his tour of inspection, we approved his genial nods to speaking acquaintances among a multitude of students. His greeting of Dr. Mead's project to study the psychoses of primitive peoples (p. 98) seemed from the heart. He paused a moment and presented us personally to four applications of lay psychology to his problem (p. 53), and to each of a gathering of fifteen members of the personality-environment and pre-psychotic child clubs (pp. 62–4). For a moment he furrowed his brow and spoke with considerable earnestness of his own contributions to the pathology of schizophrenia, smiled pleasantly at a group of critics, and accorded the endocrines a conventional nod.

But when he finally introduces us to his plans for the future, Dr. Lewis suddenly becomes reticent. He suggests that the work of the imaginative and the plodders should be coördinated, proposes a central library, reiterates the need for integrating studies of different kinds, gives us a table of fourteen fields in which research should be done, and assures us that funds have been allocated for studies in a dozen of them. But just what these are, the method of selection, their relation to an orienting central hypothesis, and above all how they will be "coördinated" is not vouchsafed. Presumably the details of these plans for the work he is organizing will be the subject of a later publication.

One formidable problem which confronts and baffles anyone who is in search of workable hypotheses on which to build a research programme, Dr. Lewis has not solved, though he recognizes it and discusses it in several places. This problem is the differential diagnosis of "dementia præcox". Dr. Lewis quotes those psychiatrists who believe that efforts to establish a homogeneous group of cases and assume a common etiology have served their usefulness. Dr. Lewis seems at times to concur with this view, and points cogently to the fact that the final criterion is

always the schizophrenic's social reactions. His argument against full acceptance of the arbitrariness and futility of our diagnostic controversies is that some system of classification is necessary; it is an indispensable premise of a scientific plan. It might seem, however, that the constructive and inevitable solution of this dilemma is to repeat what Kahlbaum and Kraepelin accomplished in their own day, and to replace a system which impedes as much as it promotes our progress with some other classification which promises to be more serviceable. Possibly the principle suggested by Freud's descriptions of "conversion", "projection", "reaction-formation", etc., i.e., a classification of adjustment mechanisms rather than symptoms, might be usefully extended and universalized. Dr. Adolf Meyer's suggestions have pointed this way but his "reaction types" are based upon the appraisal of total personalities, and are not a classification of personality functions regardless of their dominance in the total adjustment, or their pathogenicity. A new principle of classification would at any rate facilitate useful coördination of psychiatry with other sciences: for it would offer the geneticist, the physiologist, the statistician, relatively simple facts of personality with which to correlate their studies, instead of the very complex and unreal assumptions that the traditional diagnostic categories represent.

Dr. Lewis discusses briefly and intelligently the contributions of psychoanalysis in a number of places, and emphasizes its importance. If psychoanalysis has even greater importance than he recognizes, it is because it is more than one of several important methods; it is also an integrated, empirically founded concept of the interrelationships of physiology, total personality and environment.

IVES HENDRICK (BOSTON)

THE MEDICAL MAN AND THE WITCH DURING THE RENAISSANCE. By Gregory Zilboorg. The Hideyo Noguchi Lectures. Publications of the Institute of the History of Medicine, The Johns Hopkins University. Third Series, Volume II. Baltimore: The Johns Hopkins Press, 1935. x+215 pp.

Though it treats of aspects of a subject about which a whole library has been written, this very pleasing little volume has a freshness and originality of its own. And while its topic lies outside the direct line of psychoanalytic interest, it is a book which can hardly fail of appeal to those interested in the history of psychiatry, of

