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PSYCHO-ANALYSIS

BY

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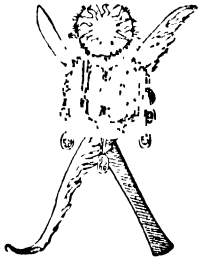

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TO THE MEMORY

OF

SIGMUND FREUD

PREFACE

The task of condensing the theory and practice of psycho-analysis within the space available in a monograph series is by no means easy. It is hoped that the present outline will give the practitioner some idea of the existing scope and future possibilities of this science. For obvious reasons stress has been laid on what might be called the more conventional aspects of clinical psychology, such as, for example, the somatic manifestations of psychic disorder. Some indication has been given, however, that clinical psycho-analysis concerns itself with a number of subjects which are not usually regarded as medical. Indeed it is no exaggeration to say that it has advanced the frontiers of medicine to include many of the territories of individual and social psychology. In so doing it has added considerably to the labours and responsibilities of the general practitioner.

For the convenience of those who wish to follow up the subject a list of recommended books has been added.

EDWARD GLOVER.

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PSYCHO-ANALYSIS

CHAPTER I

INTRODUCTORY

Although the incidence of psychological disorders in general practice has never been accurately estimated, there is no doubt that they are of extremely common occurrence. In whatever form they may appear, whether as pure neuroses for example, or as psychological complications of organic illness, they provide the general practitioner with some of the most harassing of his therapeutic problems. Partly for this reason and partly because the name itself suggests a technical method, psycho-analysis is regarded by most practitioners simply as one of a number of therapeutic methods, to which recourse may be had when the more customary procedures of organic medicine have been tried without success. The popular association of psychotherapy with the names of Freud, Jung and Adler is calculated to reinforce this somewhat restricted view. It is, of course, true that psycho-analysis was originally developed by Professor Freud as a method of treating the psychoneuroses, in particular hysteria and the obsessional neuroses. And it is still the most radical procedure that can be adopted in such cases. But within the last twenty years it has come to be applied to a great variety of abnormalities of character, to a number of social and sexual difficulties, to the mental disorders of children and, in more recent times, to various forms of psychosis, particularly the manic-depressive group. During the same period the number of so-called normal individuals investigated by means of psycho-analysis has greatly increased. As a result

of these investigations it has been established that even the most bizarre forms of mental disorder are, in a sense, caricatures of normal mental mechanisms or formations. Moreover, there are a number of peculiarities in conduct which lie between the apparently normal and the glaringly abnormal. These are rarely seen in hospital but are a frequent source of difficulty in general practice either because they interfere with the individual's social and working capacities or because they retard his recuperative processes during ordinary organic illness. Research into the mental processes of children has confirmed the early psycho-analytical view that mental disorders manifested in adolescence and adult life are based on developmental disturbances occurring for the most part during the first five years. This developmental approach has given great impetus to the classification of mental disorders in terms of psychological depth. Etiological formulae have been established, and, although there are still gaps remaining to be filled, it is now possible to solve many difficulties in diagnosis and prognosis by using psycho-analytical standards of assessment. In short, psycho-analysis is not only a method of mental treatment, it provides a technique of research on the normal and abnormal function of mind and the formulations it has arrived at constitute a theory of mind.

Freud's theory of mental structure and function is based on the old physiological concept of a reflex arc. Mind corresponds to the central system of this arc, a system whose function it is to regulate excitations arriving by afferent paths and to secure as far as possible their appropriate discharge through efferent channels. By adopting this analogy, mind can be regarded as an instrument or apparatus and can be thought of as having a psychic locality and structure. This constitutes the *topographic* approach to the problem. A second, *dynamic*, approach is concerned with the excitations that disturb this central system. Mental activity is a response to disturbances of equilibrium. These disturbances arise out of (1) the stimulations of (for the most part) unsatisfied instincts, (2) the psychic discomforts which follow or threaten to follow rise or fall of instinctual energy. Activities due to instinct-

tension may manifest themselves either as mental experiences (thoughts or feelings) or through bodily (motor and sensory) innervations of which the mind also takes cognizance.

Mind can also be regarded as an *economic* process. The economic aspects are governed by a general tendency of the psychic apparatus to master such instinct excitations as cannot be immediately discharged and in consequence threaten a variety of discomforts, one of the most compelling of which is described as anxiety. Guided by what is called the *pleasure-pain principle* the mind seeks to reduce stimulation to an optimum level and, in the case of undischarged excitations, it achieves this purpose through a number of unconscious mechanisms. These may provide a substitute discharge or control the excitation by distributing it over various qualitatively different systems, or again, inhibit the energy as near as possible to source. Some of these economic manoeuvres have satisfactory results: others have not. When the result is regarded as satisfactory by both individual and the community the individual is by common consent regarded as normal. *Neuroses and other mental abnormalities are simply forms of unsatisfactory discharge which take place when the psychic organ has failed to deal adequately with the instinct tensions to which it is subjected.*

These three approaches, the topographic, the dynamic and the economic, are essential to the full understanding of every mental event. Nevertheless each observer is likely to follow his own preferences in the matter of approach. Many can grasp the dynamic and economic aspects of mind who have no feeling at all for mental topography. This difficulty can be overcome to some extent by thinking of mind in temporal rather than spatial terms. Temporally regarded, it is a series of more or less characteristic events occurring between the phenomena of stimulation and those of discharge. The function of these events, both popularly and scientifically regarded, is to secure and maintain peace of mind and body.

A common reproach levelled at psycho-analysis is that its terminology is obscure and apparently verges on a

specialized form of jargon. This is a reproach from which the physical sciences are almost entirely immune. The terminology of biochemistry, for instance, is much more complicated than that of psycho-analysis yet no exception is taken to this inevitable expansion of a physical science. Indeed it is certain that as psycho-analysis progresses its terminology will become more rather than less complex. In many respects the state of psychological medicine to-day is comparable to that of organic medicine at the time when the circulation of the blood was discovered. The great mental systems or organs of the mind have been isolated and their general functions established. These conceptions have already been turned to service in building up broad classifications of mental abnormalities. But the time will no doubt come, when mental mechanisms and disturbances of function will be as closely subdivided as is at present the case with disturbances of physiological function. As in other sciences, a number of basic concepts are employed (compare, for example, the terms 'neural energy' and 'psychic energy'), but these concepts are merely conveniences to be adapted to the needs of the science. In many instances the terms used by psycho-analysts have been taken from current speech and given a scientific connotation, e.g. the use of the term 'repression' or 'complex'. But the same practice is adopted in natural science as, for example, when the term 'wave' is used in physics. Psycho-analysis is essentially an empirical science and has made a practice of discarding old conceptions or building up fresh ones as the occasion demands.

Space does not permit a lengthy discussion of the intimate relation of theory to practice but it may be said that an adequate grounding in the structure and function of the normal mind is as necessary to the clinical psychologist as a knowledge of anatomy and physiology is to the organic physician. Owing to the fact that psycho-analytic treatment is a highly technical procedure and that its practice involves a specialized and lengthy form of training, the rôle of the general practitioner is of necessity limited to making an accurate diagnosis of mental disorder at the earliest possible moment and of recommending the form

of treatment that appears to be most suitable. These aims can be achieved only if the practitioner is oriented as to the nature of normal mental activity. On the other hand it has to be admitted that just as a good physiologist may not necessarily make a good clinician, so an over-exclusive concern with the theory of normal mental function may blunt clinical understanding. As in organic medicine, it is essential for the medical psychologist to understand not only the etiology of a symptom but the part it plays in the total function of the individual. But above all it is essential to understand the *meaning* of a mental symptom. Neurotic and other mental symptom-formations differ from organic dysfunctions in that they have psychic significance. The simplest forms of conversion hysteria, e.g. attacks of indigestion or constipation, are not simply functional abnormalities to be summed up in relation to other metabolic processes. They also have a meaning, which, once recognized, is as intelligible as any form of everyday speech, thought or behaviour. Whether they are expressed in mental or physical form, mental disorders are essentially end-products, patterns of feeling, thought and behaviour. However distorted and disguised they may appear, they represent mental *policies* arrived at in an endeavour to resolve conflict between the inner drives or wishes of the individual and the possibility or desirability of securing gratification of these wishes in real life. They are in this sense *adaptations* of the individual to his environment although, in view of the suffering they entail both to the individual and to those in intimate contact with him, they might justifiably be called maladaptations. The peculiarity and apparent lack of meaning of these manifestations is, however, not due solely to the elaborate disguises they assume but also to the fact that the drives responsible for them are unconscious. Moreover, the patterns of these adaptations are laid down during infancy. Hence it is desirable to preface any systematic description of normal structure and function by outlining in non-technical terms the mental development which takes place in the first five or six years of human life, in so far as this can be inferred from observation, reconstructed by anamnesis or discovered by psycho-analysis.

The opening chapter of this book is an attempt at such a non-technical reconstruction. It is followed by an outline of the theory of normal mental function, at the end of which the developmental outline is repeated in more technical terms. Although of necessity highly condensed, these outlines may provide a serviceable introduction to the study of symptom formation. It should be added that no attempt is made to argue the validity of psycho-analytical views or to give the evidence on which they are based. The terms used or definitions given are limited to those which have stood the test of time. Similarly with the etiological formulae contained in the clinical section. Controversial views have been omitted or have been specifically referred to as controversial. No apology is made for the shortness of the section describing psycho-analytic treatment. Any attempt at systematic description within the scope of this monograph would inevitably give rise to confusion and misunderstanding. Readers who are interested should refer to the standard textbooks on the subject.

SECTION I

CHAPTER II

THE EMBRYOLOGY OF MIND

To be a good clinical psychologist it is necessary to understand not only that mental illness is a form of maladaptation or that satisfactory adaptation depends on a successful weathering of the first five years of life, but also that the process of 'growing up' is one of the most remarkable of human achievements. For within those first five years every infant has to abandon an almost animal state of existence in favour of civilized reactions that were established only after thousands of years of painful racial experience. When the pace of this civilizing process is too hot for the infant or when his primitive instincts are too strong, trouble is certain to brew. Indeed the wonder is not that neuroses are so common, but that major mental disorders are not universal. Actually a study of anthropology is a useful preamble to the everyday practice of medical psychology. If the physician understands how much babies, savages and civilized grown-ups have in common, he will not be surprised to find that the normal mental reactions of a two-year child can scarcely be distinguished from the magical and animistic systems of savages or from the obsessional practices and superstitions of the civilized neurotic; or again, that the precautionary anxieties, self-punishments and organic dysfunctions of the European hysteric are of the same order as the incest taboos and punishments of primitive societies. And he will be the more ready to believe that all these systems of reaction can be traced to the peculiar conditions of infantile development that every human being must pass through.

Little can be said with certainty about some of the most revolutionary stages in mental evolution, such as the dawn of consciousness or the development of self-consciousness.

Apart from behavouristic studies of infants in the first few weeks of life, no opportunities exist for direct investigation of these phenomena. Animal behaviour, even in domesticated apes, permits only the most sketchy of inferences, and, however deeply we analyse the minds of children or savages, we find primitive psychic mechanisms already in operation, behind which it has so far proved impossible to penetrate. We may assume, however, that specifically human psychology developed in response to violent disturbances of instinct, in particular frustration caused by acute environmental stresses. And no doubt the sexual instincts were the first to contribute to these developments in the history of man, since these are by far the most labile of instincts and most capable of enduring frustration. Capacity to endure delay in gratification or to secure substitute gratification is one of the characteristics distinguishing man from the other mammals. And it is no mere coincidence that *incapacity to endure frustration of the more primitive instincts is universal amongst sufferers from mental disorder.*

There are, of course, many other distinguishing characteristics. The behaviour of man like that of other animals is to a considerable extent determined by fear: and simple anxiety explains much that would otherwise be incomprehensible in his conduct. But there is a peculiar modification of fear which specifically characterizes man's behaviour and is invariably present in the more primitive layers of his mind. It is best described by the term guilt. Now guilt cannot exist until the infant mind divorces fear from its external associations and establishes by some means or another a fear of itself which necessarily implies a fear of the strength of its own impulses. And this in turn involves some degree of consciousness of self. But, although we cannot describe with certainty how the development of self-consciousness went hand in hand with the isolation of a vast unconscious territory of the mind, we now know enough about this unconscious mind to explain the origin of guilt and the animistic character of early mental activity. Wild animals are always ready to react with fear to their environment, but they do not manufacture their own fears.

The infant, however, practically from the time it draws breath creates imaginary terrors. Of course, the external world does confront the newly born baby with a massed battery of new and often excruciating stimuli, which can be justifiably regarded as real sources of fear. But the curious fact remains that for some fateful years after birth he is not adequately reassured by the security from real external danger which the family provides. On the contrary, although the infant sometimes reacts to some members of his family as if they were safe, at other times they, like the rest of environment, may become the target of his most lively phantastic apprehensions. The sequence of events, the argument so to speak, in the baby's mind is as follows. Owing to inevitable and increasing frustrations of instinct, there exists in him a state of painful tension which is reacted to with rage and terror. He blames the environment for his disagreeable experiences and thinks that it hates him in the same way that he hates it. He believes it to be as malignant towards him as he feels towards it. Supposing, for instance, he is hungry and there is some delay between the feeling of hunger and the sight of food, or between the sight of food and the satisfaction of hunger, his desire is mingled with rage and gives rise to veritably cannibalistic impulses. He wants to bite the breast that feeds him. Supposing then that suckling is followed by a colic (or when, in time, it is followed by weaning) his pains (or frustrations) are interpreted as acts of revenge or punishment on the part of the mother (more accurately, on the part of her nipples). She has injured him as he wished to injure her or her nipples. The infant has then two causes for hating and fearing the mother: the real frustration of needs and wishes which he has experienced and the imaginary (or, as we say technically 'projected') hatred which he inevitably ascribes to her. But since many infantile frustrations are unavoidable and since infantile hate is comparatively ineffective, and in any case disturbs the enjoyment of what infantile love can be secured, life with this double source of hatred and fear is altogether too painful. What cannot be endured must be cured. The infant calls up a number of

other mechanisms to assist in the emotional impasse. In the first place it can exploit a capacity for 'active forgetfulness' or 'obliviscence' a mental 'turning-away' (see Repression) by which it may succeed to some extent in remaining unaware, not only of its own frustrated impulses, but of any discomfort arising from their frustration. True, it will still desire to eat and will complain if hungry, but the love and hate components of its cannibalistic systems can be obliterated, and may then give no indication of their presence except in the form of functional eating difficulties.

In the second place the baby has a capacity to accept substitutes. In place of the original objects (or more accurately organs) loved and hated, the baby transfers the frustrated interest or reaction to remoter ones, which have the merit of being, or appearing to be, less immediately disastrous to it (see displacement). It is not exactly a case of half a loaf being better than no bread ; rather there are times when a paper-hat may be better than a loaf. All these manoeuvres do not, however, solve the infant's problem. Permanent flight (whether by forgetting or by accepting substitutes) is rarely successful in dealing with an internal stress that is constantly renewed, and projection alone would leave him in a world full of enemies. The kettle steaming on the nursery hob, the movement of curtains, lights and shadows, whispered voices or the backfire of a passing taxi would have a perpetually malignant meaning for him. But at this point yet another device can be employed, one which for the first time offers him a permanent escape from his dilemma although at considerable cost to his energies. He exploits a capacity to feel ' at one with' the objects (or organs) which he loves but which are, nevertheless, the same objects he has both real and unreal reason to hate. He now reacts as if the objects were in himself (see Introjection and Identification). It is a kind of radical 'make believe' that nevertheless produces a profound and permanent change in his mind. And this for two reasons. By abandoning the objects of his impulses he has abandoned his hate-producing drives towards them, and, by taking the objects into himself, he has reflected the hatred back on himself. In the second place his mind is

no longer his own. It is split against itself into a 'self-self' and a 'parent-self'. And these parts may love each other or hate each other. If the 'self-self' is 'good' it will feel loved by the 'parent-self' and vice versa. If the 'self-self' is 'bad' it will feel hated or disapproved of by the 'parent-self' and vice versa. The system has two advantages. A good deal of frustrated love towards parents can be effectively employed in the form of self-enhancement. But even more important the child's hatred has been split. This revolutionary manoeuvre is the first to put an effective brake on his primitive and frustrated instincts (including the hate impulses aroused secondarily by frustration). To recapitulate: the attribution of internal hatred to imaginary external enemies is not enough, because it encourages an unbridled display of passion against objects that are comparatively harmless and in any case are the main external sources of love. When, however, mainly through the need for love, the mind modifies a part of itself so that this part comes to represent parental influences and when already the child has attributed the most draconic severities to these parents, hate impulses have been hoist with their own petard. The stronger and more painful these impulses are, the more they have to be projected; the more they are projected the more dangerous and tyrannical the parents appear to be. Hence, the more the child begins to feel 'one with' the powerful parents the more it has sold itself into slavery: it now feels bound to disapprove of or control its own primitive drives. And it disapproves with the same intensity as it formerly hated the object of its impulses. In this way a sense of guilt is established. The child's aggressive impulses have been turned (played off) against themselves, the way is open for a friendlier and freer communication with the external world. Nevertheless, the system has its disadvantages. The 'parent-self' may become too powerful and tyrannical. It may induce excessive inhibition and damp down vital energies to a point that is almost suicidal, or it may give rise to such painful feelings of internal guilt that a fresh projection is necessary. The child must somehow get rid of its own sense of sin, and does so by allocating the blame to the external world which

is then felt to be wicked rather than dangerous and therefore worthy of punishment. The child has now three causes to attack the external world, first, that the external world does really attack the child to some extent all the time—a real cause this: second that in any case the child projects its own asocial impulses on to the external world—an unreal cause of fear and hatred: and third that, having tried to swallow and digest these real and unreal fears the child, as it were, mentally regurgitates the painful nexus and tends to attack the external world all the more severely because it now believes itself to be virtuous in so doing.

By the time he has reached this stage in his development the infant may have already completed the first half of the average five-year span of infantile life. Though, of course, infantile time is not measured by clocks, but by the recurrence of different varieties of emotional experience. Babies pass through many lives in the twenty-four hours and in the infantile table of measures a calendar month may vary in time value from eternity to a split second. But the more accurate the realistic measures become the quicker time passes. Little enough remains in which to cover the vulnerable organization the infant has built up. For the next year or so he is extremely busy wrapping this sensitive mind round with protective layers, the most important of which are made up of superstitions, beliefs and observances, rituals of thought, work and play. These at the same time help to control his danger-causing impulses, reassure or neutralize his animistic fears and pave the way for an expansion of reality relations to life. Of course, even the youngest infant has a good reality sense of a kind appropriate to his surroundings. And this steadily expands. But the process of expansion is in the long run reinforced by the same animistic and superstitious reactions which cause him so much trouble. For his anxieties about the external world provoke a sharpened interest in it, and once these anxieties have been alleviated a 'decontaminated' residuum of reality knowledge remains. Just as astrology led to astronomy, so an infant's animistic fear of dirt may later be neutralized by obsessional play with coloured chalks, and lead finally to acquiring the realistic uses of writing.

Anyhow, the last stage of the developmental process commences when the total thrust of infantile instinct begins to die away. The mind dons its outermost protective garments which are essentially systems of comparatively rational thought and action. And because these systems are hailed with obvious relief by the family and in any case mark his delivery from primitive strains, the infant begins and continues throughout life to over-estimate the virtues and powers of his rational thought.

The moral to be drawn by the clinical psychologist from this necessarily disjointed account is the following. In the first place *many of the syndromes of adult mental disorder are simply repetitions of (regressions to) developmental stages and mechanisms, which, being isolated and magnified, appear in grotesque disproportion to the more rational adult structure.* Childhood disorders are more difficult to detect for the simple reason that they are to some extent cloaked by the peculiar privileges accorded the child by society. He is often permitted and sometimes encouraged to behave or express himself in ways which in the case of an adult would be promptly stigmatized as neurotic, psychotic or delinquent. But to grasp the more human aspects of symptomatic regressions it is necessary to be familiar with the infant's ideological systems. At every stage of his development the child's experiences and concerns are elaborated into systems of, for the most part, unconscious phantasy. The whole of his outer and inner world is explained by him in terms appropriate to himself. The bars of a cot against which the baby strikes itself may be a number of malignant mothers whom he attacks and who, at the same instant strike him back. His thumb may be a mother-god to be alternately sucked and bitten or a father-god to be adored, a piece of tinkling glass may promise him ecstatic communion with the cosmos. Later, every recognizable object in the nursery is alive and according to his mood menacing or friendly. His inside is possessed of demons or sometimes of angels. Still later when his drives to the parents are beginning to expand, he has the most phantastic theories of the nature of sexual relations and of baby-making. These vary in accordance

with the prevailing form of infantile interest. Babies are made of the solids, liquids or gases of which the child has corporeal experience. Some forms of love threaten death to himself and to his love objects. Some forms of hate although even more dangerous may have retained a love-value and so cannot be abandoned. In short his phantasies are not to be dismissed as grotesque forms of thought; woven together they constitute a theory of life—a *Weltanschauung*, a philosophy, natural history, biological speculation and sooner or later a religion. Occasionally fragments of these systems remain on the surface of the mind, but these are merely deserted outposts of more extensive and archaic systems concealed underneath. *It is those concealed systems which, activated again in adult life, precipitate illness.*

But should the physician find this reconstruction too implausible (and it must seem highly unlikely that a placid child gazing out of the nursery window is the repository of such complex and disturbing ideas) there is still a way open by which sympathetic contact can be made with mental disabilities of all ages. It is to remember that the child's list of developmental achievements is an impressive one. By the end of the first five years he has weathered internal storms of love and hate; sustained hurts and disappointments: accommodated himself to an environment which is not only painfully inadequate to his hopes and fears but which, with the best or worst of intentions, may have behaved stupidly, even brutally, to him. Despite these difficulties he has overcome to a large extent his boundless fears, has throttled down large charges of primitive and unteachable instinct and has directed large quantities to new goals. Moreover—and this is perhaps the most remarkable of human achievements—he has succeeded in splitting some of his more primitive energies and has converted them into a more or less neutral form in which they can with reasonable luck be diverted towards more adapted aims. Mental disabilities deserve to be regarded with sympathetic understanding; they represent the price paid in later life for over-rapid or ill-consolidated victories over baby instincts.

CHAPTER III

THE DYNAMIC ASPECTS OF MIND

INSTINCTS.—Instinct in psycho-analysis is a boundary concept between the organic and the psychic. Although the nature of instincts is not yet fully understood, instinctual processes are presumably traceable in the last resort to changes in the physico-chemical economy of the body. These are referred to as the *sources* of instinct. From the mental point of view instincts are regarded as quantities of continuous psychic stimulation (excitation). They are most easily thought of in terms of flow (or rise and fall) of *energy*. Instincts have *aims* contributing to ultimate gratification and they have *objects* towards which the aims of the instinct are directed. The aims of instinct are not readily altered, but their objects can be and frequently are changed. Sexual instincts are capable of change as regards both aim and object. Classification of instincts is usually effected in terms of source, aim or object. In all cases differentiation is arrived at by studying the individual's thoughts, feelings, speech and actions. Certain feeling—thought—action *sequences* can be observed which promote an 'end result' of gratification or discharge and from which the nature of the instinct is inferred. Disturbance of this sequence produces some variety of mental and (or) physical pain. Thus, in the case of hunger, the instinct frustrated is that variety of the instinct of self-preservation which is expressed through the impulse to eat food. The tension arising from frustration of this particular instinct can be experienced, bodily, in the form of gastric discomfort or 'hollowness,' affectively. in the form of impatience or irritation and, ideationally, in the form of images of food and thoughts concerned with obtaining food. These thoughts are then followed by various motor activities

calculated to secure food, chew, swallow and digest it. Of the last of these bodily manoeuvres the mind may take comparatively little cognizance unless pleasurable or painful sensations ensue. Psycho-analysts favour simple rather than complicated groupings of instinct. They are content with a working division into sexual impulses (or love impulses) using this term in its widest sense, and aggressive impulses. Even the self-preservative impulses are regarded as a special specialized form of love-impulse (see Narcissism), although clinically speaking it is usually easy to observe that these exercise a good deal of independent action. Deeper investigation shows that this apparently over-simple grouping is justified. It is a plausible assumption that any instinct, disturbance of which is sufficient to cause mental or physical breakdown, must be of cardinal importance. *In the last resort most psychic disorders can be traced back to disturbances in the equilibrium of love and hate.*

Sexual Instincts.—Although analysts use the word 'sexual' in an extremely broad sense and refer to the energy of these instincts as *libido,* there is no vagueness about the manifestations in question. There are three main varieties of sexual excitation (1) *Adult sexual instinct* universally recognized at puberty and responsible for the manifold and manifest love and reproductive phenomena of adult life. (2) *Infantile sexual impulses* existing from birth, gradually organized during the first two years of life and reaching a peak in the fourth and fifth years, after which they either gradually or suddenly disappear. (The fallow period between infantile and adult forms of sexuality is called the *latency period.* It varies considerably in length.) (3) Libidinal excitation (charges) existing in the various tissues and organs of the body, giving rise to the so-called organ or *body libido.* Each of these three forms of sexuality plays a part in the etiology of the neuroses and psychoses. Disturbance of normal adult instinct is not as a rule responsible for mental breakdown, but if prolonged or severe, it is an extremely common precipitating factor. Major disturbance of infantile sexual instinct is invariably present in both neuroses and psychoses. Excessive rise or fall of organ-libido is a factor in neurosis, especially in the

conversion-hysterias and actual neuroses. It is still more important in the psychoses.

