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CLINICAL STUDIES IN PSYCHOPATHOLOGY

CLINICAL STUDIES
IN
PSYCHOPATHOLOGY
A Contribution to the Aetiology of Neurotic Illness

BY

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PREFACE TO THE FIRST EDITION

THE material and most of the subject-matter of this book originally formed a series of post-graduate lectures at the Tavistock Clinic, part of a much larger course in psychotherapeutic theory and method, first given some five years ago. Their place in that course ensured a good deal of antecedent acquaintance on the part of the audience with the concepts and terminology of the major modern schools of psychopathology, which is also assumed in the readers of the book. In that sense it is not an elementary book, nor is it written for the lay public, but rather for doctors and other students of psychopathology with some clinical experience of the psychoneuroses. It should not be regarded as a textbook, for it is neither systematic nor descriptive. It should, as its title suggests, be accepted simply as the contribution of an individual to the current discussion—if not confusion!—in this most interesting of human studies. The subject of the psychoses and of "delinquency" is omitted, as the writer's first-hand acquaintance with their deeper psychopathology is restricted to a few analyses.

The book lays no claim to originality, for it represents the reflections and products of digestion of other peoples' ideas, which will no doubt be recognized by the reader as he proceeds, when he will also be able to assess the writer's digestive powers.

It must be made clear at the very outset, therefore, that when reference is made in the text to psychoanalytic, "Adlerian" or "Jungian" ideas, what is really meant is the impression these ideas have made on the mind of the writer. In the process of mental assimilation some of them have, doubtless, lost their identity and have become recast into views perhaps foreign and even repugnant to their authors. This explanation may help to lessen the impression of the writer as a creature with many feet, each planted uncertainly in a different camp.

All the greater must be the writer's sense of obligation to those from whom he has so freely borrowed, especially as he has found it impracticable to verify chapter and verse of every reference to their statements.

First and foremost to Professor Freud, without whose labours the field would still have been uncultivated wilderness—a fact sometimes conveniently overlooked by others who also *an seinem Feuer Süppchen kochen.* Next, to those writers in psychoanalysis who have extended and systematized Freud's teaching, and to Professors Jung and Adler, whose work will without doubt find a worthy place in the ultimate edifice of the science of the mind.

A much more personal debt of gratitude is owing to Dr. J. A. Hadfield, whose teaching and training in theory and method have been the foundations on which the views about to be put forward in this volume have been built. The responsibility for these views, as now formulated, is, however, the writer's alone. It is a real loss to science that Dr. Hadfield has not yet presented to the world his theory of psychopathology in a systematized form—a loss that one hopes will soon be repaired.

Further, my thanks are due to my chief, Dr. J. R. Rees, and to all my colleagues and friends at the Tavistock Clinic and elsewhere for many stimulating interchanges of views and helpful suggestions, which are the breath of life to all cultural activity. Among them I wish to mention especially Dr. Emanuel Miller, who has been kind enough to read the manuscript and to give me the benefit of his scholarly criticism on many points of subject-matter and style, which but for his assistance would have remained even less intelligible than they now are.

And lastly, I want to acknowledge with gratitude the help and encouragement I have received at all stages of my work from my wife.

H. V. D.

LONDON, W.1

PREFACE TO THE SECOND EDITION

SINCE this book was first written World War No. 2 has swept over us. Much that seemed of importance to us before that event has ceased to matter greatly. This applies, in the opinion of many of us, to the quarrels between the finer shades of psychopathological thought.

The common experience resulting from pooling the manpower of various schools of psychiatry has brought about a convergence of concepts and an emphasis on essentials, at least among members of the group which formed the Army psychiatric service under J. R. Rees to which I had the privilege of belonging. The need of the moment required us to organize not only some sort of psychotherapy, but also to apply our psycho-dynamic concepts to many problems of group behaviour. We were called on to study the morale of military units, the criteria of leadership, the crises of resettlement, and even the psychology of our enemies. To these tasks we had to bring whatever background we had derived from the peace-time clinic and seminar, adapting it as best we could. We found that in all matters involving human relations those of us who were grounded in analytical work and psycho-dynamic theory possessed a technique of handling these problems which stood the test. In W. R. Bion's phrase, even if we were second-rate in most ways, we had at least had the experience of being able to stand—and often to understand—the tensions within and between human beings.