medicine, or, for that matter, of the human mind. Let it not be thought, however, that the author's subject is of historical interest only; some of the psychological aspects of the *Malleus Maleficarum* are as much in evidence in this the twentieth century as in the century of and following the composition of that Dominican monument of perverted erudition. For what Roman Catholic woman today, having undergone the spiritual degradation of giving birth, would think of appearing in public without first having been "churched"—that is, exorcised? Thus the Roman Catholic Church stands firmly behind a custom which is rather widespread among, and one might have thought peculiar to, peoples we call primitive or savage. Indeed, we have it on the authority of Ernest Jones that "officially, the Roman Catholic Church still holds to every element in the whole conception [of Witchcraft], from the influencing of weather by sorcery to pact with the Devil". And surely a very apogee of present-day obscurantism is reached by the learned Rev. Montagu Summers, the translator into English (1928) of the *Malleus Maleficarum,* in a passage which Dr. Zilboorg quotes (p. 27): "Their objects may be summed up as the abolition of monarchy, the abolition of private property and of inheritance, the abolition of marriage, the abolition of order, the total abolition of all religion. It was against this that the Inquisition had to fight, and who can be surprised if, when faced with so vast a conspiracy, the methods employed by the Holy Office may not seem—if the terrible conditions are conveniently forgotten—a little drastic, a little severe? There can be no doubt that had this most excellent tribunal continued to enjoy its full prerogative and the full exercise of its salutary powers, the world at large would be in a far happier and far more orderly position today. Historians may point out diversities and dissimilarities between the teaching of the Waldenses, the Albigenses, the Henricians, the Poor Men of Lyons, the Cathari, the Vaudois, the Bogomiles, and Manichees, but they were in reality branches and variants of the same dark fraternity, just as [and while the Rev. Summers' words had already had a familiar ring, he now rather lets the cat out of the bag] the Third International, the Anarchists, the Nihilists, and the Bolsheviks are in every sense, save the mere label, entirely identical." Dr. Zilboorg might almost have added, were it not for the detachment with which he is writing *(ad narrandum non ad probandum,* as he says himself), that as also a student and editor of Restoration comedies the Rev. Montagu Summers may perhaps be actuated by that

pruriency which Ernest Jones has demonstrated so clearly as possessing many of the Inquisitors, with the stripping and examination that attended many of the witch trials.

The first lecture having described and analyzed that milestone in the history of civilization, the *Malleus,* in its strong anti-erotic tendency ("In some aspects it is a textbook of sexual psychopathies"—p. 59), its almost incredible misogyny (indeed, the Inquisitors might have said, with Orestes, that they could never weary of killing evil women—and I have no doubt with much the same unconscious motive), and in particular its exclusion of nearly the whole field of medicine from everything that might be ascribed to the devil or his witches (for the *Malleus* finds it impossible entirely to absolve the devil even in such frankly "natural" diseases as epilepsy and leprosy—p. 38)—the second lecture develops the subject of Medicine and the Witch in the Sixteenth Century. In this it is shown, with a wealth of illustration as interesting as it will be new to many readers, how, although the sixteenth century produced such scientists as Tycho Brahe, Erasmus, Melancthon, Cornelius Agrippa and Francis Bacon, among others, and gave to medicine anatomists such as Vesalius, Fallopius, Eustachius and Servetus, and clinicians such as Fracastorius, Felix Plater and Ambroise Paré (p. 70), nevertheless, and imbued though he was with the physiology of the rediscovered Græco-Roman science, the medical man of the sixteenth century "could not help but remain the child of his age": "The devil and the witch, his chief servant on earth, remained an entity apart from medicine, and medicine openly and passively accepted the current attitude. For a long time medicine failed either to register a serious protest or to undertake a dispassionate scientific study of the phenomenon of demonolatry" (p. 89). Even Felix Plater, whom many of us have thought of as the founder of modern psychiatry (since he was perhaps the first to attempt a scientific psychiatric nosology), "came from these strenuous, serious studies a firm believer in the devil as the causative agent of many mental conditions which we would today classify as psychoses" (p. 90).