Adult Sexual Instinct.—Comprehensive study of the manifestations of adult sexual and reproductive drives is essential to a proper understanding of all psychological situations. Nevertheless two pitfalls should be avoided: (1) to regard adult sexuality as a sole or root cause of mental breakdown. (2) To limit the term to manifest erotic components of sexuality. The psychic accompaniments of sexual activity (in particular, feelings of love, tenderness, appreciation, security and the enhancement of self-feeling) are of the greatest significance. Disturbance of these feelings is a very common precipitating cause of mental breakdown. In regard to direct erotic manifestations there are three points to be noted. (1) That disturbances of normal sexual rhythm, e.g. excessive courting without adequate physical satisfaction or excessive masturbation without adequate outlet for tender relations with love-objects, may give rise to various forms of anxiety. (2) That the varieties of fore-pleasure solicited prior to coitus give some hint as to the earlier distribution of infantile sexual interest. (3) That the numerous forms of aberration of adult sexuality, e.g. perversions, fetishism, etc., are in themselves indications of conflict over earlier (infantile) forms of sexuality. They should not be regarded simply as curiosities, or solely as the result of constitutional deviations.

Infantile Sexuality and Body Libido.—Infantile sexuality consists of a number of component instincts. These are frequently named after the body-zone from which the excitations are derived. The three most important sources of infantile sexual interest are the *oral*, the *anal* (and *urethral*) and the *genital* zones. Although all these interests exist from birth each of the three zones in turn exercises a *primacy* over the others—a fact of importance in estimating the depth of etiological factors in all mental disorders. During each of these phases all the love interests of the child, its phantasies of satisfaction and its theories as to the love activities of parents are heavily biased by its experience of its own predominating libidinal needs. It

should be remembered, of course, that, although some of these phantasies and wish-formations may be conscious, by far the great proportion are and remain permanently *unconscious* (see Psychic Systems). Thus during the primacy of the oral (or suckling) phase the infant's phantasies might well be described as cannibalistic in type (sucking, biting, tearing, swallowing, etc.). In the later more organized anal phases love is phantasied in appropriate terms of anal intimacy and of excretory activities which are felt to be the equivalent of baby-making. In the genital stage love is phantasied in terms of infantile genital relations. These genital phantasies resemble in content the phantasies of adult life but are more primitive, inaccurate and unrealistic. For example, the possession of a penis by the opposite sex is part of the boy's natural philosophy, a view with which the girl agrees, accounting for her own lack of this organ on the ground that it has been taken away as a punishment. This genital stage is the one originally termed the *oedipus phase* of the child, during which the wish exists for genital relations either with the parent of the opposite sex (*positive* oedipus wish) or with the parent of the same sex (*negative* oedipus wish). Nowadays all infantile phases of sexuality are regarded as part of a *total oedipus* or incestuous stage of family relations. Nevertheless each phase has characteristic forms, arouses characteristic anxieties or guilts and has come to be associated with specific mental disorders ; e.g. hysteria is still believed to be determined specifically by conflict aroused during the phase of infantile genital primacy, and to have a special association with unconscious anxiety of sexual mutilation. In addition to these three zonal components, the *skin* is an important source of infantile sexuality and has a specially close connexion with masochistic impulse. The *musculature* is also a source of libidinal excitation and contributes largely to the sexual component of sadism. It is convenient to bracket *gastric* with oral erotism and *intestinal* with anal libido. Next in importance comes erotism of the respiratory and cardiovascular systems. Other organs and tissues are also charged with body libido, the existence of

which can sometimes be detected by study of behaviour and phantasy, particularly hypochondriacal ideas. The distribution of libido in the different zones and organs determines to a considerable extent the locality of hysterical conversion symptoms, cf. the importance of respiratory erotism in hysterias of the asthma type or of skin erotism in certain eczemas. Body libido is also the main factor determining hypochondriasis. Apart from those infantile sexual drives which are classified according to their zonal components, some are labelled in accordance with their aim. The most important of these are the impulses of *sadism, masochism, exhibitionism* and *sexual curiosity.*

Sadism results from the fusion of libidinal impulse with destructive impulse, the aim being to secure gratification by inflicting pain, injury, or humiliation (either physical or mental) on the love object. In masochism gratification is obtained by enduring pain, etc. at the hands of the love object. Infantile sexual curiosity has a large element of sadism. It is a strong urge to penetrate (and by this knowledge to master) the mysteries of family sexuality. Baffled infantile curiosity and the primitive nature of infantile sexual urges are responsible for a nexus of *infantile sexual theories,* e.g. of reproduction by sadistic coitus between the parents. Curiosity is one of the most active infantile sexual components because, in addition to its primary aims, it provides some compensation for a lack of more concrete gratifications of incestuous impulse. The libido of the child endeavours to secure gratification through every form of sensory experience, taste, touch, smell, etc., but in the long run tends to flow into auditory and visual channels.

AUTO-EROTISM AND NARCISSISM.—All sexual instincts can be subdivided according to the nature of the object to which they are attached. Two main groups can be distinguished. *Allo-erotism* refers to sexual drives which require for their gratification external objects, *auto-erotism* to sexual impulses which can be gratified by the individual without the interposition of a real external object. Infantile sexual components lend themselves readily to auto-erotic

practice. As with other sexual activities, a distinction has to be drawn between the physical and psychic aspects of auto-erotism. Study of the common forms of genital masturbation shows that, although the individual can induce the desired stimulation without actual objects, his accompanying sexual phantasies include a wide variety of interest in sexual objects. So that, apart from its specific gratifications, masturbation can function as a compensation for the absence of object relations. It can also be a defensive regression designed to protect the child against possible dangers inherent in object relations. This is of considerable clinical significance, because these compensatory regressions occur when unconscious sexual phantasies with incestuous (family) objects are activated. It is easy to prove that during infancy phases of compulsive masturbation occur when the child is in a state of conscious or unconscious conflict over incestuous drives. Moreover, it has been established that auto-erotism like allo-erotism is a frequent resource when the individual suffers from excessive anxiety.

Narcissism is a concept of a different order. As the mind distinguishes more clearly between the self and its love objects a considerable amount of infantile sexual interest (libido) is found to be attached to the mental images of the self. This is constantly reinforced owing to the existence of body sources of sexuality, both organ libido in general, and in particular erotogenic zones. This primary narcissistic investment increases when in course of abandoning early frustrated incest-drives permanent identifications with these parental objects are set up in the child's ego (see also Introjection Mechanisms and Super-ego Formation). This process expands the ego considerably, and libido can now be attached to the expanded self. Normally libido that is withdrawn from incestuous objects is considerably desexualized and in this form augments the original narcissistic charges of the ego. These augmentations are described as secondary narcissism. The libidinal charges attached to later objects can also be withdrawn and if the mental images of these objects are completely abandoned, this released energy swells the charges of

secondary narcissism. Should these processes be exaggerated or should the withdrawn charges not be sufficiently desexualized pathological consequences may follow. Overcharge with narcissistic libido increases the readiness of the ego to fall ill. In particular it predisposes to functional inhibitions. Undue withdrawal of libido from the mental objects of impulses predisposes to psychotic breakdown. At the least it affects the sensitiveness of the ego to object relations, either predisposing the individual to homosexual fixation (objects like the self) or causing maladaptation in heterosexual relations. The concept of narcissism explains why analysts tend to regard self-preservative instincts as part of a larger group of love instincts. Defence of the ego can be regarded as an expression of self-love.

It should be emphasized that although infantile and other forms of sexuality arise from body sources the concept of sexual energy or libido is a mental concept. Libido is one of the two main factors in psychic development. If the huge charges of infantile libido are successfully modified and adapted to the needs of real life the infant mind will in all likelihood develop normally. *If they are not so adapted some mental warping will ensue, and there is every probability that sooner or later the individual will fall ill.*

Aggressive Instincts (Impulses of aggression, destruction, and mastery).—Most analysts are ready to postulate a primary instinct of aggression which in addition to satisfying its own ends furthers the aims of other instincts, e.g. contributes the amount of aggression necessary to effective love and reproduction and provides the destructiveness necessary to self-preservation. Other observers are of the opinion that aggressiveness is essentially a reactive phenomenon called into existence by states of tension, e.g. by the frustration of any other instincts. These views are not mutually exclusive. Clinical investigation has shown that (1) whether or not there be a primary instinct of aggression, the mind is radically influenced from the earliest days of life by aggressive impulses; (2) as well as contributing to normal mental development, these forces can be responsible for the most severe forms of mental breakdown; (3) aggressive impulses show a readiness to

combine or fuse with and again to isolate themselves from love (sexual) impulses. Love impulses and aggressive impulses hardly ever exist in a pure state. Fusion is obvious in sadism and masochism when the openly sexual aim includes an impulse to injure or be injured by the love object. Further investigation has shown that apart from such obvious fusions, love impulses have a general tendency to combine with varying quantities of aggressive impulse. This has given rise to a somewhat slipshod use of the term sadism. Sadism is now loosely applied to mixtures of sexual and aggressive impulse towards objects even when there is no manifest sexual element present and when, in consequence of this, the aggressive aim appears to predominate.

Classification of aggressive impulses is not very satisfactory. Adult impulses of aggression can be described in the utmost detail and the adult varieties of sadistic perversion are not difficult to label. But these, however strongly charged, are not the varieties responsible for nervous breakdown. They function solely as precipitating factors. The most striking infantile forms are named (after the libidinal components with which they are associated) *oral, anal* and infantile *genital sadism*, and each has its phase of primacy over the others. The most primitive forms are discharged through the musculature, larynx, jaws, arms, legs, etc., but in the earliest stages of infancy the objects against which sadism is directed are not well defined. The child is not very clear as to the distinction between the self and objects outside the self. Hence the most violent forms of organized sadism are only recognized as such in the course of the second year of life, by which time oral and anal sadism overlap a good deal. Roughly speaking, difficulties with oral, anal and genital sadism are associated respectively with depressive, obsessional and hysterical symptoms. Difficulties with muscle-sadism are reflected in every variety of symptom from the deepest psychoses to conversion hysteria, e.g. catatonia and hysterical paralysis.

Masochistic expressions of aggressive impulse can be classified in the same way as the sadistic varieties, and are

also associated with specific disorders of function. Apart from its primary forms, masochism acts as an absorber of frustrated sadism. Sadism turned on the self becomes secondary masochism. The sadism that is combined with curiosity serves to provide discharge of aggression through the intellectual processes. This fusion may give rise to conflict and so produce various inhibitions of the intellect. Tensions of aggressive impulse are amongst the most powerful to which the human being is subject. They overcome the deepest tendencies to self-preservation much more frequently than do the tensions of sexual impulse *Fundamentally all mental conflict consists in a struggle between love tensions, self-preservative tensions and aggressive (hate) tensions.*

Ambivalence.—The isolation, for purposes of clinical description, of sexual and aggressive instincts may give rise to false impressions. Not only are these impulses permanently fused in the case of sadism and masochism, but there is a constant interplay between them. This is easier to grasp when expressed in terms of the loves and hatreds of children for their parents. The child's love of and need for love from its parents is readily replaced by hate when the parents frustrate or appear to frustrate these impulses and needs. Moreover, when one parent is regarded by the child as a rival for the love of the other parent this increases the existing hostility to the parental rival. The child is then faced with the painful situation of loving and hating in rapid alternation. Sooner or later this alternation leads to a permanent mixed attitude, a simultaneous loving and hating which is called *ambivalence.* Ambivalence is subdivided in the usual way in accordance with stages—oral, anal, genital, etc. It is the most constant source of mental conflict, and in the case of obsessional neurosis is the main etiological factor.

AFFECTIVE STATES: *Their Dynamic Aspects.*—Active instincts manifest themselves in three ways: through affective experiences, through mental images and ideations and through verbal and actual behaviour. Of these the affective states are the most important because in accordance with their pleasurable or painful tone they prompt or

compel immediate behaviour (adaptation). Affects induced directly by instinct excitation are of two kinds—tension affects and discharge affects. *Tension affects* are mostly, but not exclusively, painful. Although hunger and aggression tensions have some pleasure quality this soon gives place to painful affect. Sexual tensions are sought after and maintained in the first instance because of the pleasure tone of increasing stimulation. In the absence of discharge, however, they also sooner or later develop a painful tone. *Discharge affects* are generally but not exclusively pleasurable. The amount of pleasure is in direct ratio to the amount of discharge secured. This is most obvious in the case of hunger and love. When, however, gratification of one impulse disturbs the gratification of another impulse, pleasure is proportionately diminished. If, for example, the activation of an infantile sexual impulse appears to the child to threaten danger and so stimulates the instinct of self-preservation, or if it arouses guilt and so mobilizes the need for non-sensual love and appreciation, or if owing to rivalry it stimulates destructive impulses, the original pleasure tone is cancelled out and a painful tone takes its place. *This fact is vital to the understanding of psychological illness.* For example, a phobia (or fixed fear of some object or idea) is not simply a manifestation of fear; it indicates that a primitive wish-formation exists, the gratification of which can no longer be pleasurable. In the course of mental development primitive pleasure-drives tend to become increasingly painful. This is most obvious in the case of anal impulse, where disgust tends to displace primitive forms of satisfaction. Impulses that do not pass the barrier of censorship remain a potential source of conflict to the extent that they are capable of reactivation. Frustration of any impulse causes mental pain. When the frustrated wish is also disapproved of by the ego its tension is doubly painful. But gratification of rejected wishes is also painful, so that a primitive rejected impulse is painful at all its stages. When such wishes become active, the excitation is either checked near its source or comes into consciousness in disguise. *All symptoms represent a form of disguised wishing and disguised discharge accompanied by or threatening painful affect.*

The precise relation of different affects to specific instincts has not been very carefully worked out. Some of the tension affects of love and hate are simple enough, e.g. feelings of specific need 'longing' for the object or of impatience with external objects for frustrating these needs. These affects provide powerful incentives either to discharge instincts or, if discharge is impossible, to control them. But most affects are neither simple nor isolated. Up to the present the most useful clinical classifications of affects are into (1) simple and compound (or fused) affects or (2) primary and secondary affects. Simple affects tend to merge into compound affects capable of reduction into their elements. This reduction is easy to demonstrate in the case of affects that prove pathogenic. These can be made to disappear only after a number of distinct elements (represented by characteristic unconscious phantasies) have been analysed. Grief, for example, is often a simple affect, a direct reaction to the loss of a love-object. Jealousy, the reaction to the threatened loss of a love-object, is clearly compound. In typical instances it consists of anticipated grief, of anger, and of fear. The grief is derived from partially frustrated love, the anger from an injury to self-preservative instinct (through the mechanisms of narcissism) and the fear arises from the combined tensions of love, hate, and self-preservative impulses. Similarly with depression affects. Although these are very deep and give the impression of being primary reactions, they are often compounded of self-depreciation due to loss of love, of disguised anger against the love object (disguised because inverted), of anxiety and of guilt.

The distinction between primary and secondary affects is easy to maintain when the affects in question differ in type and can be shown to exist in causal sequence. Thus sexual tension can induce hate and the induced hate can set up anxiety. Similarly anxiety can set up secondary reactions of hate. In other words, affects in many instances are not themselves the *expression* of the original instinct tension but are aroused *secondarily* by it. Again one affect may be represented by another of an apparently antithetical type, e.g. some feelings of hate are really inverted

expressions of loving. But the most obvious, and clinically the most important illustration of the relation between primary and derived affect can be studied in the case of anxiety and guilt.

Anxiety.—Study of various affects especially those experienced in pathological states shows that one of their commonest components or accompaniments, either direct or disguised, is anxiety. Anxiety is expressed directly in various degrees of apprehensiveness (up to and including panic) in various bodily disturbances (cardiovascular, respiratory, gastro-intestinal, and muscular) and in every variety of anxiety-thinking. When these reactions or thoughts are attached to a particular object or objects, the state is described as *fear.* A *phobia* is a particular example of fear associated with an object or idea. It differs from ordinary fear in that the object is one which does not ordinarily justify fear. A phobia is a fixed form of *morbid* (unreal) *anxiety.*

The nature and origin of anxiety is still obscure. Generally speaking it is a reaction to danger and manifests itself variously in different species. The forms characteristic of man suggest that anxiety has a close connexion with experiences at birth. The overwhelming excitations occurring during labour together with the onset of function or of unassisted function in the cardiovascular system, respiratory and other organs, constitute the first traumatic experience. It is the prototype of all later anxiety manifestations both physical and mental. The anxieties experienced later are, however, merely *sample* repetitions of the original traumatic state. The function of these repetitions is protective: they force the individual to defend himself. Experiencing anxiety he is driven to take steps to avoid any stimulation that threatens to become overwhelming. A number of simple and conditioned reflexes and a number of simple or complicated behaviour patterns are set in action. These discharge the tension, as a rule, successfully. Beyond a certain point, tension of any instinct threatens danger. Loss of love, provoking love tensions, is felt to be a danger. Aggressive instincts are also felt to be dangerous, all the more so when they are of a nature which if

expressed would injure a love interest and so give rise to secondary anxiety. It was once thought that the energy of frustrated sexual impulse was *converted* into anxiety. This is now regarded as an exceptional state of affairs. The frustrated instinct *arouses* anxiety.

Guilt.—If for one reason or other an impulse is not compatible with other wishes, if an old pleasure-impulse now induces pain, it is obvious that its frustration must prevent the new reaction of mental pain and so avoid the development of anxiety. When, however, the more primitive impulse is strong enough to resist frustration, so that both the primitive pleasure system and the newer reality system suffer, then it becomes a double source of anxiety. *Neurotic and other mental symptoms are frequently called into existence because of this double threat.* Morbid anxiety is thus a sign of *conflict between the pleasure principle and the reality principle.*

The newer reality systems are acquired in the course of cultural development. Either consciously or unconsciously the mind realizes that the gratification of primitive wishes is attended by or threatens danger from without (disapproval, punishment). But in addition to such external threats it fears an internal danger—loss of love within the self. This gives rise to a feeling of *guilt.* Just as mind exploits anxiety in order to promote the perception of external danger, so it makes use of guilt as a *signal* system to prevent the development of overwhelming inner danger. Guilt is a highly specialized form of anxiety which operates internally and does not depend on the presence or existence of actual threatening or disapproving objects. Guilt and anxiety overlap a good deal. Guilt tends to mobilize anxiety: it merges to some extent in anxiety and it exists along with anxiety. Anxiety in its turn tends to mobilize guilt. Individuals vary very much both in their anxiety-readiness and in their guilt-readiness. Both may appear in a disguised form, particularly when the source of the anxiety or guilt in not conscious. Just as anger can be disguised by weakness and depression, so guilt affects can be manifested by *feelings of mental or physical inferiority.*

CLINICAL ASPECTS OF AFFECT.—Affective states are important in the first place because they provide a powerful motive for adaptation or for illness (maladaptation) and secondly because they contribute characteristic features to any illness (maladaptation) that may ensue. Some mental abnormalities are labelled quite simply in accordance with the prevailing affect. The best examples are the so-called *anxiety states* and the *depressive states.* This system of nomenclature could have been extended. The affective responses in many obsessional neuroses are guilty as well as anxious. The obsessional neuroses is essentially a *guilt-neurosis.* Depressive states also exhibit guilt reactions but of a more malignant type. They might be called *guilt-psychoses.* Jealousy reactions are seen in their simplest form in many anxiety states but appear in a more drastic form in alcoholic and various paranoid conditions. Rage responses are easy to observe in psychotic episodes. They also occur in some of the simpler hysterias, though they are not characteristic of the psychoneuroses. They can be observed in certain anti-social conditions of a psychopathic type.

By way of contrast to these more disruptive affects, pleasure affects of an excessive yet facile type are to be observed in the manias. They occur also but only occasionally in the hysterias. An obsessive form is found in various sexual compulsions (masturbation, fetishisms and a number of perverse object relations). Careful anamnesis will usually uncover phases of painful or depressed affects associated with these euphoric states. It is more difficult to detect latent pleasure affects in conditions, which manifest themselves as predominantly painful. In some conversion hysterias and even in mildly painful organic disorders a certain degree of direct pleasure is occasionally extracted by the patient from his illness, but this occurs mainly in masochistic types. *Generally speaking the guilt manifestations associated with neurotic and psychotic illness are due to conflict over unconscious aggressive (hate) drives.* In cases of chronic or refractory organic illness, it should be remembered that guilt can be effectively disguised by organic dysfunction.

CHAPTER IV

THE STRUCTURE OF MIND

The locality of mind is not a problem for the psychologist. All he need say is that in any individual psychic events occur at a certain stage of a stimulation process. The structure of mind is, however, a concept as essential to the psychologist and to psycho-pathology as concepts of atomic structure are to the physicist. Not only so, concepts of structure can be used (a) for purposes of clinical description (e.g. the use of the term *schizophrenia*) ; (b) for establishing differential diagnosis (e.g. the structure of a depressive state, as compared with that a hysterical depression) ; and (c) for assessing both prognosis and treatment (e.g. the significance of an obsessional structure of mind in estimating the importance of suicidal phantasies).

Earlier concepts of structure were essentially descriptive and expressed in terms of *consciousness* (awareness), cf , the phrases 'field of consciousness', 'rigid character', etc. When, however, mental products (ideas, affects, etc.) were found to exist apart from consciousness, it became clear that perceptual-consciousness could be only a part of a total instrument, in other words, a psychic system. The subdivision of the rest of the mind was determined by certain dynamic relations. Mental products could be descriptively unconscious and yet accessible to consciousness. They could be recalled with a certain amount of effort. The system in which these accessible memories are stored is called the *preconscious* system (*pcs.*). It is an extensive system with rich and diverse content having fairly close contact with environmental experiences. There are, however, still other mental products, dynamically as well as descriptively unconscious. No ordinary effort will render this content accessible ; on the contrary powerful forces

strive to prevent its becoming conscious. This is the *true unconscious* (*ucs.*). The content of this third psychic system is also rich but archaic. It is highly charged with mental energy. Some of it relates to previous environmental experience, particularly experiences of a traumatic or passionate type occurring in early childhood, but there is no longer any free communication between these events and conscious memories. They are opposed by a barrier which is itself unconscious (see Repression). On the other hand, a great deal of true unconscious content has never been conscious. It is extremely primitive in nature but not, as is sometimes thought, exclusively anti-social. The earliest forms of love phantasy may be as effectively barred from consciousness as the earliest hate phantasies. And moral rumination of an archaic type is a characteristic of even the deepest layers of the system. Being dissociated from consciousness, the unconscious has no direct contact with reality and is governed by certain mental mechanisms which appear alien to consciousness. These mechanisms are best studied in dream manifestations. They also provide characteristic features of the symptomatology of neurosis and psychosis.

STRUCTURAL DIFFERENTIATION.—The structure of mind has not yet been worked out very elaborately. It is based on the concept of *memory-traces* which are organized in the various psychic systems with the exception of perceptual-consciousness. Consciousness does not itself retain memory traces. It is only stimulated (*a*) by perceptions from the outer world and (*b*) by ideations and affects from within the mind. The total organization of memory traces is called the *Ego*. Used in this very general sense the term is of little clinical significance. The most elementary division of the ego is into two main departments—a department concerned with the self and a department concerned with relations to objects. An object is that which is necessary for the gratification of instinct, e.g. food (breast-mother) in eating. Strictly speaking the psychological *object* is a nexus of images and associated affects. It exists *in the mind*. This *imago* promotes effective relations with real objects. This point is essential. Mental relations with

objects can exist when there is no real object present. Similarly a person may abandon almost completely psychological relations with objects and yet apparently be 'on terms' with real persons. The energies of the mind are of necessity distributed between these two systems. When impulses towards an object cannot be gratified the mind tends to withdraw the energy of the instinct from that object. This is most easily achieved with sexual impulses, least easily with self-preservative impulses. Energy thus withdrawn tends to become fixed on to some aspect of the self. This is a normal reaction but can have pathological forms or consequences. Libido withdrawn from object to self inflates self-valuation, and in excess can produce any type of over-estimation from cocksuredness to megalomania (see also Narcissism). Withdrawal of aggressive energies on to the self can produce any reaction from slight shyness to alienation, suicidal depression or catatonia.