One result of the work of this group of Army psychiatrists is greater respect and a closer collaboration between psychopathologists of formerly divided schools with the disappearance of trivial issues, and the prospect of a broad advance into the field of social psychology. Another is the demonstration of the correctness of our major psycho-dynamic formulations. That is to say, this book deals with things that really exist and matter in human life. World War No. 1 saw the emergence of psychotherapy based on Freud's work, struggling against the resistances in the pundits of neurology and psychiatry of that day. Crichton-Miller, Culpin and others

fought that battle for us, and we honour them for establishing the treatment of psychogenic illness on psycho-dynamic principles as a permanent part of our medical services to the community.

This volume belongs historically to the end of that phase. On re-reading it, almost as a stranger, on returning from the wars, it seems still, with minor emendations, to reflect my point of view on the psychopathology of the commoner neuroses. I find that psychopathology has not changed very much during the second war—or if it has, then only to approximate to the kind of view I held and still hold. Military psychiatry, insofar as it dealt with the care of casualties, has produced nothing in this war which renders our viewpoint obsolete. The advance in this war has been to turn what was the pooh-poohed extravaganza of a small band of almost ostracized pioneers in psychopathology, on the periphery of "respectable" medicine, into the common stock of ideas widely held in the social sciences and even by many of the younger generation of doctors. The danger is now almost the opposite—a shallow acceptance and payment of lip-service to this kind of psychiatric approach without a foundation in deeper experience. This imposes on us a greater responsibility for providing adequate teaching in a subject which is perhaps the key to difficulties in human relations.

I have decided to retain the word "instinct" as applied to needs and strivings. Whilst I tend now to pay much more regard to object-relations than impulses as such, I still hold that certain basic affective needs are part of our native predisposition and form the raw material of our study.

In its first edition the present book was kindly received by reviewers in many lands. I have not made major changes in it. The case records forming the matrix of the argument had to remain as originally observed. I trust certain minor improvements which I have made will aid the reader.

I want to insist again that it should not be regarded as a primer, but rather as a text for discussion and critical evaluation.

In conclusion, I wish to pay homage here to the memory of several of my gallant young patients who gave their lives during the recent War that free discussion might not perish from our civilization.

H. V. D.

THE UNIVERSITY, LEEDS

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CHAPTER I

INTRODUCTION

THE eclecticist in the field of psychopathology has to pay for his freedom of view-point by a much greater liability to criticism both from his fellow-eclectics of different shades, and from the orthodox of the "schools." If he, therefore, attempts a more or less coherent statement of the hypotheses which guide him in the understanding and treatment of certain psychogenic disorders, he is fortified by the knowledge of the individual character of such a synthesis whose shortcomings are his alone, and which he is thus in the most favourable position to alter in the light of the further work of others as well as of his own increasing experience. In intellectual life the publication of ideas, even if they are inaccurate or incomplete, is valuable. In psychopathology the construction of a "logic-tight" and consistent theory without loose ends or contradictions will, at present, still be in advance of the clinical facts and a matter of speculation.

It therefore behoves us to be sparing with metaphysical and metapsychological concepts, and to endeavour to follow the principle of clinical observation, relating the data of the psychotherapeutic consulting-room to the phenomena of human behaviour; thinking of what others have made of these observations and choosing always the hypothesis which best explains the facts.

While it is hoped that the general point of view adopted will become clear in the chapters which follow, there remain two duties towards the reader. The first is to give him some indication of the *method* by which the clinical material has been elicited and appraised, and the second is to explain his use of *terminology*—alas, still a necessity in our subject. Of all the schools of psychopathology, only the psychoanalysts have the appearance of consistency and uniformity in these important matters, while very little is published concerning the techniques of other people. Unfortunately for terminological simplicity, some of the concepts of the non-Freudians are valuable enough to have been included in the present writer's equipment. Freudian language will be used wherever possible, and unless otherwise explained, in the text or footnotes.