The last lecture, which will perhaps be found by some the most interesting, even as it certainly makes the most original contribution, of the three, deals with Johann Weyer (1515–1588), the Founder of Modern Psychiatry—to whom, by the way, even the fullest histories of medicine have given at most but a few lines—outlining his life, his personality as man, as humanitarian, as

physician, as psychologist, and his chief work, *De præstigiis demonum,* on the one hand a critical and even polemical examination of the superstitions of the day (written some seventy-five years after the *Malleus,* it is a refutation, point by point, of that work), while on the other, its interest in the ideational content of mental reactions rather than in their forms alone makes it "probably the only medical work with this advanced psychopathological viewpoint written before the pupils of Pinel began to make their contributions during the first quarter of the nineteenth century", and in any case "the most intelligent and scientific collection of psychopathological case histories that the sixteenth century [or, I think I may add, the seventeenth and the eighteenth] has bequeathed us" (p. 167). That this treatise should have run through six editions (plus a translation into the vernacular) within Weyer's lifetime is more surprising than is the opposition which his fearless and radical attack upon what was obviously an emotional need of the age encountered—as Binz remarks, "Weyer was talking like a rational human being to the inmates of a gigantic insane asylum, and undoubtedly with the same success" (p. 187). Although as a genuinely religious man, Weyer "sincerely and rightly saw no conflict between his liberal views and the Church" (p. 192), the Spanish Inquisition put him on the Index as *Auctor secundæ classis* in 1583, but shortly afterwards made him *Auctor primæ classis*—which place he still occupies (p. 194, footnote).

I should like to close this very sketchy summary with a quotation from the concluding pages of the book: "The doctor is the product of man's needs, and as these needs have increased, the doctor's knowledge and skill have grown in proportion. This natural development has been completely reversed in the evolution of medical psychology. Hippocrates had to convince his contemporaries that the sacred disease was not sacred at all, and that it could and should be treated by a doctor. Weyer had to convince his contemporaries that the cursed state of witchcraft or of being bewitched was not cursed and was not a crime but a disease which a doctor could and should treat. . . . While a great many non-medical men have made substantial contributions to many branches of medicine, psychology—that is, academic psychology—has contributed little if anything to psychopathology. The process is here also reversed in that medical psychology has always been the pioneer in the general field, stimulating the most important advances in the study of normal psychology. Therein lies the

greatest historical significance of Johann Weyer, for he was the first medical man to insist that normal and pathological mental processes differ in degree and form but not in substance, and that human will has nothing to do with mental sickness. . . . Weyer's historical contribution is not his humane attitude towards witches, nor even his emphatic recognition that witches were mentally sick women, but his founding of a real clinical psychopathology which endured in spite of every cruel opposition. . . . In short, Weyer's accomplishment was two-fold: first, he introduced the scientific, descriptive, observational method to clinical psychopathology, and second, he reclaimed the whole field of psychopathology for medicine. . . . It is this . . . that gives Weyer the right to be called the founder of modern psychiatry." H. A. B.

PSYCHOANALYSIS EXPLAINED. By Dorothy R. Blitzsten. New York: Coward McCann, Inc., 1936. 66 pp.

This small volume is from the pen of a woman trained in medicine and sociology and the wife of a well-known analyst. There is a friendly introduction by Dr. A. A. Brill. The booklet is well written, furnishes pleasant reading, and as far as it goes is a sound presentation. Theoretical, applied and research features of psychoanalysis are omitted, and the subject is discussed solely from the therapeutic angle. The author selects for special emphasis the free association technique and the actual emotional experience of the subject while undergoing analysis. This reliving of formative personality mechanisms in the transference is the most puzzling phase of the therapy to the inexperienced, and it is difficult to give life to it on the written page. In this case the matter is expounded with a wealth of ingenious simile and analogy which will no doubt be clarifying to many readers. There is a discussion of the bisexuality of man and of certain psychological complications which may arise therefrom, but no direct reference is made to infantile sexuality. Sound observations are made on the relation of psychoanalysis to psychiatry and the proper training and qualifications for practicing analysts. This is essentially a popular exposition and might with some condensation have appeared as a magazine article. Those who read it should gain respect for psychoanalysis and a new awareness of therapeutic procedure, but for any real understanding of the subject as a whole aid from supplementary sources will be necessary. MARTIN W. PECK (BOSTON)

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Current Psychoanalytic Literature

To cite this article: (1936) Current Psychoanalytic Literature, The Psychoanalytic Quarterly, 5:4, 611-612, DOI: 10.1080/21674086.1936.11925303

To link to this article: https://doi.org/10.1080/21674086.1936.11925303

Published online: 11 Dec 2017.