In all cases it is vital to assess the balance of interest as between the self (the ego in a narrower sense) and its objects. Some freedom to attach love and hate impulses to objects is essential to health. Extensive withdrawal of interest in real objects is a clinical danger signal. It is usually a preliminary to breakdown. If withdrawal of *cathexis* (the technical term for the charges of interest attached to an object) goes so far as to impoverish the (internal) object-imagos the position is serious. A psychotic outcome may be anticipated. If, however, the internal interest in objects (i.e. in their *imagos*) is retained one need not anticipate more than a neurotic breakdown, even if the individual has apparently reduced his interest in actual objects to a minimum. Diagnostic skill depends almost exclusively on the capacity to make these assessments of ego-object relations.

Ego-Control Systems. *The Super-Ego.*—The most useful clinical differentiation of mental structure, and the one most easily confirmed by ordinary introspection, is that into *ego* and *super-ego*. The simplest experience of conscious 'self-questioning' shows that one part of the mind exercises scrutiny over and issues judgment on another

part. The scrutinizing and criticizing part is a conscious facet of the super-ego, exercising judgment on a conscious facet of the ego. Further examination shows that the cause of the conscious guilt is some derivative of instinct (thought, wish, feeling, projected utterance, speech or action) which threatens loss of love from within and is therefore taboo. Many psychologists think—and this is also the popular view—that such guilt states are transient phenomena, the result of temporary splittings of the total ego. This is only descriptively true. Naturally when conscious impulses and interests are concentrated on non-controversial or non-conflicting (i.e. innocent) aims, the divisions of the ego are not apparent. They merge in a common purpose. The surface of the mind appears unbroken and there is no sign of the existence of conscious conscience. Nevertheless the psycho-analytic view is that a much more permanent cleavage into ego and super-ego exists below the surface and that it reaches down to the deepest unconscious psychic levels. In other words there is a deep *unconscious conscience* of which conscious conscience is merely a superficial facet. All analysts agree that the super-ego exists from about the age of three: some believe that it develops shortly after birth, or at least that it is in active function by the end of the first year. Naturally the deeper the cleavage the more it is concerned with primitive sources of conflict and the less it is capable of being spontaneously affected by reality influences. For example, when deep guilt erupts, as in the depressive psychoses, we find that the self-accusations are not justified in reality. They are delusional. This expands our view of the nature of depressions. Affectively they can be regarded as guilt-psychoses but structurally they represent an extreme hypertrophy of the deeper layers of the super-ego. In such cases the super-ego is oversensitive in detecting guilts that have little or no relation to actual behaviour and issues judgments of fantastic severity, which the ego is apparently compelled to accept (as when the outcome is suicide).

Compared with the structural differentiations of anatomy or the minute functional descriptions of physiology this division of the mind into ego and super-ego appears rather

crude. Nevertheless it is possible to subdivide both ego and super-ego in a number of ways. The most useful is a subdivision into layers representing historical phases of the infantile struggle to master primitive forms of instinct. As has been indicated the main groups of infantile instinct are concerned with love and aggressivity respectively. These vary in quality, intensity and distribution in the different phases of early childhood. And there are numerous combinations (fusions) of infantile sexuality and aggressiveness. Since the majority of these impulses are concerned with hate of parental objects who are both loved and feared they cannot and may not be gratified. So an appropriate super-ego system is developed for each phase. Thus, owing to the early primacy of oral love and hate, we can say with certainty that one of the earliest nuclei of the super-ego is an *oral nucleus.* This means that ego-phantasies of oral sadism (devouring, biting the (mother) breast) are opposed by an oral super-ego which threatens a talion oral punishment (being devoured by a 'wild object'). And we know from study of depressive cases that the appropriate affect induced by this opposition is one of deep depression. Similarly, with later phases of love and hate development. Anal impulses and phantasies are restrained by an *anal super-ego,* a fact that can be confirmed by analysis of many obsessional cases. Infantile genital (phallic, oedipus) impulse is held in check by a super-ego which mobilizes in the ego genital guilt and anxiety of genital punishment (mutilation, castration). Excess of impulse or excess of super-ego activity at this stage lays the foundation of hysterical formations (conversions and phobias).

The close connexion between instinct tensions and symptomatic reactions suggests another way of subdividing ego and super-ego systems, namely by reference to the characteristic mechanisms set in action. Some of these are typically ego reactions. Forgetting is a typical example of an ego-reaction. Passivity, inertia, inaction are also ego responses. Like denial they may be considered as forms of flight. There is nothing essentially moral about them. Super-ego reactions have a very definite moral stamp, even

if it be a primitive morality. A direct manifestation of this activity is to be observed in the *moral rumination* of some obsessional neurotics. The nature of these moral systems can be deduced from the responses they evoke in the ego. The more primitive or the more sadistic the super-ego the more it demands talion *punishment* of a wholesale kind. In more developed types the punishment is more localized (e.g. castration for incest wishes) and (or) attempts are made to *expiate* or make *restitution* for the unconscious crime, e.g. phantasies of giving birth as an expiation of death wishes. The sadism of the hysteric super-ego localizes the punishment to (substitutes for) the genital organs. In obsessional cases two phases can commonly be observed. One represents the unconscious crime: the other annuls or counteracts or makes good the alleged delinquency. An 'evil' gesture or ritual is carried out and either followed by the opposite gesture or by a 'good' repetition of the same gesture. Compulsive philanthropists, though not neurotic, have a similar type of super-ego. They make restitution by giving. Compulsive gamblers and topers belong to a compromise group. They punish themselves and make restitution by wasting their own substance. *Reverse action* of the super-ego is seen in paranoid types. Paranoid patients show violent disapproval of evil, but, unlike persons with a guilty conscience, the evil is held to exist in the external world (imagined enemies who are alleged to attack them). Inner psychotic guilt is reversed. Innocence remains within: evil is first projected on to the outside, then detected and finally punished. The super-ego of the delinquent works in a somewhat similar way.

Perhaps the most interesting subdivision of super-ego structure, certainly the one that gives the clearest idea of its origin, is that made in terms of relations to the early *objects* of impulses. The supervising and criticizing nature of all conscience activities suggests that the super-ego repeats within the mind patterns of parental control already experienced in relation to family figures. But it is not due simply to an ordinary identification with these objects. In the first place the ego-differentiation is extremely rigid and under ordinary conditions permanent. The infant having

been compelled to abandon its incestuous aims towards its parents withdraws the energies of these instincts, sets up within the ego permanent parental institutions and invests them with the withdrawn energies. Freud describes the process by saying that the super-ego is the heir to the oedipus complex. It is as if a part of the mind became a parental part, as if the parents had been psychically 'swallowed' (see introjection mechanisms). Secondly, the attitudes of these parental institutions in the mind is more primitive (e.g. cruel) than those of most real parents. This is due partly to the fact that the infant projects its own hostilities on to the parents and consequently 'swallows' a hostile object, and partly to the sadistic energies that operate through the super-ego. Sometimes the attitude of the super-ego corresponds less to the image of a parent than to the imaginary attributes (savage or otherwise) of a parental organ (mother's breast, father's penis). Proceeding on these lines super-ego systems can be divided into mother types and father types. In most cases these divisions overlap considerably. But it is to be noted that the tendency in super-ego formation is to single out the thwarting aspects of the parents, hence that the super-ego is commonly modelled on the pattern of the parent of the same sex. One of the worst psychic situations is where the child unconsciously feels itself disapproved of by or hostile to both these parts of the super-ego. Division of super-ego in terms of objects is extremely important in the investigation and treatment of *abnormalities of character.* Persons who are unable to fall ill of a psycho-neurosis may inflict a good deal of suffering on themselves and others by behaving in their social and sexual relations in accordance with the dictates of an archaic father or mother super-ego.

Important as are the structural aspects of the ego, it is scarcely necessary to add that these differentiations would be of little clinical significance were it not for the fact that they help to master charges of frustrated instinct. The main function of ego-differentiation is to assist in controlling the unsatisfied tensions of primitive love and primitive hate of objects. Having failed to master them by more primitive methods (see projection) the ego succeeds in

absorbing frustrated excitations at the cost of 'adsorbing' their objects. In so doing it splits itself or, if the phrase be preferred, 'saddles itself' permanently with an *alter-ego*. But of course the energies used by the super-ego are the child's own mental energies. These, too, are split up, distributed between ego and super-ego systems and played off against each other. The channels by which energy reaches the super-ego are both direct and indirect. So devious indeed are some of them that they cannot be intelligibly described in any summarized presentation. The more direct forms can be easily identified by 'studying' the behaviour of the super-ego. Its severity and tendency to torture or persecute the ego are clearly derived from the sadistic group of instincts, reinforced by the hatred that is sometimes freed when incestuous libido is withdrawn. Its curiosity, interference and probing, its suspicion of unconscious sexual derivatives, can be traced to the child's original hostile curiosity as to the sexual functions of the parents. On the other hand, as well as attracting hate to itself via the ego, the super-ego in its 'ego-ideal' aspects attracts a good deal of primitive narcissism. It is not hard to prove that the ego has a great fear of loss of love from the super-ego. It is evident, therefore, that although the super-ego is formed by absorption of the oedipus situation, albeit in stages, and usually prevents its reactivation, it may on the other hand permit a re-enactment within the total ego of incest wishes and reactions previously operating between the ego and its objects. If this re-enactment is too active, dysfunction is certain to follow.

The Concept of the 'Id.'—As has been indicated all varieties of mental conflict or dysfunction centre round problems of instinct. But instinct is a dynamic concept. In order that it might be conceived of as part of the structural or topographic representation of mind Freud adopted the term 'Id' by which is understood an unorganized reservoir of instinct tendencies which is differentiated from the organized ego and from any super-ego derivatives. The concept of this impersonal Id is not so very useful clinically, but it facilitates systematic presentation. The Id supplies both ego and super-ego with the energies with

which they operate. It is permanently unconscious. The super-ego is for the largest part unconscious with, however, some conscious facets. The ego has also a deep unconscious part, but a relatively larger proportion of it is preconscious, accessible to consciousness and (via consciousness) to the influences of external reality. The important point is that the super-ego is much more in touch with and sensitive to the Id than is the ego. This accounts for the apparently mystifying nature of symptom formations. The conscious ego is unaware of the variety of Id impulses which stimulate the unconscious super-ego to activity. It is also unaware that super-ego activity has compelled the unconscious ego to make adaptations for which there is little or no reality justification. This explains why patients are unable to understand the cause of their illness and why they tend to accept any explanation of it other than the true one.

Some difficulty in grasping the structural aspects of mind is due to the fact that the concept of the Id was introduced comparatively late in the development of psycho-analytical theory. At first structural differentiations were limited to unconscious (*ucs.*), preconscious (*pcs.*), and perceptual-consciousness (*pcpt-cs.*) systems. And originally the content of the '*ucs.*' system was regarded as being co-terminous with the 'repressed.' Now the repressed is regarded as a special part of the Id. Only when repression breaks down can those repressed impulses obtain expression through phantasy systems. The phantasy systems are, however, themselves part of the ego, or super-ego as the case may be.

CHAPTER V

THE ECONOMICS OF MIND

The greater part of infantile instinct energy, both sexual and [illegible], and a substantial portion of adult instinct is subject to various forms of frustration. These frustrated energies are potentially dangerous (i.e. predispose to mental breakdown). They must be dealt with either by inhibition as near as possible to source, by substitute gratification, or by distribution throughout the various (topographic) systems of the mind, e.g. distributing aggression between the ego and the super-ego. The *economy* of mental function is regulated by various unconscious *mental mechanisms*. Some of these mechanisms, in particular the flight mechanisms of repression and projection, have no observable traces in mental structure. Others, although unconscious in operation, contribute distinctive features to the character of the individual, e.g. reaction formations of tidiness, conscientiousness, etc. Still others (identifications) mould the whole structure of mind in a deep and permanent way, e.g. unconscious absorption of parental characteristics or pecularities. In most psychopathological states the function of one or more of these mechanisms is found to be at fault. It is either inadequate or excessive. From the diagnostic point of view this fact is of importance. Some of the characteristic clinical features of neuroses and psychoses prove to be exaggerations (one might say caricatures) of the normal products of unconscious mechanisms. This is particularly true of obsessional ritual and character, e.g. contamination precautions based on 'germ' obsessions or excessive scrupulosity.

Unconscious mechanisms can be classified in a number of ways: according to the order of development, the rela-

tion to consciousness, or the impulses that activate them. It should be remembered that the mind acts as a whole. In other words, the mechanisms function simultaneously. Some of the more primitive types (e.g. projection) have no doubt a degree of independent action, though probably only in the earliest stages of infancy. But components of the repression group of mechanisms work in very close association, are in constant operation, and are responsible for some of the most characteristic features of mental activity. They were the first to be discovered and remain the most important.

Repression.—This is a flight mechanism *par excellence.* The mind being unable to escape from a painful situation (such as the activation of a primitive or tabooed impulse) seeks to withdraw energy from any representative of the impulse. Effective withdrawal not only prevents the emergence of forbidden ideas, but avoids the experience of painful affects. The individual is then simply unaware of the existence of the impulse. He cannot be made aware of it by any ordinary mental effort. This withdrawal is effected by the deeper unconscious part of the ego. It is stimulated either by anxiety or by guilt arising from condemnation by the unconscious super-ego. In addition to withdrawing energy (cathexis) from the painful ideas, the unconscious ego 'goes out of its way' to *counter-charge* ideas other than those provoking pain (anticathexis). The process of anticathexis can be best understood by thinking of a child, secretly afraid of what is in one corner of a room, staring fixedly at another corner (a '*not* that but *this*' system). The withdrawing of energy and counter-charging take place on opposite sides of what might be called a repression barrier existing between the preconscious and the true unconscious. Repression, although essential to normal function, can, if exaggerated or deficient, produce gross changes of memory. This is due to the fact that withdrawal of energy affects not only the guilty ideas but also any ideas, however innocent, that may be associated with them. The most massive disturbances of memory occur in the amnesias, dissociations, somnambulisms and fugues of hysteria; and, moreover, the analysis

of hysteria produces by far the most dramatic 'recovery of memories.' Hence repression has come to be regarded as the principal form of hysterical defence. It is especially adapted to deal with infantile genital libido. But there is no doubt that a primitive form of repression exists from early infancy and is capable of obliterating painful excitations of a pre-genital type. It seems, however, that repression is not very effective with sadistic overcharges.

Reaction Formation. — In this mechanism the anti-cathexes (counter-charges) are highly specialized and developed into a permanently organized system. Ideas of a type antithetical to those repressed are heavily and persistently charged. Usually, the instinct employed for this purpose has an aim opposite to that of the repressed instinct. So that, for instance, the reaction formations aroused by unconscious rivalry and hostility depend mainly on love images and energies. Unconscious sadistic impulses are barred from the preconscious by a reinforcement of kindly thinking and behaviour, injury is replaced by pity. Similarly with repressed anal interest. 'Soiling' phantasies are held in check by the reinforcement of ideas of bodily and mental cleanliness. In general, reaction formations are directed against infantile pregenital forms of love and hate. They are built up from about the age of two onwards, but are tremendously reinforced in the latency period. They constitute some of the most permanent and recognizable features of normal character, and, when they are excessive, contribute a number of characteristic features to obsessional neuroses, e.g. over-meticulous scrupulosity, or a compulsion to carry out expiatory rituals such as hand washing. There are also hysterical reaction formations, but these are concerned mainly with the replacement, by exaggerated love, of hate towards family and other figures of emotional significance; the hysteric may be quite indifferent to the fate of 'outsiders.'

Displacement.—After the repression group, displacement mechanisms are chiefly responsible for maintaining normal mental equilibrium. They depend on the fact that some instincts are capable of changing both their aim and their

object. In course of development it becomes possible for the unconscious ego to transfer interest not only from one object to another but from one emotional situation to another. This is seen most clearly during analytic treatment. As the *transference* develops, feelings originally associated with parental figures are often displaced to the analyst; or the analytic situation is reacted to as an infantile one. Normally displacement is responsible for the most astonishing variations in the range of human interest manifestation by different individuals or by the same individual at different times. Displacement naturally plays a part in most symptom formations. It occurs in most phobias when, for instance, fear of the genitals of the parents can be displaced to ideas of wild animals, which symbolize them. It affects the localization of conversion symptoms. Displacement from below upwards and from above downwards accounts for the transfer of genital anxieties to the extremities. Displacement is an important factor in the spread of obsessional ideas and rituals. It may be responsible for the most elaborate and time consuming systems. In the psychoses displacement and projection overlap considerably.

Sublimation is a special variety of displacement which not only transfers energy from one object to another, but also changes the aim of the instinct. It modifies those infantile components of sexuality which are either unconsciously taboo or incapable of gratification. In the process of withdrawal, the sexual energy undergoes a qualitative change and becomes desexualized, and, in a more or less neutral form, is readily capable of being diverted to any new aim or object acceptable to the ego. For example, sexual curiosity can be sublimated in the form of social curiosity and capacity to learn. The processes of sublimation are entirely unconscious but contribute enormously to the stability of the individual; so that their breakdown is a clinical danger signal. The efficiency of the mechanism can be estimated roughly by observing the individual's working capacity and enjoyment, together with his social and individual recreations and hobbies. Many obsessional rituals are caricatures of sublimated activities.

Projection.—Projection and its companion mechanism, introjection (mental incorporation), are held to be the earliest active forms of unconscious mental regulation. Projection has, however, some resemblance to repression and to displacement. It resembles repression in that it operates unobstrusively. As far as the individual himself is concerned, the existence of a painful impulse or state of mind is completely denied. But although he is unaware of its existence the painful excitation is not repressed : it is attributed to some external object, animate or inanimate: and in this respect the mechanism resembles displacement. Instead of experiencing the discomfort of unconscious hatred, the person asserts that someone else hates him and he is then free to react to that illusory, external stimulus with anxiety, flight or anger. Here again the mechanism differs from repression because in repression no affect of any sort is experienced. The original tendency to projection depends on a peculiarity of the psychic apparatus. From the point of view of consciousness all stimuli can be said to come from without, i.e. impinge on consciousness, so that even when the infant is able to distinguish between self and not-self, it still tends to attribute internal pains (physical or mental) to the external world. Projection exploits this tendency in order to cope with the pain of unconscious mental conflict. The mechanism is universal and is constantly used by normal persons. In its most exaggerated form projection gives rise to the delusional systems of paranoia. It figures prominently in drug addictions, in marital conflict and in the more acute phobias.

Introjection.—Little is known of the actual nature of introjection processes. As in the case of projection the infant's incapacity to distinguish between internal and external stimulation prepares the way for a confusion between the self ('me'—ego) and the object of instincts ('not me'—outer world). But in contrast to projection, which is derived from a necessity to *expel* painful stimulations from the ego, introjection is derived from an early infantile wish to *retain within the self* those pleasure experiences which in reality depend for their renewal on objects in the external world, e.g. the longing to retain permanent control

and mastery of the mother's nipples ('bottle') and so avoid the anxiety of oral frustration. Moreover, it is easy to demonstrate that when, between the ages of three to five years, the child abandons its most advanced incestuous drives towards the parents it begins to behave in a way which suggests that parental attitudes to the ego have developed *in* the mind, i.e. that the parents have been 'taken over'. What happens between these two phases is only partly understood. Psychically regarded the 'object' of instincts is represented in the mind by a nexus of images, impressions and associated emotions. These emotions may be pleasurable or painful in accordance with the amount of gratification afforded or frustration of impulse caused by the object. When frustration becomes absolute as in weaning, the tendency to take over and retain in the ego what really belongs to the object-world is overpowering. The object-system or *imago* is, therefore, 'swallowed' by the ego-system. It is this process that is described by the term introjection (mental incorporation). But since the oedipus relation to parents covers a number of years and includes a series of instinct drives, most of which are doomed to absolute frustration (see phases of libido development) a *series* of introjections occurs each one superimposed on the other. When an abandoned object was originally associated with pleasure, the absorbed imago is felt as if it were a 'good' part of the self. If it was associated with predominantly painful experience it is regarded as a 'bad' part of the ego. In the earliest phases there is more chance that the result of introjection will be felt to be 'bad.' And this for a number of reasons. The more primitive the demands of instinct the more violent the frustration ; the more violent the frustration the more sadistic is the infant's reaction ; the more sadistic the reaction, the more does the child project this sadism on the parents, thereby converting them into 'bad' objects. Naturally all these tendencies are accentuated by actual 'bad handling' on the part of parents, who, at the best of times, are capable of both witting and unwitting stupidity and sometimes actual brutality in the bringing-up of children.

Alternation of Introjection and Projection.—When early introjections set up painful tensions or when 'good' introjections are disturbed by later frustrations the mind tends to revert to the practice of projection. A vicious circle is established—projection of painful impulse, introjection of 'bad' objects, reprojection of painful tension. This can only be broken by increasing 'good' pleasurable experience in the self, by an increasing appreciation of 'good' behaviour on the part of the parents or by actual increase in love on the part of the parents. Naturally any fresh frustration tends to make the 'bad' states worse. Normally all infants alternate between 'good' and 'bad' states of this sort, and would remain in alternating mood were it not for the help of repression which, by obliterating all traces of the impulse, puts an end to frustration. The first effect is that, instead of violent swings between 'good' and 'bad' feeling, a fusion of 'good' and 'bad' takes place (combinations of good and bad introjections). These fusions, although an improvement on exclusively 'bad' feeling, are still extremely disturbing. Only when 'good' introjections predominate can development proceed satisfactorily. The exclusively 'bad' states are repeated in the depressive reactions of adults. Alternations appear in the manic depressive psychoses and in paraphrenia. Mixed reactions, with their accompanying ambivalence to love-objects, are responsible for obsessional symptoms.

Identification.—As the infant mind develops and the relation of the self to external objects becomes more realistic, earlier introjective processes are replaced to quite a considerable extent by systems of identification. This process is not so 'wholesale' as introjection. From the first the object of identification is not only clearly recognized as existing in the external world but relations with the object (more accurately with its imago) are never so completely abandoned as in the case of introjection. The basis of identification though not entirely realistic, is more elaborate, i.e. the imago is more like a person than like a set of gratifying or frustrating organs. Identification can still be divided into 'good' and 'bad' in accordance with the ego's reactions to the objects identified with. For example,

the child can unconsciously increase its feeling of stability by identifying with parental objects who exercise powers, rights and capacities which children do not possess. It can model itself on good parental objects and so feel them to be part of the self. But in so doing the child still lays itself open to criticism. The 'good' objects of identification proceed to exercise criticism over 'bad' unconscious impulse in the ego, thus continuing, although in a less primitive way, the super-ego reactions produced by introjection. The more complicated forms of unconscious mental conflicts are due to the interplay of opposing identifications. Hence identifications may figure prominently in symptom formations, particularly in the transference neuroses, some sexual perversions and a number of marital difficulties. Identification is responsible for the element of mimicry in hysteria, when, for reasons of unconscious self-punishment or reparation, the patient 'takes over' the illness of one or other parent. The influence of father and mother identifications is very obvious in both male and female homosexuality.

Regression.—Both in health and disease the mind tends to withdraw interest periodically from its immediate psychic contacts (relations to objects, modes of gratification, etc.) to reinvest earlier psychic relations and to reactivate earlier impulses. Sometimes the action of the mechanism is quite patent, as in sleep, day-dreaming, or the regressions of old age: and in many cases it obviously serves the function of psychic recuperation. Like all other mechanisms it can, however, contribute to the processes of symptom-formation. Superficial withdrawal of interest from social and sexual relations is frequently one of the early signs of a threatened mental breakdown. But the most important regressions are unconscious and involve a mental withdrawal to earlier phases which are likely to cause conflict. When the normal processes of regression are interfered with, typical disturbances of function may manifest themselves, e.g. insomnia.

Rationalisation.—Generally speaking the earlier or deeper the mechanism, the more its functioning goes undetected by consciousness. In later types, e.g. reaction

formation, a good deal of the activity can be observed in the preconscious system. The real causes of this activity, however, are not appreciated by the conscious mind. On the contrary, the conscious mind has an almost incurable tendency to account for its thoughts, feelings and behaviour in rational terms. This process of rationalization aids and abets the purposes of unconscious concealment. For not only do the individual's explanations appeal to himself, they are likely to be taken at face value by his fellows, who, having similar unconscious conflicts, are disposed to 'live and let live.' Types who 'see through' the rationalizations of others and make a point of uncovering them are usually reinforcing their own projective defences. And just as the sufferer from delusions of persecution is never entirely wrong (i.e. when he projects hatred on others he takes unconscious advantage of the fact that there is always some hatred lurking in the human mind) so the person who detects rationalizations in others may be right: but he is right for the wrong reason. Rationalizations vary in depth and complexity. The deeper they are the more they resemble the '*secondary elaborations*' occurring in dream formation (q.v.). Clinical psychologists have ample opportunity of studying them when taking case histories. The reasons given by patients to account for abnormalities of behaviour are almost invariably rationalized. Obsessional neurotics are expert at this unconscious game, whilst conversion hysterics are quick to find organic rationalizations to account for their functional crises. The rationalizations of hysterics are notoriously exaggerated and to the casual observer give a wrong impression of being wilfully deceitful.