The author can at least claim in his defence that he is not aware of having coined any *new* technical terms!

As regards the more difficult matter of technique, this can fairly be described as analytical. It is first necessary to state what fundamental conceptions govern one's choice of method, before proceeding to details. After long trial and early doubts, I have come to accept the validity of the hypotheses: (1) that there is an unconscious portion of the mind; (2) that the broad Freudian formulation of its functional relationships to the conscious, and of its structure is the most reasonable one that has so far been advanced. It follows that I accept the general theory of personality and of the aetiology of the psychoneuroses and allied disorders as elaborated by psychoanalysis,[1] viz., that the unconscious is the storehouse of certain dynamic drives (of which more anon) which, being phylogenetically and ontogenetically older than reason, are in development, as it were, pushed out of sight as in a geological process, and have in that strenuous process had much opportunity for dislocation and distortion, as well as competing with the newer rational faculty for supremacy in the government of the personality. This is another way of saying that I also accept the hypothesis of endopsychic conflict and of the mental mechanisms; which implies that I am prepared to be on the look-out for extracting meaning out of the apparently meaningless piece of mental content by applying certain keys or decoding manœuvres, presented to the world by psychoanalytic research.

Since the fundamentals of Freudian psychology and pathology seemed true and useful it was obvious to apply in treatment the method of free association, including the examination of dreams and perhaps more rarely of other expressions of mind (e.g., artistic productions), in the light of the "mechanisms," enhanced by the subtler language of gesture, demeanour and the other imponderables which are experienced in the relationship between two persons. That the method so used has been therapeutically successful in a satisfactory proportion of cases is perhaps no proof of its theoretical validity, for many things "cure" patients—often those things for which least theoretical background exists. But when the method, *in addition,* has demonstrated an intelligible and ordered aetiological, casual, teleological sequence in what previously seemed

[1] Whenever this term is used it means the strict Freudian discipline. For the non-Freudian, but allied, procedure the term analysis, without prefix, will be employed.

chaotic and absurd, as well as having reasonably accounted for the causes of failure in other cases, then we are dealing with a weapon of attack which answers to the requirements of science; it explains phenomena by reducing their complexity to a number of assumptions which when applied in practice work in a goodly percentage of properly selected cases. This is probably as near as any clinical technique will ever get to the canons of "pure" Science.

It may at this point be relevant for the reader to ask: Why then do you describe yourself as an eclectic when on every major point you appear to agree with psychoanalytic principles? One answer is that I never have sought admission to the Psychoanalytic Society through the proper channels. But more important than this—there seem to be many valid and valuable things which the Freudians do *not* accept, not least perhaps because they were first enunciated by those who had seceded from Freud even though originally properly trained according to his requirements. In other words, one may accept a framework but need not be bound to accept the contents wholesale; one may apply a method to the same clinical facts and obtain sometimes a striking confirmation of psychoanalytic conceptions, while in other cases these simply will not fit the picture. Rather than attempt to press the facts into the theory, one prefers in that event to find another explanation. Rather than try to force bolts and nuts of different sizes with one spanner, one carries a tool which allows of adjustment to a variety of nuts, even if it is not so neat and compact. In so doing one lays oneself open to the charge of discarding an important scientific principle—that of economy of hypothesis, which does not seem nearly such a serious error as that of stretching a conception beyond what it can contain.[1]

The other charge, of not applying the psychoanalytic principles *secundum artem*, as one is an outsider, can best be met by saying that perhaps the very loyalty of the Freudians to their own system (of which they have every reason to be very proud) has made them somewhat biased against conceding truth in other formulations, having, so to speak, a vested interest in making deductions unduly favourable to their theory. Thus one is inclined to agree with many of the criticisms levelled at the earlier Freudian point of view in the writings of Ian Suttie, where they are expressed much more cogently than the present writer can hope to do.