CURRENT PSYCHOANALYTIC LITERATURE

International Journal of Psychoanalysis. Vol. XVII, Part 4, October, 1936.

JOAN RIVIERE:	On the Genesis of Psychical Conflict in Earliest Infancy.
GEORG GERÖ:	The Construction of Depression.
LUDWIG EIDELBERG:	A Contribution to the Study of the Slips of the Tongue.
M. N. SEARL:	Some Queries of Principles of Technique.
A. L. COCHRANE:	"A Little Widow is a Dangerous Thing."

Zeitschrift für psychoanalytische Pädagogik. Vol. X, Number 2, 1936.

ALICE BÁLINT:	Versagen und Gewähren in der Erziehung *(Prohibition in the Rearing of Children).*
EDITH BRAUN:	Eine Kinderfreundschaft. Beobachtung aus einem Kindergarten *(A Childhood Friendship. Observations in a Kindergarten).*
ALFRED MEYER:	Das Kleinkind und seine Welt *(The Infant and its World).*
OTTO FENICHEL:	Die schwarze Köchin *(The Black Cook).*
HANS SCHIKOLA:	Über Lernstörungen *(Disturbances in Learning).*
EDITH BUXBAUM:	Detektivgeschichten und ihre Rolle in einer Kinderanalyse *(Detective Stories and their Rôle in a Child Analysis).*

Vol. X, Number 3, 1936.

EDITHA STERBA:	Schule und Erziehungsberatung *(The School and Child Guidance).*

Vol. X, Numbers 4 and 5, 1936.

EDITH BUXBAUM:	Massenpsychologie und Schule *(Mass Psychology and School).*
MARGARETHE SCHMIED:	Ess-Störungen und Verstimmung *(Disturbances in Eating and Dejection).*
EDWARD LISS:	Spieltechniken in der Kinderanalyse *(Play Technique in Child Analysis).*
EDITHA STERBA:	Zwei Arten der Abwehr *(Two Methods of Defense).*
BERTA BORNSTEIN:	Leugnung durch die Phantasie *(Denial by Means of Fantasy).*
ANNA MÄNCHEN:	Denkhemmung und Aggression *(Inhibitions of Thought and Aggression).*
ERWIN STENGEL:	Prüfungsangst und Prüfungsneurose *(Examination Anxiety and Examination Neurosis).*
RUTH WEISS:	Psychoanalyse und Schule *(Psychoanalysis and School).*

The Psychoanalytic Review. Vol. XXIII, Number 4, October, 1936.

DAVID LINDSAY WATSON:	In the Teeth of all Formalism.
BERNICE S. ENGLE:	Attis: A Study of Castration.
MARK G. KANZER:	The Personality of the Scientist.
RALPH G. GREENSCHPOON:	A Case of Agoraphobia.
ELLIANE ELMORE:	Mrs. Miller: A Study of Psychic Blindness.

The American Journal of Orthopsychiatry. Vol. VI, Number 2, 1936.

DAVID M. LEVY: Hostility Patterns in Sibling Rivalry Experiments.

Vol. VI, Number 3, 1936.

SMITH ELY JELLIFFE: Children's Problems: A Generalized Approach.

Character and Personality. Vol. IV, Number 4, June, 1936.

EDWARD GLOVER: War and Pacifism: Some Individual Unconscious Problems.

Bulletin of the Menninger Clinic. Vol. 1, No. 2, November, 1936.

WILLIAM C. MENNINGER: Psychoanalytic Principles Applied to the Treatment of Hospitalized Patients.

American Heart Journal. Vol. XI, January, 1936.