Voluntary Mechanisms.—The unconscious mechanisms described are reinforced by a number of conscious defences. Closer examination shows that most forms of behaviour can be classified into groups, each of which is derived from a characteristic unconscious form. Thus conscious denial is derived from the repression group. It differs in one important respect, viz., that in many instances denial is a preliminary to ultimate assent. Similarly refusal to pay attention or 'take in' what is happening is a combination of

a repression and a projection reaction. Lack of concentration, on the other hand, is more a result of introjection processes than a purposive mechanism. Lying is a typical displacement derivative. Obstinate argumentation is a defence derived from displacement, reaction formation and projection, reinforced by repressed curiosity. The same is true of 'defence by criticism'. Voluntary change of occupation is clearly a sublimation derivative. Excessive or frivolous forms of acquiring information are derived from the period of introjection of anal objects. Each of these and other conscious forms of defence is associated with appropriate moods which are similar in tone to those accompanying the unconscious 'root-mechanism.' For this reason a study of the most prominent of the thousand and one conscious reactions of the individual can often assist in determining the main outlines of unconscious economy. By adopting this procedure many difficulties in diagnosis and prognosis can be overcome.

CHAPTER VI

PHASES OF MENTAL DEVELOPMENT

Although no psychic event can be understood unless it is analysed in terms of mental topography, dynamics and economics, it cannot be repeated too often that the mind functions as a whole. Hence the subdivisions of mind which contribute most to understanding of both normal and abnormal functions are those into *developmental layers*, each stratum of which should be regarded as having a total function appropriate to its period. This total function is essentially one of adaptation. Abnormalities (symptoms in the clinical sense) can therefore come to expression in any of three ways: first, when as the result of strain there is *excess or deficiency* of the reactions appropriate to the period; second, when in the face of strain the psyche *regresses* to an earlier and simpler level than the appropriate one; and third, when the psyche makes a precocious *advance* to a more developed layer than is appropriate to the period.

Problems of etiology, of differential diagnosis and of prognosis are greatly simplified if the essentials of mental development during the first five or six years are properly understood. Little is known of the very earliest stages. Available evidence suggests that most primitive instincts exist from birth, that most mental mechanisms are present as 'tendencies,' and that within a few months the first psychic structures are laid down. Nevertheless, any reconstructions of the first year and a half are extremely hypothetical; considerable differences of opinion inevitably arise between psycho-analysts as to their plausibility.

First Year.—The infant is subject to violent fluctuations of primitive instinct which it is incapable of mastering through its own unaided efforts, since both gratification

and denial of instinct depend to a large extent on the activities of external objects (parents, nurses). Primitive mental activities are due to the need to control or reduce the violent (painful) fluctuations in tension. No doubt all unconscious mechanisms operate in a rudimentary way, but there is reason to suppose that the burden of mental activity is carried by regression, projection and introjection and primitive forms of repression. Regression is indicated by periodic retreat to the comparative immobility of sleep and by the use of primitive hallucinatory thinking, which is, in principle, an attempt to recapture pleasure states by the reanimation of their images. Early dream activities occur at this point. All instincts are present except those varieties which depend on pubertal changes. The most important instinct zones are respiratory, oral, gastro-intestinal, anal, urinary, cutaneous and muscular. Oral interests predominate in the first place because they can gratify simultaneously self-preservative needs, love impulses and hate reactions and in the second because the maximum frustration falls on the oral group (periodic and/or final weaning). Sadistic drives are at first expressed mainly through the musculature but are concentrated in the oral system from the stage of teething onwards. The structure of the ego is primitive. There is no very clear separation of ego and external objects. The infant tends to react to painful internal experiences as if they originated without the self or as if they were derived from hostile foreign bodies within the self (objects in the ego). According to some analysts a rudimentary super-ego system is established towards the end of the year. Anyhow it is certain that by the end of that time object relations are much more clearly defined. Reality sense (i.e. estimations of the relation between instinct needs and their sources of gratification or inhibition) is present from the beginning, but is periodically suspended owing to the strength of emotional crises. Emotions fluctuate from occasional ecstasy to the deepest depression. Rages are uncontrollable. A good deal of apparent contentment is due to regression.

Owing to the absence of ordered speech, phantasy

systems are presumably expressed through 'thing' presentations, i.e. revived images of affective and sensory experiences. The external world is experienced as an organ, painful or pleasurable as the case may be.

An echo of this state of affairs is to be found in the apprehensions of disaster and cosmic catastrophe appearing in later neurotic and psychotic manifestations. The sense of disaster is a sample repetition of actual (emotional) disasters experienced by the infant. It is projected on to the external world because the infant confused the relation of inward states to outward events. And it is cosmic because originally the organ gratifying (or frustrating) infantile needs is for the time being the whole external world.

Obviously this period contributes extensively to all psychotic reactions, particularly to the disintegrated phases of schizophrenia. It must be remembered, however, that babies vary considerably in their original reaction types. Some are lethargic and slow in reaction, falling quickly into immobility; others react in a violent and hostile manner. And there are numerous intermediate types, anxious, restless, querulous, dissatisfied, satisfied, etc. The various forms of schizophrenia can be related to some of these temperamental divisions. Paranoia and manic-depressive states also draw some of their delusional and emotional characteristics from the period, but owing to more extensive ego-development they are much more systematized. Which psychosis develops depends largely on whether the majority of instincts have been disturbed as in schizophrenic types, or whether one particular group has caused difficulty, as, for instance, the oral sadistic impulses in cases of melancholia. It is sometimes thought that the psychological factors in epilepsy can be traced to this stage. Experience during the first year contributes also to *neurotic predisposition.* This is due to the fact that the infant not only suffers very considerably from floating anxiety but soon develops an extraordinary sensitiveness to it (anxiety-readiness). Phobias arising from localization of this anxiety are found in both neuroses and psychoses.

Second Year.—The various feeding difficulties of this

period and the affects accompanying them predispose not only to psychotic hypochondriasis but to the later readiness to form hysterical conversions. The infant's mind is still dominated by conflict over the frustration of primitive instinct. The mouth phase of development (the oral oedipus situation) gradually closes. Actual breast and bottle weaning may have been completed earlier, but during the first half of the second year a good deal of energy is devoted to mastering delayed oral-sadistic reactions to the final loss of the earlier oral satisfactions. As the oral phase closes the primacy of impulse is taken over by the urethral and anal group. Phantasies of love and of aggression are built up mainly in terms of urethral and anal erotism and sadism. To begin with, the control of urethral and anal activities is far from complete, hence the tendencies of the mind during the first half of the second year are in the direction of rejection and expulsion mechanisms, e.g., projection and various reactions of negativism. During the second half sphincter control is rapidly established at the cost of considerable hatred against external objects. Conflict over oral sadism is thus replaced by conflict over excretory sadism. Whatever unresolved oral conflict remains goes to reinforce the intensity of anal conflict. Infantile genital impulses increase in intensity but arouse an anal type of mutilation anxiety (unconsciously the penis and faeces are equated). Affects still fluctuate violently and the mechanisms of regression, projection, introjection and repression are still dominant. On the other hand repression is reinforced by displacement of interest and by this means a solution of mental tensions offers itself. Some primitive forms of reaction formation are set up. Aided by the more co-ordinated forms of play these displacements and reaction formations open up channels for sublimation. Word-formation, though still rudimentary, permits a rapid expansion of unconscious phantasy products, but most thinking is still expressed in relatively unco-ordinated 'thing' images. The baby's view of the external world is animistic. Inanimate objects are treated as if they were alive and potentially malignant. Under the influence of

gastro-intestinal experience and phantasy the infant regards his inner world as vulnerable and frequently possessed by evil and pain-causing objects. Nevertheless, ego-structure is much more coherent and there is much less confusion between the ego and its objects. But, although it is more coherent, the ego is at the same time beginning to show internal differentiation. The abandonment of earlier object drives and the introjection of objects leads to the formation of early nuclei in the super-ego. Although this view is controversial it seems justifiable to describe these nuclei as 'anal-sadistic super-ego forms'. Those who believe also in an early oral super-ego think that conflict between the ego and this later anal type of super-ego though less violent and fluctuating than oral conflict is more persistent.

The second year is responsible for many psychotic patterns. It also provides the background for borderline or 'transitional' states. The graver drug addictions have their origins in this period. Schizoid and asocial character reactions are developed. There is an extensive overlap between psychotic and neurotic reactions. Obsessional forms begin to appear but are frequently obscured by more obvious depressed or paranoid reactions. Anxieties are still acute and give rise to phobias which may be either psychotic or neurotic in type. Inhibitions of play can frequently be detected.

Third Year.—During this period defences against the excretory phases of hate and love are consolidated. These usually take the form of displacements and reaction formations, and are strongly reinforced by increased capacity for verbal expression. In consequence emotions are more controlled. On the other hand the infantile genital impulses increase and, in some children, reach their peak at the end of the third year. This was once regarded as the first stage of the oedipus phase but it is now considered as the genital stage of a total oedipal series. The third year may be regarded as the most fateful of all the infantile years. There is a tremendous increase in the complexity of mental structure; the ego begins to bear close resemblances to that of an adult. Fortified by energies derived

from the repression of anal-sadistic impulse, sublimation, in normal children, proceeds apace. Unconscious ego super-ego conflict although still acute is more localized on sadistic, or homosexual, or early genital, incest drives. Introjection processes are still active but identifications with complete objects are also laid down. These not only afford considerable stability to the ego but are responsible for many permanent character formations. Some analysts believe that there is no true super-ego formation until this period.

The numerous and varied abnormalities that may be traced back to the third year are in keeping with the complexity of the mind at that time. A great deal depends on whether the child, having weathered the last of the pregenital phases, is plunged too suddenly or too passionately into his last battle with infantile love and hate, namely the positive and negative genital oedipus phase. The neurotic symptoms corresponding to this phase are mostly of the obsessional type, mixed with a certain amount of phobia formation. The phobias are, however, no longer of a psychotic type but represent a defence against precocious genital sexuality and are therefore early hysterias. Various inhibitions can be traced to this period, in particular inhibitions of learning and of the intellectual capacity. Social anxiety appears, confined mostly to the family or immediate extra-familial environment, a pattern which is repeated later on in more adult forms.

Fourth to Sixth Years.—Although some children pass through the climax of genital interests in the third year, these are more often spread over the fourth and fifth years and practically disappear by the sixth year. This is the classical oedipus phase. Aggressive impulses are deflected through genital systems and produce the classical forms of infantile sexual rivalry. Innumerable forms of unconscious genital anxiety (castration and mutilation fears) appear. These constitute the main etiological factors for both conversion and anxiety hysteria. By far the greatest number of cases combine true hysterical formation with social anxieties and inhibitions. Various forms of psycho-sexual inhibition (impotence, frigidity, etc.) and some of the milder forms

of homosexuality can be traced to this period of development. Seductions commonly occur at this period. Infantile masturbatory activities begin to diminish. The unconscious mechanisms characteristic of this period are repression, displacement and inhibitions. As the infantile drives towards parents reach their climax and are gradually abandoned, more sophisticated identifications with objects are set up. In this way the finishing touches are given to the unconscious super-ego system. It should be added that these identifications not only hasten the processes of inhibition but are largely responsible for the nature of adult object choice. Needless to say, a great number of marital difficulties in adult life depend on patterns laid down during this phase.

Towards the end of the period a considerable degree of ego-synthesis occurs, i.e. the ego having passed from an unformed state into one of acute differentiation begins to knit together and conceal its dissociations. But this synthesis is never complete. Throughout life instinctual problems tend to bring out the division between ego and super-ego. This is by no means unhealthy. On the contrary complete absence of superficial conflict is sometimes a sign of mental regression.

Latency Period.—This is essentially the period of psychic consolidation and synthesis. The psyche has a respite from infantile urges and a few years in which to establish defences which will be severely tested at the onset of puberty. In some cases the duration of infantile sexuality is abnormally prolonged and pubertal manifestations make such a precocious appearance that clinically the latency period would appear to be absent. Even so there is always a quantitative reduction in the amount of stimulation. Experiences laid down during the latency period contribute very largely to smoothness of social adaptation in later life. Heavy social maladaptations are aggravated by traumatic experiences occurring during this period.

CHAPTER VII

DREAMS AND SYMPTOMATIC ACTS

To appreciate the significance of any given symptom in a patient's mental economy the physician must first be able to decipher its meaning. Useful practice in this form of decoding can be secured by studying those mental products which resemble symptoms in being apparently incomprehensible, irrational or absurd. Of these, dreams are by far the most important. Their interpretation constitutes, as Freud himself has said, the *via regia* to the unconscious mind. Not only so, the study of dreams helps to correct a number of false impressions that might arise from a purely analytic approach to psychic function, e.g., the view that each unconscious mechanism works independently of the others, or again that different parts of the ego are in a state of permanent isolation. On the contrary, one of the most important functions of the ego is a 'synthetic' function. Unless a state of active conflict exists the different parts of the ego tend to merge with one another; and however exaggerated its activity may be no mechanism works alone. This synthetic function of the ego though obviously of great service to the individual can also work against his interests, as when his ego comes to terms with a neurotic system and seeks to encapsulate it. In dream formations it is possible to observe not only the simultaneous operation of a number of mechanisms but the manner in which different parts of the ego are combined and again dissociated.

Like all other mental formations dreams can be conveniently examined from both structural and functional aspects. The principal function of dream activity is to preserve sleep. Sleep is threatened by unsatisfied unconscious wishes. The dream seeks to satisfy these disturbing

wishes but owing to the action of the censorship this gratification must be disguised. If it were not sufficiently disguised (i.e. guarded against), the mind would mobilize more powerful controlling forces by waking. The apparent absurdity of a dream is thus seen to be a form of defence. In other words—the *manifest content* is an allegorical expression of deeper (latent) content, rendered still more obscure or even absurd by various forms of *distortion.* The building up of this manifest content out of the *latent content* constitutes the *dream-work.* It is, however, a mere translation or *transformation* and does not itself involve intellectual activity. In most cases a visual *dramatization* occurs. This is aided by the process of *regression* which allows thoughts to be discharged as hallucinations at the sensory end of the psychic apparatus. Regression in dreams is stimulated on the one hand by the censoring action of the mind and on the other by the attraction exercised by infantile memories. Apart from this theatrical activity of the dream, the mechanisms most commonly employed are those of *condensation* and of *displacement* (q.v.). By virtue of condensation each element of the manifest content represents several thoughts. Thus persons appearing in a dream are usually composite, combining the characteristics of a number of different individuals; or alternatively, a number of persons can be represented by one characteristic they have in common. Displacement takes a number of forms. Important elements are represented by unimportant ones or affects are disguised by a shifting of emphasis from one element to another. There is also an infinite amount of *allusion.* Puns are exploited in the interests of disguise as are double meanings and other forms of word-play. Representation of the whole by a part or of a part by the whole is common. Another important factor in dream disguise is the expression of phantasies through *symbolism.* In symbolic representation not only is the abstract represented by the concrete through a process of sensorial or visual identification, but the unconscious material is represented in ways which are independent of individual factors. Symbols express the love and hate wishes of the self to members of the family. The great

majority have a sexual significance, e.g. serpent, eye, knife, gun are phallic symbols ; house symbolizes female genitals ; emerging from water is a birth symbolism. Their meaning is constant. The manifest content usually contains quite *recent impressions* occurring during the previous waking period. Although these may not have aroused attention at the time, examination shows that they are of emotional significance or are connected with events of emotional significance. Less frequently somatic stimuli play a part in evoking dreams but these stimuli are woven into the texture of the dream. Memories of childhood also contribute to the manifest content. Nevertheless, the wish-elements invariably refer to latent content. In the dreams of children the element of wish fulfilment is more obvious than in adult dreams since there is little distortion. Finally, just as the conscious mind uses mechanisms of rationalization to deflect attention from unconscious motivations so in the dream a process of *secondary elaboration* occurs representing more conscious mental activities. This sometimes lends a specious air of reasonableness to the remembered dream.

The resemblances between dreams and symptoms are manifold. Indeed it is sometimes said that the dreams of the normal person constitute 'normal neuroses' as distinct from 'symptom-neuroses'. Both are apparently absurd yet both have a hidden and consequent meaning. The defensive mechanisms are the same in both instances and in both dream and symptom the conflict is aroused by unconscious impulses. Both represent imaginary gratifications of these unconscious wishes and in both cases an element of compromise between the repressed and the repressive forces is present. As a rule there is more secondary elaboration in dreams although many obsessional states exploit this mechanism to an outstanding degree. Regression, theatrical representation of infantile content and symbolism are found in both. Dreams and symptoms both tend to be forgotten and many inaccuracies creep into the recital of their course or history. Even closer are the clinical resemblances. In hysteria the environment is frequently reacted to as it would be in a dream ; and many twilight states, dream states, somnambulisms and states of

exaltation are easy to understand if regarded as dream reactions occurring in waking life having as their aim the gratification of unconscious wishes. Whereas hallucinatory mechanisms are normal dream procedures, this intrusion of dream mechanisms in waking life usually stops short of hallucination. True hallucination is, however, a common manifestation of psychotic breakdown. In conversion hysteria free use is made of body symbolism to represent infantile ideas. *Dream pairs* in which the first fragment represents the gratification of unconscious wishes and the second their rejection have obvious resemblances to the diphasic structure of obsessional neuroses (q.v.). The precipitating factor in symptom formation has roughly the same dynamic significance as the *day-remainders* which evoke dreams. The effect of both dreams and symptoms is congruous with the nature of the unconscious wishes, i.e. however unrealistic they may appear they are always appropriate to the intrapsychic situation. Some dream affects are, however, more pathological than others, e.g. in 'anxiety dreams' and 'nightmares'.

Examination of *recurring dreams* is frequently of service in differential diagnosis. There are many typical dreams and easily translated symbols which give a clue to the central anxieties and conflicts of the individual, e.g. symbols of phallic mutilation, pregnancy symbols, active and passive homosexual dreams, guilt and persecution dreams. Tension dreams are particularly significant in cases where suicidal tendencies are suspected.

Symptomatic Acts.—From every point of view it is worth while paying attention to what Freud aptly described as the psychopathology of everyday life. Most individuals from time to time make slips of the tongue or pen or perform 'slip-actions' which if examined with tact may shed considerable light on their general psychic constitution or underlying difficulties. The business man who takes out his office key when approaching his home has obviously more conflict about his domestic relations than he may be aware of, if indeed he is aware of any such difficulty. And the individual who constantly inflicts minor 'accidental' injuries on himself is in all probability not only

masochistic in type but suffering from unconscious guilt (more accurately, from the need for self-punishment). The unconscious homosexual frequently betrays himself in his confusion of genders or by his tendency to mix up 'right' and 'left'. The depth of the unconscious conflicts can sometimes be judged by estimating the incidence of such symptomatic acts. They tend to occur during temporary mental stresses of whatever nature, but a persisting tendency is naturally of more significance. On the whole they are of more common occurrence in individuals whose symptom formations are not excessive but whose characterological difficulties are of a pronounced type. On closer examination the psychic structure of a symptomatic act is seen to have much in common with both dream formations and symptom formations. This is particularly true of 'absent-minded' actions which are really miniature hysterical fugues and share with fugues their dreamlike technique.

The investigation of dreams and symptomatic acts is not only a useful way of learning how to approach clinical symptoms but has the additional advantage that the physician can experiment on his own dreams and actions. Such investigations are not in any sense comparable with analytical interpretation, a procedure which can only be acquired with proper training. It is sufficient if they induce a proper respect for, or insight into, the nature of symptoms.

CHAPTER VIII

SYMPTOM FORMATION

Theoretically regarded, a symptom is an attempt on the part of the unconscious ego to adapt to some instinctual stress. Stimulated in most instances by the primitive moral interference of the super-ego, the unconscious ego mobilizes a number of unconscious mechanisms which are intended to control or distribute the energy causing tension. Should this manoeuvre be unsuccessful a compromise is effected. Part of the energy is discharged in a disguised form. This disguised form (symptom formation) is painful, sometimes repugnant, and always a source of inconvenience to the conscious ego, which, knowing nothing of the original stress, is unable to understand what has happened. Many of the familiar clinical features of symptoms are due to the reactivation in an adult setting of infantile situations, phases of development, mechanisms and affects. In other words, the main defence of the unconscious ego to a threatened stress consists in abandoning some adult relations to reality and making a partial regression to an appropriate period of infancy. The period chosen is that infantile period during which the mind first learned how to deal with stresses of the kind with which the adult is now threatened. Having fortified itself by enlisting these old defences, the mind advances once more on its problem and sets up within the confines of the adult ego what might be called a 'provisional infantile government', which, more often than not, fails miserably to govern. It will be seen therefore that a symptom is essentially a spontaneous attempt at self-cure: a fact which more than any other explains why many mental symptoms are refractory to treatment. The mind in such instances prefers its own methods of treatment. Like all other

mental phenomena symptom formations can be described in temporal or spatial terms. Despite the variety of clinical manifestations the symptomatic series of movements, or, as the case may be, the symptom structure, is roughly the same in all cases. Topographically regarded, the symptom is a psychic construction straddling the barrier between the unconscious and the pre-conscious and drawing energies from both systems.

Although the internal causes of stress leading to symptom-formation are unconscious, a few questions may elicit the fact that before the immediate breakdown some real event of unusual significance has occurred: onset of puberty, engagement, marriage, child-bearing, climacteric, illness or deaths in the family, rupture of friendship or forced contact with uncongenial people, changes of residence or occupation, loss of money, personal illness, etc. In the last analysis this *precipitating factor* involves a change in the distribution of instinct energies. Either there is some interruption of current gratifications causing both frustration and hurt (deaths in the family) or (as in the case of engagement to marry) there is an increase in instinct tension causing unconscious anxiety. In some cases the apparent precipitating factor (e.g. loss of or squandering of money, loss of occupation) is really spurious or has been unconsciously induced to provide occasion and excuse for a neurotic breakdown. In others, owing to the fact that the breakdown has taken place imperceptibly over some years a recent precipitating factor appears to be lacking, but can be traced. In others again, particularly in the psychoses, no obvious precipitating cause can be determined.

When the precipitating factor is an obvious one, it is sometimes easy to observe that a withdrawal of interest in external relations follows, which is disproportionate to the immediate stimulus. But this manifest *regression* with or without obvious cause, is only part of a total unconscious regression occurring in all symptom formations. If the forward flow of libido or other instinct energy is interfered with, the energy tends not only to withdraw but to flow back and activate earlier psychic interests. For instance

loss of or rejection by an adult love object is often followed by an increase in need for child-like non-erotic affection. Once started, this backward flow does not stop until some earlier *fixation-point* is reached. Fixation-points lie deeply in the unconscious. They represent early phases during which infantile drives towards family objects were overcharged. These may have been totally frustrated and so have given rise to powerful systems of unconscious phantasy: or they may have succeeded in securing some measure of gratification and so have induced an intense longing to remain 'fixed' at that stage of development. In either case the ego, during these fixation periods, is compelled to acquire new methods of mastering tension or of overcoming traumatic experiences. And to the extent that these methods are successful the ego has acquired additional strength. Regression is, therefore, a retreat to these unconscious vantage points, satisfying also a need to re-establish old pleasures and old defences. It is not in itself an abnormal process, and must be judged by its results. Unfortunately, in those predisposed to mental conflict, the backward flow, besides reactivating infantile interests, stirs up an old conflict about them. When this conflict has up till then been held in check, as, for instance, by repression, the results are bad. Hence the psychoanalytical formulation: *no adult neurosis without an infantile neurosis.* The reinforcement of energies at the fixation point puts too great a strain on repression, which is in any case faulty in those with a psychoneurotic predisposition. Only then does the process of symptom-formation begin. Other unconscious mechanisms (displacement, distortion, condensation, projection, etc.) are called into play in order to provide a *disguised gratification* of the reinforced unconscious wishes. The symptom represents at the same time an unconscious *repudiation* of these wishes. In so far as they are painful, or a drawback to the ego, symptoms represent a *punishment,* an admission of guilt on the part of the unconscious ego brought about by the excessive disapproval of the super-ego. This punishing process is more obvious in hysterical manifestations where the symptoms cause a considerable degree of

physical discomfort or actual pain. In obsessional neuroses an element of *reparation* as distinct from mere expiation through punishment can be detected. As contrasted with hysteria which is mono-phasic, the obsessional neurosis is usually diphasic. One stage of the symptom represents the unconscious gratification (crime) which is followed by a phase intended not only to cancel or expiate it, but to make good the alleged damage to objects. Both unconscious punishments and reparations 'fit the crime.' They are talion punishments and reparations.

Although the main function of the symptom is to deal with unconscious conflict, and although it may appear to have little or no connexion with current events, once it is formed it usually exercises a direct influence on the patient's relations to his immediate family or other social environment. He unwittingly extracts a good deal of advantage from both family and friends, either in the form of emotional consideration and attention, or as release from the responsibility of adapting to existing or threatened crises. Not infrequently the patient has to be supported financially. These are forms of *secondary gain* to be distinguished from the *primary gain* which is essentially a relief from unconscious stress obtained by means of the mechanisms adopted. These gains encourage the ego to come to terms with the symptom. In spite of their sufferings, some patients develop an attitude to their symptoms that is almost affectionate. They tend to encapsulate them, resist strongly any attempt to remove them and experience a sense of loss when they begin to disappear. In such cases the normal synthetic function of the ego works to the individual's disadvantage.

A word of caution about the nature of secondary gain. It must not be assumed that this gain is a prime factor in symptom formation or that the amount secured outweighs the discomforts of the symptom. It is necessary to emphasize this for two reasons, first, that there is a natural tendency to confuse secondary gain with conscious malingering and, second, that the physician might be tempted to attack the neurosis by cutting off any obvious

sources of gain. This procedure is more likely than not to aggravate the condition.

Comparison of the structure of psychoneurotic and psychotic symptoms shows that although they have much in common, there are characteristic differences. When a precipitating factor is present the reaction of the psychotic patient is much more massive. Frequently no precipitating cause can be demonstrated, but it appears that the psychotic reacts less to obvious relations with external objects than to the symbolic valuation of his general environment. Thus on a foggy evening a psychotic type may feel either comforted or contrariwise oppressed by a deep sense of evil. The withdrawal of interest is also more profound, and affects not only relations to real objects but also to the mental images of objects. This throws an excessive strain on the narcissism of the ego and predisposes to serious mal-function. In any case, psychotic individuals have seldom succeeded in establishing stable relations with real objects. Regression is more profound. The fixation points are much earlier (within the first 2-2½ years of life). Hence libido regression activates more primitive forms of infantile sexual impulse; similarly the ego reactions awakened belong to an early period when ego-synthesis was very weak and dissociation the rule. These factors lead to a more or less complete rupture with reality. In schizophrenia the rupture is more complete than in paranoia or manic-depression. Clinical features such as delusional and hallucinatory systems, are attempts to re-establish relations with the outside world by means of primitive mechanisms (e.g. projection). The attempts, it is true, fail, because they end by distorting true reality sense. Nevertheless like many neurotic manifestations these psychotic products are best understood when they are seen as attempts at spontaneous cure. The psychotic, as it were, plants his hallucinatory products at that point of his relation to the external world where he is actually suffering the greatest disturbance of instinct equilibrium.

SECTION II

CHAPTER IX

INTRODUCTORY

IT is difficult to combine psycho-analytic practice with the exacting and irregular routine of general practice. Psycho-analytical understanding is, however, of considerable value in arriving at the diagnosis and prognosis of mental disorder. It enables the practitioner to recommend the most suitable form of treatment, and, should he decide to undertake personally some form of psychological guidance, it enables him to direct these efforts to the best advantage. Moreover, the prophylaxis of mental disorder depends on the recognition and appropriate handling of abnormalities in infancy and childhood, a task for which psycho-analytical orientation as to child development is essential.

Although the therapeutic range of psycho-analysis has gradually widened until it has come to include practically any form of mental abnormality, discretion must be exercised in recommending cases for psycho-analytic treatment. Even when the diagnosis is perfectly straightforward, e.g. an apparently simple phobia or obsession or inhibition, it does not follow that the patient will automatically respond favourably to psycho-analysis. He may accept a strong recommendation to undergo treatment and yet remain refractory, either because of his fears of mental 'interference' or because the primary and secondary gains derived from his illness are sufficiently great to sap any effective drive to recovery. Even should he commence treatment, this type of patient may break off in a few weeks on one pretext or another. It is just as important, therefore, to recognize the existence of these 'pre-analytic resistances' as to distinguish accurately the clinical variety of disorder. If the resistances should appear to threaten

success, the position should be explained to the patient, but no pressure should be brought to bear on him. A brief delay will usually bring matters to a head. If a suitable decision cannot be arrived at in this way analytic recommendations should be shelved and in the meantime any form of psychological handling to which the patient is ready to respond can be recommended or tried. Many patients will turn to psycho-analysis only after they have tried every known form of non-analytical treatment.

Another problem in selection of cases depends on accuracy in differential diagnosis. For example, it is sometimes difficult to distinguish between hysterical and psychotic syndromes. Yet therapeutically regarded, there is no question that, owing to deep processes of dissociation and to the weakness of relation to reality, the psychotic case is much more 'inaccessible' that the hysteric, and, therefore, will not respond to psycho-analysis to the same degree, if at all. A mistake in diagnosis leading to an over-sanguine recommendation of treatment will inevitably cause disappointment to all concerned. In severe sexual perversions, chronic marital difficulties, or persistent delinquency it is not easy to assess this *factor of accessibility*. Some abnormalities of character are more inaccessible than psychotic symptoms. In such instances pressure to undertake analysis should come from the patient's side and he should not be led to entertain false hopes of an early cure. On the other hand, many severe cases are by no means so intractable as they look, and on occasion a threatened crisis can be averted by a rapid analytical exploration. Moreover, it is important to recognize that, particularly in the case of psychoses, symptoms may follow predetermined cycles, during some phases of which the patient is inaccessible to treatment. If a depressive case has already started on a downward curve or is entering on an agitated phase, it is more than probable that this phase will be completed, whatever therapeutic steps are taken. To recommend analysis at this stage is to court disappointment for some time ahead, and, as a rule, it is better to wait for remission in the cycle before commencing treatment.

Apart from personal training in psycho-analysis, the

best method of acquiring the necessary judgment in these matters is to combine clinical experience with an adequate orientation as to the etiology of different varieties of disorder. In particular it is desirable to be able to estimate rapidly the significance not only of the standard neuroses and psychoses, but of those numerous sexual and social disabilities which constitute a large part of psychoanalytical practice. The first step towards acquiring this capacity is to become familiar with the series of diagnostic and prognostic valuations that have been worked out for the neuroses and psychoses; in other words, to acquire a sense of the comparative depth of mental disorders

CHAPTER X

PSYCHONEUROSES

Psycho-analytical discoveries were originally made in this clinical field and the psychoneuroses (or 'transference neuroses') are still the conditions most suitable for analytic treatment. For some time clinical diagnosis was complicated by the existence of vague captions such as 'neurasthenia,' 'anxiety states,' etc. As investigation of the syndromes of conversion hysteria, anxiety hysteria and obsessional neuroses proceeded, the neurasthenic group was divested of much of its significance. Some forms were recognized as conversion phenomena, others as obsessional symptoms. No doubt a true neurasthenic syndrome exists just as there are true states of frustration anxiety (so-called 'actual neuroses'), but they are practically never unaccompanied by psychoneurotic reactions.

(1) *Hysteria.*—Two major types of hysteria exist, namely, conversion hysteria and anxiety hysteria. These are distinguished clinically by the nature of their symptoms. In the first the symptoms are somatic, in the second mainly emotional, in character. Patients belonging to the first group exhibit relative freedom from anxiety because their pathogenic instinctual drives and intrapsychic conflicts have been *converted* into physical symptoms. The unconscious phantasies receive concrete bodily expression and the development of anxiety is obviated by this method of displaced, but nevertheless, effective discharge. The second group, on the other hand, are martyrs to anxiety. This anxiety may be free-floating and vary in intensity from vague forboding and formless apprehension to spasms of acute, irrational panic, or it may be canalized by the formation of phobias. In the latter

case it will be aroused only in the specific situations which have come to be 'dreadful.'

(*a*) *Conversion Hysteria.*—Conversion symptoms may arise in any organ of the body and may involve any physiological system. They may occasion either excess or diminution of the physiological function involved. Sensory disturbances are common. Anaesthesias, paraesthesias and hyperaesthesias of anomalous neurological distribution (e.g. the classical 'glove and stocking' type) may be of hysterical origin, especially if they are variable and intermittent. The special sense may be affected, as when there is contraction of the field of vision, blindness, or deafness. Conversion headaches are very common indeed. Motor disturbances range from mild cramps, pareses and tremors to disabling paralyses and fits. 'Occupational neuroses,' such as writer's cramp, often belong to this group. The distribution of such motor disturbances is functional rather than anatomical, and the dysfunction is variable or intermittent. Major convulsions ending in opisthotonos (arc-en-cercle) are now seldom met in practice. Narcoleptic phases, rigidity and somnambulism may occur and have to be distinguished from the stupor and catatonia of schizophrenia (q.v.). Respiratory symptoms are frequent: as, for instance, globus hystericus, aphonia, and asthmatic conditions. Some stammers belong to this group. Alimentary disorders are extremely common and may resemble any type of organic digestive disturbance e.g. anorexia, vomiting, flatulent dyspepsia, diarrhoea and constipation. Many anomalous skin and circulatory disorders belong to the conversion group and many types of uro-genital dysfunction. When functional disturbances persist over a number of years they may give rise to severe complications of an obviously organic nature. Chronic gastric neuroses may end in the formation of peptic ulcers, arterial hypertension in cardiovascular disease and cramps and paresis in severe contractures and muscular atrophy respectively.

Where recovery from organic disturbance is unduly delayed, e.g. where nausea and vomiting persist indefinitely after an acute attack of genuine food-poisoning, or a sprained ankle continues to give pain for weeks after all

swelling, etc. has disappeared, it may be that the organic disturbance has been succeeded by a conversion condition. Such a condition is often termed 'fixation' hysteria. In general, any anomalous somatic disturbance, for which no adequate cause can be found, may legitimately be queried as a possible conversion symptom.

From the genetic point of view, conversion symptoms present three outstanding characteristics. In the first place, they are compromise formations. The single symptom expresses both the instinctual drive and the reaction against it, both the unconscious wish fulfilment and its appropriate punishment. For this reason they are described as *monophasic*. In the second place, the organ affected (or in the case of such symptoms as vomiting or diarrhoea, the substance ejected) is identified with the person towards whom (or towards whose organs) the unconscious impulses are directed. Thirdly, the formation of the symptom depends more upon displacement and repression than upon other unconscious mechanisms. Hence the subject is completely unaware of the nature of the pathogenic drives from which he suffers. Thus a young wife, consciously devoted to her increasingly impotent husband, developed a paresis of the hand. The paresis represented both the damage she wished to inflict upon the husband's ineffective organ and the protective reaction against doing it, the loss of the use of the hand at the same time punishing the patient herself. While there is little doubt that symptom-formation may be precipitated by a current situation, it can only come about where the current situation revives an unresolved infantile conflict. In the case referred to, the husband was unconsciously identified with the father to whom the patient had been strongly fixated in childhood. Findings of this order gave rise to the tenet that the oedipus complex is the nuclear complex of the neurosis. The hysteric is unconsciously attached to an infantile parental love object, and, because this incestuous attachment is unconsciously formulated in terms of infantile genital activities the patient is usually incapable of full adult genital love and activity. It has sometimes been said that the hysteric is capable only of object love with exclusion of the genitals.

An important predisposing factor in hysteria is the existence of a strong bisexual constitution. This leads to an overemphasis of the 'negative' as well as of the 'positive' oedipus complex. This attachment to the parent of the same sex ('negative' complex) is also expressed unconsciously in infantile phallic terms. The gastro-intestinal disorders of unconsciously passive males are peculiarly adapted to represent and at the same time to reject unconscious homosexual phantasies of pregnancy. In women, attacks of migraine serve a similar purpose. Phantasies of possessing a phallus with which the little girl can impregnate her mother and thereby outvie her father are displaced from below upwards and at the same time expiated through the painful degree of 'splitting' headache and sickness that ensues. In all cases there is a degree of infantile genital sadism present, and this together with the anxiety associated with infantile genital wishes gives rise to a strong unconscious fear of castration. This castration anxiety is expressed and at the same time denied through a painful disturbance of function in a non-sexual organ, or body-system.

Conversion symptoms due to genital and other infantile anxieties are usually localized: (i) In the physiological systems or organs that contribute to infantile sexual interest. The erotogenic *zones* are specially vulnerable: e.g. mouth, anus, gastro-intestinal, genito-urinary and cutaneous systems; (ii) in the body systems normally discharging anxiety. For this reason cardio-vascular, respiratory and gastro-intestinal systems are especially prone; and (iii) in parts of the body that are suitable unconscious substitutes (symbols) for genital organs, e.g. head, eyes, hands, feet, etc. These are affected through the mechanism of displacement.

(*b*) *Anxiety Hysteria.*—In this group the cardinal symptom is anxiety. The physical symptoms which occur are the somatic reactions associated with fear of real danger: sickness, palpitation, tremors, dizziness or faintness and sweating. The anxiety usually takes the comparatively mild form of constant apprehension or vague dread, with occasional exacerbations. This does not appear

to be related to any obvious external situation, though in some instances it tends to occur at certain regular periods, as when an adolescent suffered for a year or so from an hour of horrible dread almost every day at twilight. In adults of both sexes such free-floating anxiety is often found associated with conditions in which sexual excitement is combined with inadequate satisfaction, as during the more ardent phases of courting of long-engaged couples. For this reason the condition has been described as an 'actual' neurosis, i.e. as a disturbance due to current real deprivation. But it appears more likely now that marked anxiety does not occur in such circumstances in the absence of hysterical predisposition.

A diagnosis of true 'actual' neurosis is justifiable only when there is no gross evidence of true phobia formation and when the disturbances disappear shortly after instituting a more balanced system of psychosexual stimulation and discharge. Otherwise it is good policy to regard these floating anxieties as a sort of penumbra to real anxiety hysteria.

In true hysteria the anxiety is tied to one or more specific situations and appears in force only in these situations. Classical types of such phobias are claustrophobia (dread of closed or confined spaces, possibly in one particular form, such as travelling by tube) and agoraphobia (fear of open spaces, most often in form of fear of being out-of-doors alone). The advantage of this canalization is that as a rule the patient can remain free from anxiety as long as he avoids the conditions which precipitate it. To a city-dweller for instance a phobia of snakes is much more advantageous than a dread of being poisoned by motor-exhaust gas. In the phobia-formations of the adult, displacement and repression play a considerable part, but the fundamental mechanism appears to be the more primitive one of projection. A phobia in an adult is invariably a revival of a phobia present in childhood, though not necessarily in the same form, and involves the attribution to the object or situation feared of some reactions of aggression or of aggressive sexual wishes really belonging to the patient himself. Thus a patient with a phobia of cutting

instruments turned out to have strong 'Jack-the-Ripper' tendencies. In addition, the object or situation feared has a symbolic significance which varies according to the particular sexual component involved in the conflict. The typical adult phobia, like most phobias of five-year-old children, show an unmistakable infantile genital (incestuous) origin, e.g. fear of knives in women. As in the case of conversion hysteria a strongly bisexual disposition can be detected. In most female hysterics the infantile incestuous phantasies have a strongly phallic character and in both sexes it is often possible to demonstrate pregenital elements which lend themselves to homosexual phantasies. This is particularly true of poison and food phobias, where analysis shows that the infantile incest is phantasied in unconscious oral or anal terms. The more highly charged and more primitive the aggressive (sadistic) components present the more likely are the hysterical symptoms to be complicated with obsessional or even psychotic reactions. A marked food phobia has obviously a close resemblance to a delusion of persecution. Indeed where the infantile genital elements in the phobia are weakly represented it is an open question whether the condition should be called a true anxiety hysteria or a paranoid type of anxiety. This distinction is all the more necessary in the case of children whose anxieties are more clearly paranoid in type during the first three years and show true hysterical form only in the third, fourth and fifth years. Hence diagnosis of anxiety hysteria will depend less upon the presence of phobias as such than upon the absence of symptoms indicating grave disorders (*vide* following sections). It is sometimes possible to make a clinical distinction between hysterical and other phobias by studying the symbolic significance of the phobia-object. Where the representation is clearly genital in type—knives, mice, burglars, small apertures, etc., or suggests the existence of infantile pregnancy phantasies, e.g. phobias of insects, eggs, sand, etc., the probability is that the case is one of pure hysteria.

Anxiety hysteria is more common in woman but by no means rare among men. Apart from special difficulties due to the symptoms themselves,

the patients usually give an impression of fairly good adaptation to reality. There may be a good deal of emotional instability, with a tendency to pass into emotional crises, but the personality seems moderately well integrated in spite of the dissociation of the elements which return as symptoms when repression partially fails. This is due partly to the fact that hysterics tend to adapt to their symptoms, much as tissues sometimes adapt themselves to the presence of a foreign body. In some instances they extract so much unconscious advantage from their symptoms (as when an invalid tyrannizes over his home) that the secondary gain has even been considered as an etiological factor. But this is going too far. In doubtful cases the quality of love-interest may help to confirm the diagnosis. Hysterics display an over-readiness and over-intensity in their attachments, but the range of their interest is usually limited and combines over-solicitousness and anxiety with a tendency to sudden rages.

(2) *Obsessional (Compulsion) Neurosis.*—The name given to this group of neuroses indicates the leading clinical feature of the symptoms. These manifest themselves either in the intellectual sphere, as a constant pre-occupation with a stereotyped train of thought (e.g. a man may constantly imagine himself stabbing his wife with a breadknife) or, in the realm of action, by the repetition of stereotyped forms of behaviour (e.g. perpetual hand-washing). Compulsive behaviour may attain to ceremonial dimensions, as in the case of a woman who took some four hours to get to bed, because every detail of undressing and arrangement of clothing, bed and furniture had to be exact; any slip in the ritual meant going back to the beginning. Whereas the conversion symptom is a single (monophasic) compromise formation, the compulsion symptom is often in two parts (*diphasic*) one part representing the doing of a guilty deed, the other, its undoing, e.g. a man with the compulsion to untie and reknot his tie dozens of times a day. The undoing represented, at the current level, freeing himself from his wife, the reknotting, continuing to live with her.

The obsessional neurotic, like the hysteric, recognizes

the irrationality of his symptoms and is 'normal' in other respects. But whereas the hysterical symptom appears to be a dissociated part of a more or less integrated whole, the obsessional personality is profoundly divided against itself. The ego is hemmed in and encroached upon. It may ultimately be invaded and overrun by the opposing and evenly matched forces of infantile instincts and unconscious conscience. The severity of this internal war is paralleled by the ambivalence of the patient's unconscious attitudes towards external objects. The tie symptom showed the intensity both of the man's love and his hate for his wife, his relation to her repeating his earlier emotional attitude to his mother. Because of the element of latent cruelty in the symptoms and their frequent connexion with dirt and excretion, it used to be said that the obsessional neurotic had regressed from the infantile genital oedipus phase to an earlier anal-sadistic stage of development and that the symptoms concealed a strong unconscious homosexual organization. Although this view is still tenable, there seem equally good reasons for maintaining that obsessional cases have not succeeded in progressing beyond their primitive ambivalence and that only a small part of the total libido has succeeded in passing the anal-sadistic homosexual phase. There is an emotional type of this disorder in which the victim suffers from no stereotypy in thought or behaviour, but from constantly recurring and swift alternations of feeling. In some instances there is no indication of the source of the feeling. The patient knows only that any state of internal 'goodness' *must* be followed by a 'bad' state otherwise disaster will follow. Others experience alternating states of attraction to and repulsion by women. This alternation of feeling is the true larval stage out of which the more complicated obsessional or compulsive symptoms develop. In yet other types two sets of feelings, instead of alternating, may cancel each other out, producing a condition of apathy. Alternation may be accompanied by anxious indecision, and apathy often goes with great difficulty in doing anything at all, and excessive fatiguability. An obsessional deadlock of this kind presents the picture which

used to be labelled an actual neurosis, viz. 'true neurasthenia' and ascribed to the effects of excessive masturbation. Broadly speaking every obsessional neurosis is an unsuccessful attempt to cope with an ambivalence to objects which threatens the stability of the ego. This ambivalence is an heritage from the earliest phases of life, in which co-ordination is imperfect and the baby is at the mercy of a succession of intense 'all or none' feelings and impulsive states. In course of development these violent changes become focused in an alternation of love and hate attitudes to objects. The obsessional tries to cure this unsatisfactory state of affairs partly by increasing the number of his objects by substitution (the would-be husband was attracted to any number of women) and partly by compounding or blending his affects. This compounding fails when the feelings in question are too disparate, e.g. when love and hate are too strong and too evenly balanced, with consequent relapse into alternation. Paranoid and melancholic states are frequently associated with obsessional conditions. Obsessions may also be associated with true phobias, which appear to act as auxiliary defences. The man with the bread-knife obsession developed a phobia of knives (an additional defence against carrying out the stabbing). In any case phobias represent a less sadistic attitude to objects and help to localize anxieties: hence the appearance of phobias during the analysis of severe obsessions is a sign of progress. It should be remembered that increase in the number of objects by substitution (leading to a widening of extra-familial interests) and compounding of varied feelings into stable emotional attitudes towards people is a necessary step in normal mental development. In this sense it can be said that all infants pass through an 'obsessional' phase. Many adults use obsessional mechanisms throughout life or employ them temporarily in moments of stress. Most life routines are supports of this type, and there must be few people who have not at one time or other suffered from transitory *folie de doute,* wondering whether they did or did not lock the safe before leaving the office, and so on. Whereas the relatively normal pass through this

phase or fall back on it occasionally, obsessional neurotics appear unable to get beyond it, seemingly because they have more infantile sadism than they can cope with. The violence of this aggression is offset by an exaggerated severity on the part of the super-ego or unconscious conscience, which imposes an apparently absurd, yet crippling, series of expiatory rituals. The obsessional neurosis is essentially a 'guilt neurosis.' It is commoner among men, but not at all rare among women.

(3) *Mixed Types of Psychoneurosis.*—Pure cases of anxiety hysteria or obsessional neurosis are comparatively rare. Every possible combination of the three types can be observed in general practice. The commonest are (a) Conversion symptoms with anxiety states ; (b) Conversion symptoms with phobias ; (c) Phobias with obsessional symptoms. Phobias and obsessions with an undercurrent of depressive reaction are rarer. Differential diagnosis is seldom difficult. In combined conversion and anxiety states it is necessary to detect any hypochondriacal elements suggesting a psychotic substructure. Eating difficulties are somtimes hard to assess in this respect. Where the symptomatic elements are disproportionately large and the integrated personal remainder correspondingly small, diagnosis from schizophrenia may be uncertain. Although hysterics may show hypersensitive reactions, their contact is more sanguine, less negativistic, hostile or inaccessible than in schizoid types. The more chronic obsessional states usually have a concealed depressive or paranoid structure and in some cases the symptoms shade off into depressive or mildly paranoid reactions. Nevertheless the existence of an obsessional neurosis is generally a guarantee against psychotic breakdown. Although there is no great difficulty in arriving at a diagnosis of these mixed states, it is frequently hard to determine what degree of psychoneurotic symptom formation calls for treatment. As has been emphasized some mild forms of anxiety readiness or phobia formation or obsessional reaction are present in most 'normal' people, sometimes a combination of all three. As the practitioner becomes more expert in detecting such minor formations,

he tends to recommend treatment without due discrimination. As a rule minor formations of this sort should be discounted in making a serious diagnosis. An important exception to this rule should be made when the physician has reason to suspect that the whole personality is becoming unstable and that the minor formations are warning signals pointing to an ultimate breakdown.

CHAPTER XI

PSYCHOSES

Psycho-analysts are essentially in agreement with psychiatrists in isolating three main group-reactions: schizophrenic, paranoiac and (manic) depressive. Their therapeutic interest in these groups is limited for the most part (*a*) to cases where psychotic formations underlie psychoneurotic symptoms (so-called 'border-line' cases), (*b*) to mild types of manifest psychosis, mostly of the depressive group, but occasionally paranoid or schizophrenic, and (*c*) to psychotic types of character. Whether many advanced cases without gross deterioration will respond to or repay analysis is still an open question. In any case they are not suitable for the ordinary 'ambulant' technique of psycho-analysis. They call not only for special methods of analytic approach, but for special environmental settings, e.g. various degrees of supervision. Another unsettled problem which has recently become acute is whether schizophrenic types treated by 'convulsion' and other drug therapies are more easily accessible to psycho-analysis during the remissions that so frequently follow these procedures. But on the whole the psycho-analyst's interest lies in the early recognition and prevention of psychotic breakdown. Hence nicety of diagnosis is at first of less importance than early recognition of a positive psychotic trend. Once a provisional diagnosis has been made, the next step is to decide whether to recommend psycho-analytic treatment or whether to suggest a policy of temporary hospitalization. Comparative stability of the ego in the face of current emotional stresses is a point in favour of analytic exploration.