KARL A. & W. C. MENNINGER: Psychoanalytic Observations in Cardiac Disorders.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Notes

To cite this article: (1936) Notes, The Psychoanalytic Quarterly, 5:4, 613-614, DOI: 10.1080/21674086.1936.11925304

To link to this article: https://doi.org/10.1080/21674086.1936.11925304

Published online: 11 Dec 2017.

NOTES

THE NEW AUTHORIZED TRANSLATION of Professor Freud's *Hemmung, Symptom und Angst* prepared by Dr. Henry Alden Bunker and serialized in this QUARTERLY has been released in book form under the title The Problem of Anxiety. The book is published by The Psychoanalytic Quarterly Press in association with W. W. Norton & Company, and is the latest addition to the Psychoanalytic Quarterly Library series. Another book to be released shortly by The Psychoanalytic Quarterly Press is Dr. Sándor Ferenczi's Thalassa: A Theory of Genitality.

THE WASHINGTON-BALTIMORE PSYCHOANALYTIC SOCIETY announces the establishment of an institute for research and education in psychoanalysis and related fields of study, The Washington School of Psychiatry, with Dr. William A. White as its Honorary President. The school is an outgrowth of the William Alanson White Psychoanalytic Foundation. During the fall, winter and spring sessions the following lectures and seminars will be given: 1. The Literature of Psychoanalysis, a series of eight monthly lectures by Drs. Brill, Dooley, Fromm-Reichmann, Blitzsten, Zilboorg, Graven and Horney.——2. Clinical Conference, by Dr. Frieda Fromm Reichmann.——3. An Introduction to Human Biology, by Dr. Ernest E. Hadley, eight round-table sessions.——4. Research Studies in Psychopathology, by Dr. Lucille Dooley, eight lectures.——The Psychopathology of Interpersonal Relations, by Dr. Lewis B. Hill, eight lecture discussions. The training committee of the Society also announces a series of ten to twelve lectures on Social Case Work by Dr. Hill, and a seminar on The Application of Psychoanalytic Concepts to Social Case Work conducted by Dr. LeRoy M. A. Maeder. Letters of inquiry concerning the School should be directed to Dr. Ernest E. Hadley, Executive Director, The Washington School of Psychiatry, 1835 Eye Street, N.W., Washington, D.C.

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE is holding its twenty-seventh annual luncheon on November 12th at the Hotel Roosevelt, New York City. Dr. Arthur H. Ruggles will preside. Dr. Marion Kenworthy will deliver an address on the late Dr. Frankwood E. Williams, former editor of the QUARTERLY and Medical Director of The National Committee for Mental Hygiene.

A NEW NEUROPSYCHIATRIC PERIODICAL, believed to be the first to be published on the Pacific coast, *Jornadas Neuro-Psiquidtricas del Pacífico,* has been established at Santiago, Chile, and will appear next January.

IN COMMEMORATION of the late Dr. Eder's long services to psychoanalysis it has been decided to offer to the Hebrew University in Jerusalem a Psychological Library that will bear Dr. Eder's name. Zionist friends, who intend to issue a wide appeal, aim at filling a lack in the Hebrew University the existence of which Dr. Eder himself keenly felt. It is proposed that psychoanalysts in sympathy with this aim should be asked to contribute a fund which would be added to the Zionist fund collected for this purpose. The appeal for this fund is signed by Professor Freud and Dr. Ernest Jones. Subscriptions should be addressed Eder Memorial Fund, and sent to: 81, Harley Street, London W. 1.

THE MENNINGER CLINIC of Topeka, Kansas, is issuing a Bulletin of which two issues have appeared thus far.

The Psychoanalytic Quarterly

ISSN: 0033-2828 (Print) 2167-4086 (Online) Journal homepage: https://www.tandfonline.com/loi/upaq20

Index

To cite this article: (1936) Index, The Psychoanalytic Quarterly, 5:4, 615-627, DOI: 10.1080/21674086.1936.11950916

To link to this article: https://doi.org/10.1080/21674086.1936.11950916

INDEX