1.—*Manic-Depression : Mania and Melancholia*

The names given to these disorders are self-explanatory. Manic-depressive patients exhibit recurrent cycles of mood

and behaviour (cyclothymia). They pass from a phase of depression and inactivity to a phase of mental exaltation with hyper-activity. This is followed by a period during which they seem more 'normal' and which is usually described as an intermission. In many cases this apparently normal phase is characterized by obsessional mechanisms. The phases vary in relative proportion, duration, and intensity from patient to patient, but the type of cycle usually remains fairly constant in any given individual. In mania, the depressed phase appears to be absent, though traces of it can frequently be detected on careful examination. A maniacal condition can appear as a sporadic attack, the prognosis of the attack itself being often favourable. The intervals between recurrent attacks vary considerably, and the conditions may become chronic. In melancholia, the exalted phase is missing except in so far as it is represented by states of 'agitation'. Clinically, melancholia is a state of severe chronic depression.

Changes of mood are, of course, common among people who give no impression of mental illness and for this reason the sequence of phases in manic-depression is sometimes described as an exaggeration of normal alternations of feeling. However this may be, it is certain that many so-called normal people have manic-depressive tendencies without becoming clinically ill. The 'artistic temperament,' with its bouts of intensive creative activity and its slump periods of barren inertia, is typically manic-depressive. The disorders are grouped with psychoses because, in their fully developed form, the everyday personality, the reality ego, is swamped by unconscious forces, and contact with reality is lost in proportion as the mind is dominated by phantasy. In depression, misery is accompanied by self-hatred which may culminate in suicide. In relatively mild cases the self-hatred may be confined to feelings of worthlessness, boredom and inactivity. In severe melancholia there may be an appreciable slowing-up of vital processes (psycho-motor retardation) and inability to eat or take even ordinary care of the person, together possibly with delusions, e.g. of having committed the unpardonable sin. Hypochondriacal ideas are common, convictions that some

internal organ is misplaced or suffers from malignant disease, or that some animal or devil exists inside. The manic picture is a striking contrast. In mild cases, the patient experiences a sense of freedom and release as if a burden had been lifted from him. He feels 'good' (euphoric) and full of energy and may be intensely, even feverishly, active. In acute mania, the euphoria may amount to megalomania and the activity become literally frenzied.

In this manic-depressive group the personality is more completely dominated by unconscious conflict between the ego and the super-ego than is the case in obsessional neurosis. In the latter, the reality ego may be cramped and inhibited to the point of paralysis but it remains a reality-ego. The patient retains his awareness of the pathological character of his symptoms. In a fully-fledged manic-depressive this insight is lost. The alternations of feeling and the strife between primitive impulse and primitive conscience manifest themselves in sequences of moods which colour the whole personality. The ego loses more of its objective neutrality than it does in obsessional neurosis.

Whereas the obsessional neurosis is a guilt-neurosis, depressive states are guilt-psychoses. And the mechanisms employed are correspondingly more primitive. In obsessional neurosis the relation to objects, although ambivalent, is preserved. Defence against guilt is achieved through exaggeration of the mechanisms of displacement and reaction formation, etc. In depression the relation to objects is weakened and the dominating mechanism is that of introjection. This emphasis on introjection distinguishes depressive from paranoid reactions, where projection mechanisms are exploited. Whether there is any actual loss of love from the external world or not, the depressive type reacts as if he had 'taken into himself' ('swallowed') an object he has ceased to love. In this way he repeats an infantile phase of identifying with parental images which he can no longer love. He lives in a mental prison with these objects, hating them in himself, thereby hating himself. In other words, he sides with his cruel primitive

conscience in heaping on himself reproaches which are really directed against the person he formerly loved but who has now become worthless to him. On the other hand he suffers excruciating guilt and despair at having done irreparable damage to the once loved objects. This feeling of hopelessness is a more tragic version of the kind of distress a normal person may feel if he accidentally smashes something of great sentimental value. The preoccupation with these painful feelings may be so extreme as to prevent any attention being paid to anything else. The psycho-motor retardation is more than a mere shutting-off the external world. It is a defence against sinfulness. The dangerous sinner immobilizes himself, lest he continue to destroy. But he thereby increases his worthlessness because he is unable to do anything creative to offset his imagined delinquencies. Hypochondriacal ideas are the consequence of translating these animistic modes of thought into terms of corporeal sensation. The patient complains of bodily changes and decay because he is unconsciously convinced that he is possessed by evil objects (the hated objects) who reside in his organs.

Sometimes these preoccupations afford clues to the variety of unconscious instinct that has originally been directed towards parental objects. Mouth and stomach preoccupations suggest that the oral sadistic organization is strongly reinforced. This implies that the oedipus situation with its attendant rivalries, fears and guilts is phantasied in terms of the most primitive oral love and hate. The depressive remains fixated to infantile views of life which might be appropriately described as 'cannibalistic' in organization, and for this reason is especially more prone to imagine states of 'inner evil' either physically or mentally. Many transitional types suffer from excessive excretory (anal and urethral) sadism, a state reflected in hypochondriacal concern with abdominal sensations. Mental expression of these libidinal and aggressive components are easy to observe in dreams and phantasy products. As far as action is concerned there is usually a marked inhibition of those varieties of activity (speech, eating, muscular movement) that might be unconsciously suspected of carrying sadistic tension.

The dynamics of mania are not yet fully understood, but the condition may be regarded as an attempt to cure depression. The guilt which is so marked in melancholia is 'denied' in mania, possibly by some primitive mechanism akin to repression. In effect, the rule of the savage primitive conscience is abrogated for the time being and a flow of instinctual energy released through the ego. Inhibition gives place to hyperactivity, mourning to 'festival'. The 'denial' is combined with a process of projection, which differs somewhat in its effects from those produced in paranoia (q.v.) and which may be described as active externalization. The hyperactivity is the result of an inner anxiety which drives the patient to expression in word and deed. External situations are invested with a significance and reacted to with a zest that is essentially infantile and sometimes depends on a process of symbol reading. Where in spite of a manic-depressive constitution the reality sense is strong, manic activity may be usefully directed and issue in constructive or creative work. In other cases bursts of social and sexual activity are initiated but are abandoned before their ultimate aims are achieved. In acute mania the activities are devoid of reality value and may pass quickly into a frenzy of purely destructive rage.

A diagnosis of psychosis, and the correlated question as to whether hospital treatment is necessary, depends on the degree to which the stability of the ego and the patient's reality sense is impaired by his manic-depressive organization. The risk of suicide in depressed phases and in melancholia must not be lost sight of. The phenomena of normal grief closely resemble melancholic conditions, but since the lost object which is introjected is beloved, the self-hatred usually takes the form of remorse or regret for real or fancied omissions and lapses in behaviour towards the beloved. The withdrawal from reality comes to an end as grief subsides, and fresh ties may be sought to replace lost ones.

Manic-depression is commoner among women than among men. It occurs in men with strong feminine trends. Melancholic conditions may supervene in women after

childbirth but are most common during or after the menopause. Constitutional factors are of considerable importance but have not been very accurately determined. A combination of excessive masochism, strong oral and skin erotism and powerful muscle sadism are significant. There is frequently evidence of early hypersensitiveness to sensory stimuli and emotional crises. Hence in cases where a true depression is suspected, considerable diagnostic value can be attached to stereotyped emotional reactions, e.g. an excessive or prolonged reaction to emotional trauma and (or) frustration. Depressives are in the early phases acutely sensitive to hurt or neglect and have violent reaction formations against ideas of injury, e.g. to animals. In this respect they resemble hysterical types with whom they have a number of other affinities.

2.—*Paranoia*

The typical symptoms of paranoia are delusions created by projection. Projection is perhaps the most ancient of all unconscious mental mechanisms and one that every human being employs to some extent throughout his whole life. The essence of projection consists in the ascription of feelings and impulses belonging to the individual to some external person or thing; in other words, the faulty localization of something inside the mind as something outside the body. There is a family likeness between phobias and paranoid delusions. The earliest phobias of infancy are probably rightly described as paranoid, in that they depend on projection; and we have seen that adult phobias are always preceded by infantile ones. But whereas phobias are ranked as psychoneurotic symptoms because the patient recognizes his anxiety as a symptom, delusions are psychotic because the patient is convinced of their truth. Neurotics often show generalized paranoid tendencies, e.g. they exhibit a readiness to feel ill-used by a hard world, acutely self-conscious on public occasions and so on, but the man who believes, without any real grounds, that there is a conspiracy among the members of his family to poison him or that every woman he passes in the street tries to accost him, is psychotic. Like phobias,

paranoid delusions are usually systematized and localized. The patient's reality sense may be unimpaired except in the delusional region. For this reason a paranoiac may pass unsuspected unless his delusion induces some type of extraordinary behaviour which draws attention to it. There is a blend of suspicion and secretiveness which is highly characteristic and which should be regarded as suggesting the possibility of paranoid conditions. Actually many comparatively harmless eccentrics and cranks are paranoid: they attempt to master their own instincts by a roughly stabilized projection system.

Clinical types of paranoia are described according to the nature of the delusion, e.g. persecutory, hypochondriacal, religious, amorous, etc., but they all resemble each other in ground plan. Thus in the delusion of persecution by poisoning, the patient's own hatred of his family is felt by him as emanating from them. Paranoia, however, is almost always connected with strong unconscious homosexual interests, which are denied and then projected. There are a number of stages in the development of this defence against homosexuality, but the essence of the matter is contained in the formula of delusional denial: 'I do *not* love him, he *hates* me'. The homosexual defence is, however, not just the denial of a potentially active adult system, but the rejection of a reinforced, but repressed, infantile phase of homosexual development. Patients with an 'accosting' delusion project on to women their guilty interest in prostitutes, but this interest both denies and reveals their homosexual inclinations; they do not love men, they love women, but they love women who have dealings with numbers of men. In other words, although the paranoiac may appear to have advanced to the infantile genital level of attachment to parents the amount of free adult genital libido is small. By far the largest quantity is unconsciously fixed to the anal sadistic phase, and the oedipus form is predominantly of the negative rather than the positive type. When, owing to some instinctual stress, these fixations are reactivated the paranoiac withdraws to a more animistic phase of development.

Paranoiacs project successfully, that is to say, they are

unaware of the rejected impulses in themselves, but they then have to deal with the consequences of this success. They have to defend themselves against the people about whom they are deluded. This defence may be passive or active, resulting respectively in reactions of flight or aggression. Passive self-projection will result in a technique of avoidance, as in phobia. The 'poison' paranoiac may finally refuse to eat at all in his own home. The active reactions will lead to all sorts of attacks, ranging in seriousness, according to the individual, from quarrelling and slandering, to bringing lawsuits or making physical assault. It may even end in homicide. When projection is only partially successful, or fails, it gives way to depressive states. A hypochondriacal delusion is a halfway phenomenon, due to a combination of introjection and projection mechanisms.

There is a similarity then between manic and paranoiac mechanisms inasmuch as both depend upon externalization. Indeed manic-depressives as well as obsessional neurotics often exhibit paranoid trends. On the other hand paranoia is commoner in men than in women: and whereas in manic depression and melancholia it is oral and urethral sadism which dominates the phantasy picture, in paranoia it is anal sadism which seems most accentuated.

3.—*Schizophrenia* (*Dementia Praecox*)

This is an omnibus group which covers a diversity of psychotic conditions. They have in common a more complete loss of contact with reality and greater weakness and helplessness of the ego than is found in the groups previously described. The personality gives the impression of being split up or fragmented. The disintegration is probably made possible by developmental failure of integration, the persistence of an infantile type of imperfectly co-ordinated part-egos, that has never permitted a sound relation to reality. These disorders show themselves, more often than not, in young people of both sexes with a history of a maladapted, 'shut-in' childhood. The first signs may be neurasthenic, excessive fatigability and boredom, leading on to a steadily diminishing capacity for work and inability

to feel interest or affection. These may be accompanied by great anxiety and feelings of need of love and for help. The fully developed picture varies greatly in clinical detail. Hallucinations are frequent, also delusions. Marked negativism is often present. Mannerisms are common. Apathy may amount to stupor, depression may be accompanied by a peculiar generalized rigidity (catatonia) different from the attitude of listless grief typical of melancholics. States of impulsive excitement also occur, which resemble mania, but are more aimless and inchoate. The maniac who has a 'flight of ideas' may be incoherent because he is thinking so fast, but the excited dement talks nonsense (word-salad). The impression given may be less that of a person than of a bundle of sporadic impulses devoid of adequate central control and responding (perhaps by a strange fleeting smile or grimace) to some intrapsychic stimulus. In so far as the patient may be said to live as a whole at all, he lives in a phantasy world of his own, in a dream. His behaviour may mirror this withdrawal, displaying a more and more infantile disregard of adult standards. Schizophrenic conditions may underlie hysterical and obsessional neuroses. There are border-line conditions, known as paraphrenias, which combine paranoid and schizoid features. Recognition of an endstage or of a case with well-marked features such as hallucinations is not hard. The initial stages are much more difficult. Psychotic mannerisms, however slight, do, however, convey a 'peculiar' impression which, once experienced, is never forgotten. Complete failure to establish 'contact' with the patient produces a peculiar feeling of 'inaccessibility' on the part of the patient, which differs in quality from the barrier raised by paranoid suspiciousness and suggests that the case is schizophrenic.

Although the schizophrenic has had difficulty at every stage of infantile development, the nature of his mannerisms and hallucinations suggests one or two main sources of conflict. As a rule he has passed through a precocious and exaggerated phase of anal sadism, but behind this organization there exists a deep oral-sadistic regression. The schizophrenic exercises a wider range of unconscious

defence mechanisms than any other psychotic type. But he does so in an apparently more capricious, less systematized and less purposive way than the depressive or paranoiac. Favoured methods are the defensive and protective immobilization systems of catatonics, the projection systems of paraphrenics and the primitive introjection mechanisms of depressive types. Owing partly to the primitive nature of the regressions, partly to the variety of defences employed and partly to the degree of ego-disintegration it is difficult to get a very clear picture of the schizophrenic's early unconscious relations to parental objects. But to judge from those cases where the hallucinating and delusional systems are more organized, two conclusions are valid. First, that severe conflicts involving sadistic reactions to both parents have occurred at an unusually early stage of development and second that these conflicts are readily expressed in symbolic terms. Many of the more grandiose schizophrenic systems are merely translations into a simple (infantile-symbolic) idiom of very early oedipus relations both positive and negative. Stereotypies are usually concerned with isolated aspects of this main conflict. In doubtful cases it is advisable to scrutinize the early history as carefully as possible. Fortunately, in a sense, the infantile history of schizophrenics usually provides more positive indications of early and severe parental conflict than is the case with other mental disorders where preliminary anamnesis may reveal little of apparent importance.

CHAPTER XII

TRANSITIONAL GROUPS

Drug Addictions

Certain mental disorders do not fit into the usual classifications of psycho-neuroses and psychoses. They are more severe than even advanced neuroses, yet clinically speaking cannot be called border-line psychoses. The mechanisms producing them are both neurotic and psychotic in type, although the symptoms produced are neither neurotic nor psychotic. They take the form of disturbed social and sometimes sexual relations. In the absence of a better label and in order to suggest comparative 'depth' they can be described as transitional states. Like all mental symptoms they are curative in aim, even if harmful in effect: for example, they tend to preserve their victims from becoming clinically psychotic. For convenience in description some of these conditions can be considered under the heading of characterological changes, others as advanced sexual perversions. By this process of elimination it is possible to isolate a characteristic group of disorders which are generally called 'drug addictions.' The commonest variety is alcoholism, but the group includes every form of malignant drug addiction, as well as a few of the more benign types, e.g. bromide, aspirin, tobacco, coffee and tea habits.

Most addictions bear close resemblances to manic-depressive disorders. They are diphasic in nature, the phase of painful abstinence corresponding to the depressive phase of cyclothymia. Actually an addiction occurring in a manic-depressive case may be a substitute for and a safeguard against suicide. On the other hand the amount of projection used by some addicts suggests a close affinity with paranoid states, a connexion which is also suggested

clinically by the frequent appearance of persecutory ideas and delusions of jealousy in certain stages of alcoholism. But instead of the 'external enemies' who trouble the paranoiac there is a powerful and dangerous drug which *must* be taken even if it 'knocks' the taker 'out.' In place of a paranoid delusion, there is a compulsive action. In this respect the condition has obvious resemblances to an obsessional symptom. In addition the physical consequences of drug taking (e.g. loss of weight and appetite, gastro-intestinal upset) function, according to the strength of the drug, as slow or rapid conversion hysterias. Finally the hallucinatory and other disorders of mental function although transient are otherwise not unlike the more chronic schizophrenic dissociations.

The compulsive play with drugs is a symbolic dramatization of primitive unconscious (love and hate) relations with parental objects. The family fixations lie between the ages of eighteen months and three and a half years. In the more malignant addictions the objects of the unconscious impulses are more representative of dangerous parental organs than of complete parental imagos. The more injurious the drug the greater the amount of sadism in the primitive system. The drug represents to the unconscious an external (loving and hating) family object. A dangerous substance is chosen because owing to the projection of the individual's sadism parental objects are felt to be dangerous. The patient's attitude to the drug is, however, ambivalent. It is hateful but necessary. It is necessary because the person feels that there is something 'bad' inside him (evil parental spirits, bad body-organs, or, more simply, anxieties and guilts due to mental conflict). The drug either anaesthetizes this internal badness or, being more powerful, 'knocks it out.' But in so doing it 'knocks out' the individual. A good example of this system is the development of sleeping draught addictions in cases where the drugs were taken originally in order to annul anxiety of insomnia. The libidinal gratification in addictions is usually of the oral-sucking type, but there is frequently a strong charge of anal interest. The importance of unconscious homosexual impulses is most obvious in the case of

alcoholism in men. Unconscious genital (castration) anxieties are prominent particularly in those addictions involving piqûres. The patient's unconscious sadism is, therefore, a mixture of the oral, anal and genital varieties. This is projected, focused and localized on the drug. It is then controlled by internalization. This latter process is essentially an animistic reaction, depending on the unconscious theory that an evil spirit or object, however damaging, can be better restrained when taken into the body.

Although abstinence is easier to induce with some drugs than with others, e.g. with cocaine than with morphine, rapid abstinences should not be induced before discovering, not only the clinical type of the addiction, but the protective functions performed by it. For practical purposes three main types can be distinguished. The mildest forms are those due to reinforced unconscious homosexuality. Next come the addictions with a cyclothymic organization, cases of this type are inclined to favour frequent self-imposed abstinences. By way of contrast the third or paranoid type of addiction is more chronic and shows only occasional spontaneous remissions. Differential diagnosis is not difficult. In the first type heterosexual inhibitions are frequently present and the patient's social habits confirm the impression of homosexual unbalance. Such cases show either an over-convivial disposition in the company of men or are extremely shy with men. Paranoid types tend to secret drinking. Depressive types usually show abundant evidence of excessive unconscious guilt. In all cases the tendency to relapse is strong although occasionally spontaneous recovery may take place usually when, after the lapse of years, organic sequelae take over the symptomatic functions of the original addiction, in particular when they are severe enough to satisfy the unconscious need for self-punishment.

CHAPTER XIII

PSYCHOSEXUAL DISORDERS

It is important to realize that psychosexual difficulties are not simply disturbances of the sexual instinct. They are *systems* of mental and physical reaction which, like psychoneuroses and psychoses, have protective functions to perform. Quite grave sexual perversions can exist in individuals showing practically no symptom formation, and, although this is less common, some extensive neuroses are compatible with apparently normal sexual function. In actual practice combinations of symptom formation and some degree of sexual dysfunction are by far the most common. The vast majority of sexual abnormalities are never examined, because the individuals in question readily 'come to terms' with these, their favourite peculiarities. Cases proceeding to consultation have experienced either conscious moral conflict or some other variety of mental pain, or again, some social disability, e.g. marked inferiority. In such instances perversions copy the self-punishing mechanisms of neuroses. An important difference between neuroses and perversions is that symptom formations disguise the true sources of unconscious conflict, whereas sexual disorders plainly indicate at least one of the sources. The admission is, of course, qualified. Attention is distracted from unconscious factors in the situation by overstressing conscious elements, and, except in the case of sadistic and masochistic perversions, there is no hint that unconscious hate and aggressiveness are important factors. The most convenient way to classify psychosexual difficulties is: (a) inhibitions; (b) perversions; and (c) mixed groups in which social reactions are also distorted, e.g. marital difficulties. Detailed examination of these groups shows that each is capable of sub-division in

terms of depth, chronicity and stages of infantile mental development concerned. It seems probable that in course of time it will be possible to arrange an exact parallel series of neuroses and psychoses on the one hand, and sexual inhibitions and perversions on the other.

(1) *Sexual Inhibitions.*—The main feature of sexual inhibitions is their economy of function. They protect against unconscious anxieties and guilts without the expenditure of psychic effort necessary for symptom-formation. Inhibitions can affect (a) sexual interest and curiosity, (b) the quality of sexual satisfaction, or (c) the actual technique of sexual activities. Interference with action is the most obvious form and in the sense of protection the most effective. Mild impotence in the male, e.g. ejaculatio praecox or difficulty in erection or penetration, is one of the commonest forms of psychological disturbance. The corresponding state in the woman is some degree of frigidity (anaesthesia). This may be accompanied by spasm (vaginismus) with or without dyspareunia (pain in coitus instead of gratification). The significance of these inhibitions varies with their depth and with the amount of unconscious anxiety they conceal. Many of them have the same protective functions as mild conversions or anxiety hysterias. They defend against infantile genital (incestuous) anxieties, i.e. unconscious fear of castration in the male, unconscious conviction of castration and fear of seduction and penetration in the female. The underlying disposition in both cases is mildly homosexual. Unconscious (infantile) love drives are charged with sadistic pregenital components (urethral and anal). When these components are overcharged or when the unconscious homosexual interest is more active, the forms of sexual inhibition are more obvious and more intractable. They correspond more to obsessional than to hysterical defences. The inhibition is proportionate to the unconscious compulsive and sadistic love attitudes. Some of the deepest and most intractable inhibitions function as substitutes for psychotic defences. They may be part of a depressive guilt system, e.g. a denial of body function based on an animistic conception of the essential 'evil' of the genital organs. Projection

anxieties can also give rise to sexual inhibition, but as a rule, in paranoid and schizoid types, inhibitions are more selective (apparently capricious) and alternate with periods of sexual perversion.

Apart from these main features there are a number of inhibitions of interest, pleasure and activity affecting the different components of fore-pleasure in coitus. Although less obvious, these can cause serious disturbances of sexual rhythm and of satisfaction in intercourse. Differential diagnosis is not easy unless other symptoms are present by which the severity of the inhibition can be judged.

(2) *Sexual Perversions.*—It is a long established Freudian view that although a neurosis is the negative of a perversion they share some protective functions. Whereas in sexual inhibitions any or all of the components of sexuality may be under-expressed, in perversion one or more components are exaggerated at the expense of normal genital function. The degree of genital denial varies. Surprising as it may seem, the conflict giving rise to perversions is not exclusively sexual. It is true of all exaggerations of sexual function that they serve to conceal unconscious anxieties concerning the aggressive or sadistic accompaniments of infantile sexuality. Perversions allow a degree of pleasure gratification more or less accepted by the ego. In this respect they differ from neurotic formations, which are rejected by the ego. Study of the commonest forms of perversion (e.g. viewing, exhibitionism, varieties of sexual tasting, touching, smelling and hearing, active and passive forms of beating and tying, oral and excretory systems of love-making and a variety of 'mixed' types of perversion show that they are derived from infantile sexual components, some of which are gratified during the normal fore-pleasure of coitus. But perversions are not just unmodified infantile remainders due to arrested sexual development or to constitutional factors. Like neuroses they are the result of a psychic regression. Adult genital sexuality is sacrificed because of active incest wishes that have remained in a state of faulty repression. The infantile (perverse) component singled out has the function of covering and gratifying (by proxy, as it were) the full incestuous demands of the unconscious.

Homosexuality.—This is by far the most advanced and organized form of sexual perversion. So far, only a few of the main types have been exhaustively studied and classified. Like neuroses and psychoses the forms vary in accordance with the level of infantile fixation. Some simple types of male homosexuality are the following. The love-object chosen is essentially a substitute for the self and is loved as the subject wished to be loved in the first instance by his mother and later by his father. Or again, the subject endeavours to satisfy his needs in the main by an identification with the mother imago. At the same time he ousts and revenges himself on the mother. His purpose now is to be loved by and submit to the father. The love-submission is frequently of an anal type, but particularly in oral forms there are still remainders of the former wish for a passive relation to a good mother (breast). In all cases the original ambivalence to the mother is a fundamental factor, and according to the depth of this reaction a variety of different fears of women are developed, the commonest being a conscious horror of the female genitals with unconscious fear of castration. A third common type is where incestuous drives have been displaced from mother to sister. This accentuates the factor of rivalry with the brother. The homosexual love object is then a substitute for the brother. Hatred and rivalry are denied and a mixed active-passive relation is substituted, frequently expressed through mutual or alternate masturbation. The psychic situation in female homosexuals is more complex. It is true that a number of types exist which, allowing for an appropriate alteration in gender, bear close resemblances to those described above. Homosexual attachments concealing an earlier sister rivalry, for example, are extremely common. In all cases, however, there are two complicating factors to be taken into account; first, that the female passes through her negative (mother) phase *before* reaching the positive (father) oedipus conflict (not *after*, as in the case of the boy), and, second, that her castration anxiety links up with deeper phantasies of body-mutilation than in the case of the male. She believes that she has already suffered castration and that she is bound to

suffer still further injury. Penis dread is reinforced by earlier breast dread which in its turn was provoked by oral hate of the breast. Moreover, the girl has had stronger sadistic reactions against the mother's inside (babies and reproductive organs). All this combines to increase anxiety lest her own internal organs should be damaged or destroyed. This anxiety is denied, in active types, by usurpation of male function, in passive types, by simultaneous identification with the mother and with the more active partner.

The same principles of serial differentiation according to developmental fixation should be applied to other standard forms of perversion. It is usually possible to identify two main types: (1) those in whom, although the manifestations are severe, the anxiety which gives rise to them belongs to a comparatively late infantile fixation, usually about the age of 3 to 5, i.e. roughly comparable to hysterical fixations; (2) those in whom, even if the manifestations are comparatively mild, the anxiety is of a deep type. In the latter there are usually other indications present to help in diagnosis, e.g. the association of fetishism with alcoholism suggests that the perversion is a deep one involving some psychotic or pre-psychotic mechanisms. In *fetishism* the processes of dental (repression) and displacement of incest wishes are more accentuated than in homosexuality. The sexual aim is displaced to clothing symbolizing the organs of most significance to the fetishist. The symbols represent primarily a penis, but in most cases their significance is bisexual (shoes, stockings, hats, etc.). The unconscious need to displace sexual interest from body to clothing has a number of sources, but the main factor is an unusually profound horror of the genital organs, which is stimulated by a particular type of infantile unconscious phantasy, viz., that the female (mother's) genitalia include a penis or that a penis exists within her body. This phantasy is universal but gathers unusual strength in individuals of an unconscious homosexual disposition.

Displacement of sexual interest from body to clothes is also observed in *transvestitism*. The narcissistic and homo-

sexual elements are more obvious here. By dressing himself and usually masturbating in female clothing the male transvestitist dramatises himself as a 'woman (symbolized by clothes), with a (real) penis'. By so doing he gratifies his unconscious homosexuality but denies his castration fears. For corresponding reasons the female transvestitist represents herself as a '(real) woman possessing a penis (symbolized by male clothing)'. In both fetishism and transvestitism pregenital (anal and urethral) sexuality is emphasized, and in both cases there is regressive denial of genital oepidus wishes. Exhibitionism and sexual viewing are defences against similar incestuous anxieties, but generally speaking the anxieties are less intense, and the compensatory pleasures greater. The displacement to the whole body is partly a substitution for genital anxieties and partly due to the fact that in earlier infancy strong anxiety of body mutilation has existed. The importance of *sadistic perversions* (including a variety of beating and tying interests) varies. When they are associated with *coprophilic phantasies* or *coprophagic activities,* the fixation points may be regarded as deep. Some of these perversions correspond with obsessional formations: others are defences covering anxieties of a paranoid type. Similarly *masochistic perversions* though partly due to simple infantile genital anxiety of a homosexual type may mask a depressive system. In the latter case, oral sadism is a predisposing factor and source; but in all cases anal, skin and muscle sexuality should be investigated.

(3) *Marital Difficulties.*—Strictly speaking these are combinations of sexual and social difficulties and vary in depth, severity and painful consequences. Many people succeed in avoiding a psycho-neurosis in middle life by making an unhappy marriage or by allowing a previously satisfactory relation to come to grief. They are essentially abnormalities *a deux.* Both parties are in an emotionally unbalanced state. Indeed, to begin with, this very factor appears to arouse a certain fascination leading to impulsive marriage. As a rule, the unbalance lies in the faulty distribution of unconscious homosexual libido and

in unconscious anxiety or guilt over the (incestuous) significance of hetero-sexual drives. Types vary greatly in detail but show many features in common.

On the husband's side there may be a difficulty in attaining an adult male attitude to women, behind which lies a passive feminine disposition. These men are usually mother-fixated, but the attitude to the mother imago is nevertheless strongly ambivalent. Potency varies considerably. Some are potent but get no pleasure in intercourse, others have uncertain potency combined with promiscuous and rather compulsive sexual drives. Others again are very weakly potent, irregular and infrequent in intercourse. As a rule, the sexual and social techniques of marriage include a habit of disappointing the woman, or alternatively of inciting the woman to attack (nag) the man.

The reactions of wives also vary. They have frequently a strong homosexual fixation with unconscious hostility to the male organ covering an equally strong ambivalent attitude to the father. Such cases are usually rather frigid. The frigidity combines hostility to the father with an expression of hatred to the mother-imago whose genital functions are denied. In other instances there is no frigidity but a concealed (hysterical) fear of penis function, particularly of penetration. In the former type the husband is treated as an inferior possession, subjected to criticism and subsequently neglected in favour of children who are nevertheless a constant source of anxiety.

The reciprocal relations of husband and wife are of especial interest. The following are common instances. An obedient, passive type of man who is nevertheless potent marries a woman who is temperamentally aggressively homosexual and who becomes increasingly dominating and possessive. He becomes more and more cowed but succeeds in discharging, unobtrusively, an increasing amount of hostility to his wife. In extreme cases this becomes openly explosive and ends in strained relations or complete rupture. Again, women of a masochistic hysterical type may marry rather impotent and narcissistic men. They dread coitus and protect themselves against it, e.g. with vaginismus. The husband inclines to become

increasingly cruel on a psychic level. Once such a woman has overcome her difficulties she tends to welcome love-making, at which stage her husband's inhibitions become a source of trouble. He is made to feel inadequate and she becomes increasingly discontented. Or, again, the Don Juan type of man marries a slightly frigid and unconsciously (active) homosexual woman. The marriage remains successful until children are born, when simultaneously the man turns from the woman and the woman turns to the male children. Many of these cases are incurable. Most marital difficulties are hard to resolve (a) because of the emotional tendency of both partners to repeat almost compulsively their painful crises, and (b) because of the fact that usually only one of the partners is ready to undertake analytic treatment.

CHAPTER XIV

SOCIAL DIFFICULTIES

From both structural and functional points of view there is a close resemblance between abnormalities of social reaction and sexual difficulties. In both cases unconscious conflict is denied, and in both cases the abnormalities are to a considerable extent accepted by the ego. But whereas in the latter instance a *sexual* factor is openly inhibited or exaggerated in order to conceal deeper conflict, in the former, sexual conflict is denied by displacement: the inhibitions or perversions affect *personal character* and *social relations* to objects. The fact that the ego accepts them differentiates both social and sexual difficulties from psychoneurotic symptoms in which the disguised results of conflict are dissociated from and rejected by the reality ego. This acceptance also explains why social dysfunction is more difficult to treat than the corresponding neurotic or psychotic symptom. Like sexual difficulties, social abnormalities can be divided into three groups (a) inhibitions; (b) perversions; (c) mixed groups where the social difficulty is combined with sexual inhibition or perversion.

(1) *Social Inhibitions.*—These can be sub-divided into inhibitions affecting mainly the capacities of the individual (e.g. lack of concentration or working and learning capacity), and those affecting his social relationships (e.g. shyness, blushing, inferiority feeling). But this is a rather arbitrary division: there is always a good deal of overlapping between the sub-groups. Many social difficulties correspond closely to mild anxiety or conversion hysterias. Thus social shyness may be the equivalent of an ereutophobia (i.e. fear of blushing) or of a functional eczema or erythema. Undue shyness is a compound of anxiety, guilt and aversion, diffusely expressed through

personality reactions instead of being localized in the form of a phobia. It is sometimes difficult to distinguish between inhibitions of an anxiety type and those of an obsessional nature. Lack of concentration and inertia may be due to hyper-activity of unconscious phantasy (hysterical type) or it may be due to an over-expenditure of energy intended to hold unconscious sadistic phantasy in check (obsessional type). In obsessional inhibitions there are usually other signs present which help to confirm the diagnosis, e.g. tendency to indecision, undue scrupulosity, sensitiveness to dirt, food faddiness, irritability in situations of social intimacy, etc. Inhibitions in learning and play have a close relation to conflict over infantile sexual curiosity, the more so when the unconscious sexual theories are sadistic in type. Many forms of inertia and lack of concentration are related to a deep inferiority reaction of a depressive nature. In some cases the effect of extensive inhibition on social adaptation is almost as profound as a mild catatonia. In such instances a deep sadistic (guilt) factor can be presumed.

The specific unconscious components giving rise to the inhibition can frequently be surmised either from its localization or from the symbolism of the activity inhibited. In types corresponding to hysteria and associated with conflict over infantile genital (incestuous) sexuality, the sexual symbolism is not difficult to translate, e.g. occupational cramps (piano-playing, typing, etc.) due to conflict over the incestuous phantasies associated with infantile masturbation. Activities symbolizing coitus (shooting, motoring, driving, climbing ladders or heights) are often affected by this type of (anxiety) inhibition. In inhibition of work there is usually a strong masochistic (self-punishment) element present, but if the lack of earning capacity should also involve dependents an unconscious attitude of revengefulness towards the family based on infantile conflict may be suspected. Some pseudo-hysterical forms apart, the more widespread the inhibition the deeper the fixation and the more serious the prognosis.

(2) *Character peculiarities* (social 'perversions'). As distinct from inhibitions, these are positive reactions

(psychic and behaviouristic patterns) which more often than not produce social frictions. The varieties most easy to detect are those corresponding to psycho-neurotic or psychotic mechanisms. A true *hysterical character* exists although it frequently goes undetected because it is taken to be an exaggeration of normal behaviour. Where it is recognized it is usually wrongly labelled as true hysteria. Hysterical characters are not only over-sanguine and passionate in their social likes and dislikes but in both social and sexual relations are exacting and demanding. They are generally extremely babyish in emotional contact and readily subject to illusions. An element of infantile sado-masochism in their make-up is expressed and denied by a combination of masochistic over-solicitousness and querulous self-sacrifice which usually ends in alienating their social environment. In acute phases the hysterical character tends to dissociate himself temporarily from social contacts and may give a false impression of depersonalization. The *obsessional character* groups include such conditions as lack of emotional feeling or response to emotional situations, incapacity to make up the mind or to act decisively, aimless thinking, superstitiousness, rigid formalism, wasting time on the minutiae of life, miserliness, etc. Such individuals tend to be disappointing to others and frequently get into hot water on that account. They may make good officials but lack enterprise and tend to give way to a masochistic defeatism. Also they do not readily fall in love.

Slightly *paranoid characters* are easy to recognize although they seldom come to consultation. Believing the external world to be at fault, they feel that there is 'nothing the matter' with them. They are above all suspicions, critical and hostile, and these attitudes alone are sufficient to produce a crop of social misfortunes. The clashes that ensue are repetitive and closely resemble each other. Usually they occur with persons of the same sex. Persons having difficulty in sublimating unconscious *homosexual* drives are notoriously 'difficult' to get on with. They are either unduly reserved, or, like paranoid characters, use the mechanism of projection to rid themselves of inner

self-depreciation, and in so doing become aggressive and quarrelsome.

Depressive characters are more inhibited than peculiar in a positive sense. *Manic* types with their sanguine and euphoric activities rarely come under observation unless their activities end in 'crashes.' Some of the most intractable character formations belong to a *masochistic* group. Individuals of this type repeatedly manoeuvre themselves into self-injuring situations, e.g. losing their money or their employment, being 'taken-in' by strangers and acquaintances or 'let down' by friends who appear to be chosen because of their readiness to 'let' others 'down.' *Schizoid characters* may present every known character peculiarity with the exception of hysterical traits. But in addition they exhibit a marked reaction of egocentricity, which has frequently been described under the heading of *narcissistic character.* The more cultured types have a marked predilection for metaphysical speculations of a fruitless kind. Almost all of them tend to sexual inhibitions or perversions. When marital relations exist these are almost invariably unhappy. The etiological factors producing these various types are practically identical with those described for the corresponding neuroses or psychoses (q.v.).

(3) *Mixed Types.*—Various combinations of social and sexual inhibitions and peculiarities exist. They can be classified in accordance with the type, the mechanisms employed, or the depth of conflict. Some of these have already been described (see Marital Difficulties). Many obsessional bachelors and agitated spinisters combine the most remarkable peculiarities of conduct with sexual habits of a mildly perverted order, or alternatively with gross sexual inhibitions. A more intractable group is comprised of individuals who have passed the climacteric or are faced with the impotency of middle-age. They combine regressions to infantile sexuality with regressive character changes.

(4) *Delinquency and Anti-social Conduct.*—The chief difficulty in classifying delinquencies lies in the fact that the diagnostic standards are set by civil and criminal law.

Nevertheless, violent and compulsive opposition to laws that are generally accepted by the community can be regarded in some cases as a form of mental disorder. The main clinical varieties of psychopathic delinquency are easily determined. The two commonest forms are stealing and sexual aberrations. The latter should, strictly speaking, come under the heading of Sexual Perversions (q.v.) rather than delinquency, but it is a significant fact that social delinquency is frequently associated with either sexual inhibition or perversion. Social delinquencies can be sub-divided according to fixation levels, in the same way as social inhibitions and character difficulties. Classified in accordance with the unconscious mechanisms employed, they can be related to the standard psychoneuroses and psychoses. Episodic 'hysterical' delinquency leading to crimes of violence is commoner than has been supposed, e.g. 'slashing,' ink-slinging, etc. It is a reaction against internal fear of loss of love, combined with an unconscious impulse to seek revenge for neglect. External loss of love is re-assuring by comparison with internal loss. A great deal of compulsive pilfering (kleptomania) is obsessional in type: it differs from obsessional neurosis in that pilfering involves an attack on an external object. Whereas the obsessional neurotic turns his unconscious sadism against himself, the compulsive delinquent courts or receives punishment from external objects. He differs unconsciously from the paranoid type who acts as a judge of society and attacks (punishes) it for its delinquency. The unconscious sexual organization is of a pre-genital type, and there is usually a strong oral-sadistic constitution with a violent sensitiveness to hurt. Guilt reactions are concealed by this system of externalized [illegible] Hence the analysis of delinquency is more difficult than that of a corresponding type of psycho-neurosis. Although the analysis of delinquent states is only in its infancy, already many characteristic clinical syndromes have been isolated. A typical example is that compulsive form of pilfering common amongst adolescents of a narcissistic type. They have a strong latent or unconscious homosexual disposition and consort with, or are taken up by, people of a superior social

position. The delinquency usually begins after this intimacy is strongly established ; it is rationalized on the score of having to keep up appearances. It is a favourable sign when, in the course of treatment, previously concealed neurotic reactions come to the surface. The least favourable forms of delinquency are schizoid in type. Such individuals are frequently vagrant in habit and their delinquencies (e.g. arson, hayrick burning, cattle-maiming, etc.) have a grotesque character. Mentally deficient delinquents constitute a special group. As in the case of character difficulties the etiology of different groups is identical with that of the corresponding neurosis or psychosis.

CHAPTER XV

PSYCHO-ANALYSIS OF CHILDREN

Although the mental structure of the average six-year-old child does not differ materially from that of the average adult, it has been found advisable for technical and clinical reasons to create a special department of child-analysis. Psycho-analytic methods can be applied to children as soon as two conditions are fulfilled, first, that the child evinces some appreciation of the relations between itself and the nearest familial objects, and second, that it has sufficient command of language to understand simple talk about these relations. Special modification of analytical methods (in particular substituting child's-play for 'free association') (see Section III) is necessary up to the age when more adult behaviour is preferred by the child. This age limit varies widely. Some children can associate in quite an adult fashion from about seven years onwards: others, particularly infantile types, prefer 'playing' up to the age of puberty. Beyond that period play technique is essential only in cases of arrested development.

The mental disorders of children are just as clearly differentiated as those occurring in adults; they may be divided into infantile neuroses, psychoses, sexual inhibitions and perversions, social (familial) inhibitions, anti-social or asocial conduct, etc. Oversights in diagnosis are usually due to the fact that, apart from these more familiar forms, many mental disorders are regarded as 'natural' reactions of children. This is particularly true of fears and eating disturbances. Many children exhibit a degree of fearfulness which, were it observed in an adult, would be diagnosed as acute hysteria or a paranoid state. Despite this fact many night terrors, or rage frenzies arising during waking life, are erroneously regarded as inevitable

manifestations of ordinary infantile development. And although eating disturbances or intestinal upset are amongst the commonest signs of infantile neurosis or psychosis they are frequently discounted. Eating difficulties can occur at all phases of infantile development: the difficulty is to assess their significance at each stage. Should they occur at the age of 4 to 5 years they are generally conversion-hysterias. In earlier stages their significance varies: they may indicate the existence of deep persecutory phantasies, or they may be somatic expressions of a temporary frustration-anxiety. Intestinal disturbances of neurotic origin begin to appear in the second and third years.

All children exhibit anxiety reactions. These can be of a 'free-floating' type readily bordering on panic, or can be fixed to specific objects and situations (phobias). The earliest fixed fears are concerned with noises, or other strong sensory stimuli, with darkness, or with being deserted (actually or apparently). As knowledge of external objects increases, phobias secure a much wider range of displacement to a great variety of inanimate objects, animals, strangers, etc. Despite this it is not unusual for anxiety to concentrate once more on one particular object. Should this second phase of concentration be excessive the child may be regarded as psychologically 'ill' and the very greatest attention should be paid to the nature of its emotional reactions to parents and nurses. Anxiety states are usually mixed, e.g. phobias are associated with night terrors. In essence these phobias represent displacements of fear of loss of love, or are the result of projecting internal hostility on to the parents and subsequently displacing these hostilities on to the phobia object. The reactions to inanimate objects are animistic in type, i.e. the child behaves as if they were alive and potentially hostile. Excessive phobia formation in the earliest years is of grave prognosis, particularly if accompanied by constant outbursts of hostility or marked immobility reactions. It is psychotic in type.

Between the early phase of primary phobia formation and the phase when true hysterical phobias occur

(i.e. between the ages of 2 to 4 years) it is usually possible to detect an obsessional phase. This is expressed in ritualistic and compulsive behaviour, e.g. bedwetting, habit spasms or tics, nose-boring, etc. Many habits commonly regarded as signs of 'naughtiness' belong to this obsessional group, e.g. difficulties in dressing or undressing, washing, going to the lavatory, eating at table, going for walks, etc. A good deal of the overt sexual activity displayed at this period is already compulsive and ritualistic. These sexual habits resemble the sexual perversions of adult life in that some components of sexuality (e.g. anal or genital masturbation) are overemphasized in order to conceal unconscious (incestuous) drives. A history of passive sexual seduction at this age should not be taken at its face value, since many children with passive sexual aims succeed in inciting other more active children (or adults) to seduce them. Exaggeration of sexual habit is frequently followed by inhibition of non-sexual habit or capacity. Early inhibitions of play or of the intellectual faculties, particularly of curiosity, belong to this group. But above all, diminution of an existing capacity for emotional enjoyment is a danger signal. Morbid inhibitions can also be observed following a period of violent social reaction, e.g. tantrums. Normal inhibitions are a feature of development from four onwards. They multiply rapidly as the latency period approaches. During latency (5 to 10 years), owing to the complete repression of infantile impulse and the increase in affectionate drives, the child's character becomes much more controlled. Abnormalities during this latency phase may take a violent form, e.g. compulsive lying and stealing, or acts of violence and destruction. Pathological lying, *pseudologia phantastica*, occurring at this stage is merely an exaggeration of an earlier preoccupation with phantasy and day-dream. Etiologically regarded most of these exaggerations or abnormal inhibitions of function can be related to unconscious phantasies of a sexual and aggressive type which are inducing anxiety or guilt, but, particularly in early childhood, the influence of environmental factors in bringing out these difficulties is much greater than in adult life. Avoidable frustrations, psychological mis-

handling, moral and ethical bullying, punishment, etc., tend to set up a vicious circle. The child normally projects its own hostilities into external objects, and mishandling not only confirms its worst unconscious suspicions but increases its anxiety-readiness. Children can, however, withstand a good deal of maltreatment, and masochistic types with early super-ego formation many even appear to thrive on it, although to judge from the difficulties that arise in later life the appearance is often deceptive.

Differential diagnosis, particularly between psychotic and neurotic types of child reaction, is difficult, all the more so if some degree of backwardness is present. Although normal children have at all stages of development a reality sense which is perfectly adequate for the conditions in which they find themselves, they indulge more in regressive thinking and play (whether pleasurable or painful) than adults do. Hence a number of psychotic characteristics do not attract the physician's attention so readily as they would in the case of adult psychotic formations. This is especially true of persecutory anxiety. Nevertheless both quantitatively and qualitatively there are forms of anxiety expression which suggest a psychotic reaction even in childhood. The same is true of depressive reactions. Many infants exhibit a rapid reaction to frustration or hurt which takes the form of shutting themselves off in a state of apparent inertia. It is difficult to distinguish depressive from schizoid reactions except where cyclothymic types of behaviour are present. In any case it should be remembered that the mind of the average child is able to resolve unaided a considerable amount of conflict. Many early symptoms disappear spontaneously on the onset of latency. It is a good working rule that infantile symptoms persisting after the age of five should be regarded as morbid. Early diagnosis repays any effort that may be necessary, since the sooner analysis is commenced the better are the prospects of ultimate success. In any case study of the psychological ailments of children adds considerably to the understanding of adult abnormalities. Many early anxieties have a specific relation to adult symptoms, e.g. fear of going to the lavatory with adult fear of coitus. Early eating

difficulties of an anxiety type may be responsible for inhibitions in learning occurring during childhood and adolescence and may play a part also in adult inhibitions, e.g. incapacity to make money. They are usually prominent in the history of persons who subsequently develop drug addictions.

SECTION III

CHAPTER XVI

PRACTICAL APPLICATIONS

EXAMINATION: DIAGNOSIS: PROGNOSIS: RECOMMENDATION OF TREATMENT: THE NATURE OF PSYCHO-ANALYSIS: DURATION OF TREATMENT: COST OF TREATMENT: THE FAMILY SITUATION.

Psychological Examination.—Two main qualifications are necessary for a successful psychological examination; first, the capacity to make easy and sympathetic contact with individuals in a state of mental suffering or malfunction, and, secondly, a good understanding of the various groups of psychogenic disorder and of their comparative significance as indicators of conflict. From the clinical point of view the physician should be familiar with the main classifications of neuroses, psychoses, sexual inhibitions and perversions, and should be able to estimate rapidly their depth, spread, and chronicity. He should also have in parallel series classifications of domestic, marital, social and occupational difficulties, so that, for example, he can assess roughly what variety of social difficulty or sexual perversion corresponds with any given neurosis or psychosis. This involves a fairly extensive acquaintance with a variety of so-called norms of function or behaviour. From the psychological point of view, it is essential that the physician should be ready to let the patient tell his own story in his own way. By adopting this policy some of the advantages of the technique of free association can be secured in diagnostic work. Some idea of the relative importance of the patient's symptoms can be gained: his spontaneous, though often inaccurate, account of their incidence, and his, usually defensive, explanation of their origin can be assessed. Naturally, it is necessary to be on the outlook for both inaccuracies and

omissions, all the more so that these are forms of unconscious protection. But at least one-half of the interview should be devoted to obtaining a spontaneous account.

The methods used to check the patient's own story or to amplify it in a systematic way depend on the case. In the long run a skeletal outline of the patient's life is necessary for accurate diagnosis. This can be obtained either by working backwards from the statement of current difficulties, tracing each item to its earliest remembered or reported manifestations in childhood, or, starting in a more systematic way, by inquiring about difficulties in childhood and gradually arriving at the existing symptom picture or social state. For example, examining the history of anxiety or of phobia-formation one can commence by enquiring about night terrors in infancy, fear of the dark, etc. Having investigated a representative group of these manifestations one can trace their modifications down to such sophisticated adult forms as social anxiety or stage fright. Similarly with conversion phenomena, with obsessions, compulsive rituals, or superstitions, with depressive, paranoid or schizophrenic reactions. In short, one can take the classical symptoms of the chief psycho-neuroses and psychoses, and estimate the total symptom picture at different phases of development. Examination of the symptom picture is a 'shorthand' method of investigation. Nevertheless, provided the results are duly corrected for what might be called a normal amount of abnormality it gives a rough idea of the seriousness of the case. It is even more useful in indicating the directions in which further inquiries should be made. No psychological examination is complete that does not include an investigation of the patient's psycho-sexual and social history. Moreover, it is essential to examine the negative (aggressive) as well as the positive (libidinal) aspects of both sexual and social contacts. When, as is sometimes the case with sensitive individuals, an exhaustive examination is contra-indicated, preliminary assessment of symptoms enables the physician to be sparing in inquiry without missing essential points. The investigation of psycho-sexual development extends in a number of directions. The nature of overt sexual

experiences (either autoerotic or with external objects) can be ascertained. The sexual compulsions of early infancy and childhood together with any history of active or passive seductions should be assessed. The development of pubertal manifestations should be followed, also the form and nature of adult relations whether natural, inhibited or perverted. It will be found that this investigation shades over naturally into examination of affectionate or friendly relations with objects at all stages. A parallel examination should be made of hostile impulses or suspicions occurring from infancy onwards. Special attention should also be paid to the existence of ambivalence in social or sexual relations, e.g. to a mixture of unconscious sadism with love drives. All this enables the physician to assess the strength of general social relations, both friendly and hostile. At this point working capacity, hobbies, recreations should be estimated from the point of view of inhibition or perversion of function. Conclusions of importance can be drawn from the patient's temperamental habit: his tone or level of happiness or unhappiness, elation or depression, optimism or pessimism, openness or reserve, credulity or suspiciousness, his tolerance or touchiness, placidity, apprehensiveness, presence or absence of adequate emotional response to everyday life or crises, conscientiousness or lack of scruple, superiority or inferiority feeling; in short to what is generally called his character and emotional set. Wherever possible the nature of stereotyped phantasy preoccupations or systems of daydreaming at different phases of life should be ascertained. This leads naturally to an investigation of the phenomena of sleep. Characteristic dreams, particularly those surviving from childhood are often of considerable diagnostic value because of their symbolic reference to unconscious (kernel) phantasies. A working estimate of the more general mental functions, e.g. of memory, orientation, will-power, concentration, etc., can usually be elicited by a few questions or inferred without direct questioning during the general examination. It should be remembered that patients are extremely sensitive on the subject of their capacities and all these questions

should be put as tactfully as possible. It may be assumed that the practitioner has already made a thorough physical examination. This precaution is indispensable in cases where the mental manifestations are somatic in type and therefore must be distinguished from organic symptoms. Moreover, should the case ultimately be sent to a psychological consultant, a preliminary examination saves the latter a good deal of time and trouble. As a rule psycho-analysts prefer not to make physical examinations of prospective patients and are naturally glad to receive an accurate physical report from the physicians in charge of the case. In the absence of such information they are obliged to arrange an organic overhaul. It should be remembered that even when the existing physical condition is normal, careful note should be made of previous physical illness. In cases of functional disorder it is important to estimate the amount of somatic predisposition This predisposition is more marked after serious organic illnesses of whatever nature.

The next, and last, stage of psychological examination is in some respects the most difficult. It is easy to see that the spontaneous history offered by the patient is inadequate. To some extent this can be offset by systematic examination. But in making this detailed survey, the physician may lose sight of the fact that the patient's illness is essentially a life-problem. If he has not already done so, he should, at this point, try to piece together the main patterns of his patients life, e.g., the instincts that have dominated the patient and the degree to which they have been subordinated to the demands of reality adaptation. To do this effectively he must be able to assess the importance of environmental factors at various stages of the patient's life. Actually, considerable divergencies of view exist between psycho-analysts on this issue. In the early days great importance was attached to the occurrence of infantile traumatic episodes e.g., seductions or observation of parental coitus. At a later date Freud made the discovery that many of these episodes are products of unconscious phantasy. And since then the accepted psycho-analytical view is that the most important factors in neurosogenesis are endopsychic. This

view is reflected in the relative unimportance attached to precipitating factors in symptom formation. But it does not follow that environmental factors are of no significance. On the contrary, accuracy of diagnosis and, needless to say, of prognosis, depends to a large extent on an accurate appraisal of infantile environmental conditions. Persecutory feeling, for example, occurring in persons whose upbringing and environment have apparently been satisfactory, is more likely to be psychotic in type than when it occurs in persons who have been persistently ill-treated, either physically or mentally, during childhood. It is important to ascertain whether traumata endured have been occasional or spread over a prolonged period. It is also desirable to make a psychological assessment of existing environmental conditions. In making assessments the practitioner has considerable advantages over the psycho-analyst, who, for a number of reasons, is usually debarred from exploiting second-hand sources of information. The practitioner is in a position to act as his own social worker, i.e. he can actually observe the family and social situation. He may also obtain useful information from discriminating friends, though he should remember that his patient is likely to resent anything that smacks of family interference.

Diagnosis.—Having collected all available information as to the patient's symptoms, his psycho-sexual and social difficulties or habits, his working capacities or incapacities, his standard temperamental reactions, and his environmental difficulties, both past and present, the physician can proceed with some confidence to effect a provisional diagnosis and prognosis. At this point he is faced with the difficulty that the descriptive labels usually employed are not very suitable for purposes of differentiation. Diagnosis should rarely be made on the symptom picture alone. For example, phobias associated with suspiciousness, hostility or marked social reserve are of a different order from identical phobias associated with mild sexual inhibition and a potentially friendly and sanguine social reaction. The former belong to a much deeper developmental level. Nevertheless it would be going too far to describe such conditions as 'paranoid' phobias because in fact they can

be resolved much more easily than true paranoid fears. The same difficulties arise in the case of obsessional neuroses. An uncomplicated contamination obsession is 'deeper' than an uncomplicated touching obsession. The former covers anal-sadistic fear, the later conceals mostly infantile genital anxieties. Similarly obsessional neuroses with a depressive background are to be distinguished from obsessions associated with mild phobias. Obsessional reactions with a paranoid understructure, e.g. associated with marked food phobias or a tendency to heavy drinking, differ from both of the foregoing types. They are more grave, although, interestingly enough, when they do take a favourable turn they resolve more quickly and dramatically than depressive obsessions. Psycho-sexual inhibitions or perversions may be graded like phobias and obsessions. The more primitive the perversion, the deeper the mental disturbance. Apart from this, differentiation of types depends on the presence of neurotic or social reactions indicating the level of conflict. Mild degrees of impotence correspond roughly to mild anxiety states. Hence, when impotence is accompanied by symptoms of mild anxiety, it may be assumed that the inhibition belongs to the true genital type. Marital difficulties should be assessed according to the mechanisms involved and the type of emotional reaction. The same applies to asocial or delinquent behaviour. The less primitive forms either show an obsessional type of reaction or exhibit sporadic outbursts of a rather hysterical pattern. More severe cases have a mental structure or pattern which is either paranoid or schizoid in type.

Unfortunately the classification of characterological difficulties (type-psychology) is still inadequate. There are no diagnostic labels corresponding to those attached to neurotic or psychotic symptoms. And since in fact most mental disorders are 'mixed,' i.e. show a variety of symptoms, inhibitions and characterological or social abnormalities, it is necessary to assess each manifestation in terms of depth or level of conflict before arriving at a final diagnosis. This task is easier when there are obvious indications of excessive function of a particular unconscious

mechanism, e.g. projection phantasies. As a general rule sexual inhibitions, mild perversions, the simpler marital frictions, diminutions of working capacity and lack of concentration, should be placed in the same category as anxiety states, phobias, or conversion symptoms. Similarly psychotic episodes would have on the whole the same value as primitive forms of perversion (e.g. coprophilia, violent sadism), total absence of sexual drive and capacity, grave marital disturbances or total incapacity to work.

Prognosis.—Broadly speaking the prognosis established for the various psycho-neuroses and psychoses can be used as a measure of the accessibility of those characterological or social difficulties that correspond with them. It is generally agreed that the transference psycho-neuroses (anxiety hysteria, conversion hysteria and obsessional neurosis) respond readily to psycho-analysis. Anxiety hysterias are the most suitable of all, particularly when associated with gross memory disturbance. There are, of course, exceptions to this rule. Monosymptomatic hysteria (an isolated phobia in an otherwise apparently fairly stable person) is usually difficult to resolve, and phobias with any suggestion of underlying psychotic reaction should be treated with respect. Next in order of amenability to treatment come the conversion hysterias. These are more difficult than anxiety states, but much less intractable than the obsessional neuroses. Fixation hysterias attacking body systems that have been rendered psychologically 'prone' by reason of previous organic illness are more difficult than uncomplicated varieties. The same applies to conversion hysterias in individuals suffering from organic disease of other systems. The situation allows too much defensive interplay between organic and psychological factors. Uncomplicated obsessional neuroses and obsessions associated with anxiety symptoms have a good prognosis although they require much longer treatment than cases of anxiety hysteria. The prognosis of transitional states (such as alcoholism) which lie between neuroses and psychoses is uncertain, but a major reduction of the addiction can be expected. With the various psychoses the prognosis is not favourable, but in selected

types considerable amelioration and occasionally cure can be effected, more often in the depressive group than in paranoid and schizophrenic types.

Applying these standards to perversions, inhibitions and character peculiarities a fairly accurate prognosis can be given. Generally speaking, sexual and social inhibitions are more easily reduced than the corresponding neuroses and psychoses, whereas sexual perversions are more difficult. The prognosis of homosexuality varies according to the type. Where passive elements predominate or strong constitutional factors can be presumed only the most guarded prognosis should be given. Neurotic character cases (anxiety or obsessional characters) are harder to resolve than the corresponding neuroses. Depressive character types are more rigid than true depressions. On the other hand, schizoid types, although requiring prolonged analysis, are in the long run more amenable than even mild cases of schizophrenia. Paranoid characters are perhaps the most difficult of all. Marital difficulties also vary according to mental pattern. Prognosis is more favourable when the case is taken early (within six months to two years of marriage). It should be remembered that it takes two to make a marital crisis, hence even favourable cases may not respond unless the marriage partner is analysed at the same time. Delinquency cases of a psycho-neurotic type are more intractable than the corresponding neurosis, but have nevertheless a good prognosis. Schizoid delinquents are extremely difficult. The accessibility of all cases gradually declines from the age of forty but advanced age is not so much of a contra-indication as was once thought. Elasticity of mental function, comparative freedom in the flow of libido and absence of regressive characteristics are more dependable criteria.

As has been suggested, prognosis depends to some extent on an accurate assessment of environmental factors. This applies particularly to the environmental influences existing during childhood. Generally speaking the prognosis is worse where the infantile upbringing has been unsatisfactory. The influence of adult environment depends on the case. A bad environmental setting may inflame an

existing neurosis. On the other hand, particularly in masochistic types, a considerable amount of social friction can be endured and, in some cases, may protect against a neurotic breakdown. In characterological cases and in sexual perversions a bad environment lessens the probability of cure. Where prognosis is uncertain it is better not to express any opinion until the analyst has been consulted. Timorous patients should be reminded that the analyst may not find it necessary to recommend radical treatment.

Recommendations for Treatment.—The fact that, clinically speaking, a case belongs to a favourable group does not justify an automatic recommendation of psychoanalytic treatment. Nor does it justify giving sanguine estimates as to the duration of treatment. An attempt must be made to assess the patient's 'will to recover,' both conscious and unconscious. In the first place the primary and secondary 'gain through illness' should be estimated. The primary gain (the maintenance of a balance of unconscious conflicting forces irrespective of the pain and discomfort caused by symptoms) is difficult to assess without a preliminary analysis. But with increasing experience it is possible to estimate the depth or level of conflict responsible for different varieties of disturbance and correlate this factor with the possible strength of instinctual factors. Thus the existence of conversion symptoms in men with a passive sexual disposition is not a promising combination. Similarly, marital difficulties in masochistic types are likely to afford too much primary gain for a ready response to treatment.

Secondary gain is not so difficult to observe. The patient usually succeeds, although at a cost, in entrenching himself in a favoured or protected position relative to his family, his psycho-sexual life and his social or occupational environment. These gains are more obvious in people of middle age and over. In adolescence the 'gain' factor is frequently expressed through delinquent anti-social conduct or by simple inhibition of working capacity. In such cases apparent self-injury covers a revenge motive directed against the parents. Naturally both primary and secondary gains are extracted from the same set of symptoms.

For example, anxiety states or obsessional outbreaks in men between 40 and 50 years of age whose hetero-sexual drives are diminishing, help to balance the relative increase in unconscious homosexual libido: this constitutes the primary gain. They also provide a situation of illness in which the individual is safe from reproaches of diminishing affection (secondary gain). Such observations explain why age factors in prognosis depends less on a hypothetical rigidity of mind than on the extent to which mental regression has been accepted by the unconscious ego. Nevertheless it is generally true that the earlier analysis is carried out the better. As in the case of certain organic diseases it is highly desirable that diagnosis should be effected if possible in childhood. Not that analysis of children is invariably successful. There is just as sharp a distinction between the prognosis of anxiety manifestations and of schizoid reactions in childhood as there is in adolescence and adult life. Despite this fact, even in the worst case, an analysis conducted in childhood is to some extent an insurance against more severe breakdown in later life.

The Nature of Psycho-analytic Treatment.—Should the physician decide to recommend psycho-analytic treatment, he will find the patient's natural query 'What *is* psycho-analysis?' by no means easy to answer. The best plan is to explain in the simplest language the nature of unconscious mental conflict, the fact that it gives rise to symptoms, and to follow this up with a brief indication of some of the procedures necessary for resolution of conflict. The physician should correct the popular impression that any kind of mental investigation constitutes a psycho-analysis. In principle there are really only two varieties of psycho-therapeutic approach, viz. suggestion and psycho-analysis and many forms of psycho-therapy, although superficially 'analytical' in tendency, depend for their therapeutic effect on the influence of suggestion. When suggestion is used the state of rapport existing or developing between physician and patient is exploited in order to counter the symptom-formation. In psycho-analysis no attempt is made to oppose the symptom: on the contrary, every effort is directed to promoting an unusually free function-

ing of the mind. The standard technical device employed for this purpose goes by the name of 'free association.' The patient is encouraged to say everything that comes to his mind and to describe his feelings during this process. Usually the first effect of this procedure is to release a good deal of memory and emotion, but sooner or later *difficulties* arise The association rule tends to be abrogated. These difficulties constitute 'resistances' and act as indicators of conflict. It is now the task of the analyst to resolve these resistances. This he does by means of 'interpretation.' Interpretation can be either positive, when the unconscious content giving rise to the difficulty is communicated to the patient, or exploratory, when the unconscious emotions (usually anxiety and/or guilt) causing the hitch are ventilated. Interpretations are based partly on the analyst's reading of the material contributed and partly on his experience of similar cases. The interpretative process is also applied to the patient's dreams and phantasies. These are specially informative owing to the fact that in dream life unconscious drives and fears obtain more immediate expression, both directly and indirectly by means of symbolism, than they do in waking thought.

Although analysts do not exploit rapport to combat symptoms directly, the existence of a more or less friendly rapport helps to start off the analysis and to overcome some preliminary resistances. Later it becomes apparent that some of the most stubborn resistances are themselves due to unconscious varieties of rapport. These are given the special name of *transferences* and are divided into positive and negative varieties in accordance with the degree of friendly or hostile reaction they express. The point about these positive and negative transferences is that they are displacements of mainly infantile reactions from unconscious (family) images to the person of the analyst. As a result of this transfer infantile attitudes and situations are brought into the open and can be analysed in a fresh state. In a typical neurosis the symptoms begin to loosen up at this stage and are replaced by the so-called 'transference neurosis.' Thorough analysis of this transference neurosis must be effected before symptomatic improvement can be

regarded as permanent. Once it has been achieved, warning of the approaching termination of the analysis should be given. The last stage of transference analysis is then carried through under the stimulus of this approaching threat of independence, which implies final abandonment of the gain through illness.

In the analysis of character cases or of anti-social conduct transferences do not follow the same comparatively simple course. Usually they have an unobtrusive form or express themselves in a persistently negative (resistant) way. In such cases a preliminary step in the resolution of difficulties is the uncovering of concealed neurotic reactions. Once the latter have appeared the transference begins to conform to the usual neurotic pattern and permanent improvement or cure can be looked for. Psychotic patients frequently create the impression that the transference relation is minimal. This is a misapprehension. The inaccessibility of many psychotic types is partly a spontaneous negative transference and partly a protective regression. The trouble about psychotic transferences is that when they become active they tend to express themselves in the form of psychotic episodes. Hence one of the most satisfactory signs during analysis of psychoses is the outcropping of neurotic as distinct from psychotic episodes. They pave the way for neurotic transferences. For example, during the analysis of depressive psychoses the eruption of acute obsessional states is a good sign, and is usually followed by increased ego-stability.

On occasion prospective patients ask what is the difference between psycho-analysis and various other forms of investigation. As has been suggested, the most fundamental distinction lies in the fact that psycho-analysts are concerned to uncover, analyse and resolve infantile transferences. This does not imply that analysis is the only method of investigation whereby cures can be effected. Even the simple procedure of taking a good case history can have at times surprisingly good therapeutic effect. This can be enhanced by adopting some form of association technique. Or, using both history-taking and association methods, a frontal attack can be made on the symptom.

Interpretation of this material can be given and can be reinforced through persuasion, exhortation, declamation or some other variety of suggestion. But even in the absence of open suggestive procedure, such interpretative approach does not constitute a psycho-analysis. There are, of course, other ways of distinguishing between psycho-analysis and other forms of therapy, e.g. the content of interpretations, the nature of etiological views, the correction of unconscious mechanisms and the analysis of unconscious ego structure. But unless the patient has read of controversies between different psychological schools and asks for enlightenment there is no point in going into such details. Nor is it advisable, as a rule, to attempt any descriptions of transference situations or analysis. It should be emphasized that symptoms, whether expressed by disturbances of thought, feeling, action or bodily function, constitute a distorted 'language' giving outlet to conflict but in a disguised and often symbolical way that is not only ill-adapted but positively detrimental to the reality interests of the ego. These points can be illustrated by a few simple examples. Attempts to describe the technique of analysis should be avoided, and in any case do not convey much to persons who are not already orientated on the subject. A brief explanation of the nature and effect of 'free association,' together with a description of the conditions under which it is carried out, are usually sufficient to give the prospective patient some idea of what may be expected of him. It will also prepare him to face the fact that psycho-analysis is of necessity a lengthy process.

Duration of Treatment.—It is important for both practitioner and patient to be thoroughly acquainted with the time factor in psycho-analysis, and this not merely for practical reasons. Preliminary resistances to analysis very often seize on and magnify the importance of this factor. In the case of chronic organic disease the physician neither feels disposed, nor is called on, to apologize for the duration of any treatment that may be indicated. A moment's reflection will show that it is absurd to expect a deep neurosis of several years' standing to be capable of analytic resolution in a few weeks or by attending once or twice a

week. It is true that many symptoms can be considerably alleviated in a few weeks. Some may even disappear after one consultation. This may be due to a sudden relief from marginal anxiety, but more usually it is a 'transference' phenomenon and lasts only so long as the unconscious rapport with the imago of the physician persists. Considerable disappointment can be saved the average patient if it is made clear from the outset that radical alteration of mental structure or fixation must of necessity be slow. It is a much better policy to give conservative estimates and to avoid the temptation to reassure the patient by promising rapid cure. The length of time necessary depends on the age of the patient, the clinical type of disease (in particular its chronicity, severity and depth), the patient's pre-analytic resistances and his unconscious gain from illness. But there is no exact ratio between these factors and the length of treatment. Apparently severe attacks sometimes readjust rapidly: on the other hand an apparently simple monosymptomatic neurosis, e.g. a mild phobia, may involve a prolonged exploration of the very wide area of unconscious organization on which it may be based.

Notwithstanding these difficulties, it is usually possible to give a roughly accurate estimate of duration. In the average case of anxiety hysteria rapid symptomatic improvement can be observed within the first six months, followed by a slower and more difficult phase in which improvement alternates with regression. Sometimes, on the other hand, the opening phase is difficult but is followed by slow improvement which reaches its maximum in the terminal phases. Even if symptomatic improvement is rapid, this does not determine the length of the analysis, which must be thorough enough to prevent relapse. Hence, even in simple phobias it is well to warn the patient that his difficulties may take two years to eradicate. Similar estimates can be given in conversion hysterias. Caution should be exercised where there is an organic fixation element (previous or concurrent organic disease in the organs psychologically involved). Somatic manifestations of anxiety and some neurasthenic manifestations may

clear up quite suddenly, but this of itself is no guarantee of a short analysis. Obsessional cases are difficult and usually lengthy. On rare occasions a complicated obsessional system may clear up superficially in a few months but ideally the analysis of obsessional cases should not be less than two and a half years in duration. It may have to be continued for four to five years. In psychotic cases no time estimates should be given. Depressive symptoms may exhibit comparatively rapid remissions, but this depends to some extent on the phase of the cycle at which analysis has commenced. It is no criterion of ultimate success. Mild sexual inhibitions often clear up within the first six months. Mild social inhibitions are also readily amenable to analysis, but take longer to improve than sexual inhibitions. In the case of mild sexual perversions, sanguine estimates should be avoided. The underlying structure is frequently hard to resolve, and a conservative estimate should be given, i.e. a minimum of two years. Mild delinquency cases of the hysterical type may clear up within a year: obsessional types require much longer. In the case of severe sexual perversions and the more outstanding character difficulties no immediate estimates of duration should be offered. As with the psychoses, accurate estimates cannot be made until the preliminary stage of analysis has been completed, usually at the end of six months. This is not the same policy as the 'trial trip,' i.e. recommending a few weeks probationary analysis with a view to completing diagnosis and estimating accessibility. Generally speaking, estimations of duration should be based on the physician's impression of the total function of the patient's mind, the strength of his instincts, the stability of his ego and the strength or weakness of his mental defence mechanisms—not on the apparent strength of his symptom constructions.

The proper recommendation for patients whose time is limited, for reasons beyond their control, depends on the nature of the case. Should there be reasonable expectation of major alleviation of symptoms or cure within the time available, or, better still, if there is a margin left over in which additional consolidation of the ego can be secured.

the practitioner is justified in recommending psycho-analysis. Should only a few months be available, it should be explained that satisfactory analysis is not possible, that symptom improvement is a gamble and that some short-cut method of treatment should be considered.

Cost of Analysis.—One of the main obstacles to arranging an adequate period of analysis is financial. Psycho-analysis involves attendance at the analyst's consulting room for a minimum of five sessions per week, during an 'analytic year' of at least 40 weeks, i.e. a minimum of two hundred sessions per annum. Fees are usually paid monthly, or, by special arrangement, weekly. At first sight the prospect appears intimidating, and many patients arrive hastily at the conclusion that analysis is beyond their means. The proper way of overcoming all such difficulties is to ascertain what annual sum the prospective patient can set aside, preferably from income. From this figure it is easy to calculate what fee the patient can afford per session without causing undue strain. If this sum is not large enough to secure private treatment the patient should be recommended, in the first instance, to the London Clinic of Psycho-analysis. Should the patient be anxious to avoid possible delay in securing a suitable clinic vacancy and be ready to set aside a fixed sum from capital resources, an accurate estimate should be made of the length of analysis necessary, and a private fee should be arranged that will cover this period, allowing an ample margin for eventualities. The fact that treatment may need to be limited for financial reasons, or for that matter for any other extrinsic cause (work, residence, etc.) sometimes provides an unconscious as well as a conscious incentive to respond quickly. But although some resistances are curtailed others may be mobilized, and, on the whole, the situation is an unsatisfactory one. The patients who respond most favourably to these restrictions are of an anxiety type: more intractable cases do not respond, and masochistic types are unconsciously tempted to exploit these hardships. Knowing that time or money is limited they strive unconsciously to 'play out time' with the result that, despite some preliminary improvement, the analysis ends in stalemate.

The Family Situation.—As a rule, once the patient has embarked on analysis, the rôle of the practitioner should be a purely expectant one. There are occasions, however, when he can be of considerable assistance to the psycho-analyst by helping to keep the peace within the family. On many occasions both relatives and friends are openly suspicious of or hostile to psycho-analysis. Even when their conscious attitude is genuinely co-operative, they may unconsciously resent or be jealous of the situation, and, quite unwittingly, do everything they can to obstruct it. This reaction is all the more likely when, as is sometimes the case during analysis, the opening up of hidden conflict makes the patient behave for the time being in a more trying way than usual. Moreover there are occasions when, despite the discomfort of having a neurotic individual in their midst, the family may unconsciously tolerate the crippling of, for example, some unusually talented member. It should be remembered that although some neurotics use their illnesses as a mask for real incapacity, others, particularly obsessional and paranoid cases, are persons of superior intellect. Their falling ill may provide a 'secondary gain' to those of the family who are jealous. This is naturally concealed, frequently by an over-solicitous reaction, e.g. expressing anxiety lest the patient should be 'driven mad.' The psycho-analyst is at a great disadvantage in dealing with such situations. Unless the patient expressly desires him to do so, he cannot make contact with the family, and must face the risk of incurring their displeasure by refusing interviews. The practitioner, on the other hand, can smooth over many of these difficulties and, in the last resort, should act as a buffer between the family and the psycho-analyst. In so doing he may be sure that he is advancing the patient's interests. These situations demand the exercise of considerable tact; as in the case of examining patients, it is undesirable to adopt any attitude that might be regarded as coercive. Should the practitioner himself be in doubt either about the progress of the case or as to the best way of handling the family situation he should not hesitate at any time to raise such matters with the analyst.

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