[1] Karen Horney, also publishing in 1939, has arrived at very similar conclusions in her *New Ways in Psycho-analysis*.

There are, however, indications that psychoanalytic views are tending more and more towards that broadening of conceptions about the variety of instinctive needs involved in the human personality and its disorders in which many non-Freudians of the eclectic sort have long found a basis for agreement. One is thinking, firstly, of Freud's acceptance of an independent instinct of *aggression*—no longer miscalled sadism as it was when it had to be fitted into the pan-sexual theory. Then there comes to mind the remarkable increase of emphasis on yet another instinctual drive as having priority even over libidinal trends—namely *self-preservation*. Dr. Brierly, in her admirable summary of Freudian views[1] says: "We must continue to find room for self-preservative impulses." She even points out the danger of too great a swing away from libidinal priority towards regarding anxiety—admittedly the infantile dread of insecurity—as all-important. The term "fear of loss of love" or "loss of the mother," which is, so far as one can observe, steadily ousting the older and inadequate conception of "castration fear," would seem to betoken a similar change of outlook towards what has to us appeared to be a more biological position. Another Freudian, Alexander, in his recent writings employs the term "dependence" in a sense in which Hadfield used it as far back as 1923, to describe the operation of this very instinct, at a time when the primary nature of aggression even had not yet been accepted by phychoanalysis, whereas Hadfield had then already correctly gauged the significance of this instinct also.[2]

The leaderless eclectics in England have perhaps felt unnecessarily diffident about publishing systematizations of their views in the face of the homogeneous bodies of psychoanalysts and of the other "schools" all marching in step; perhaps it will be found that much in the supposed divergences of view is not fundamental but formal, polemical or terminological, and that the reproach of continual fission and intellectual friction (as opposed to healthy controversy) levelled against psychopathologists by the other scientists will in a measurable period of time no longer be valid. It is in this hope that the present volume is being launched.

[1] BRIERLY, M., "Present Tendencies in Psycho-analysis," *British Journal of Medical Psychology*, vol. xiv, 1934, pp. 211–29.

[2] The reader should not here be led into thinking that the acceptance of certain clearly observable trends is a matter of dogma. If these trends were later found to be but variants of one and the same basic Instinct, nobody would be more happy than the writer. For me the spectrum of instinct analysis shows so far the just named three primary "needs."

It remains now to complete the account of our approach to the patient—i.e. the source of our data—as this is obviously an essential preliminary for the appraisement of the inferences drawn from the method. Not the least of the advantages of an "unattached" psychotherapist is that the patient has very little idea of what the doctor expects of him. It cannot be denied that a large proportion of our patients belong to the thinking and reading section of the community, and have learnt that "psychoanalysis" means "sex," whereupon they endeavour to do their best for the kind doctor and produce the right stuff. *Mutatis mutandis*, this applies equally to the adherents of other "schools." This form of resistance is reduced to a minimum if the patient has no *a priori* ideas about the analyst's views. The atmosphere of neutrality is further strengthened and given reality if indeed the analyst is regarding each case as a novel revelation of psychic combinations, takes very little for granted or diagnosed until it has been confirmed out of the patient's own statements. This intellectual neutrality is a very different thing from the studied detachment which, in earlier days psychoanalysts were taught to simulate. The latter is, in my opinion, unnecessary and harmful, often delaying the expression of the deeper material through a sense of lack of sympathy. It is, indeed, permissible to argue with Suttie and others that the intensity of "transference" difficulties in treatment is proportional not only to past frustrations in human relationships but to that of the consulting-room also. When this has been said, it seems essential for the even background of the analysis that the degree of friendliness for a given case should remain approximately constant throughout the sessions, to show up the patient's phantasies in better relief.

We have already alluded to the use of free association. At the time when the case material on which this book is based was being studied, the greatest latitude and non-interference with the spontaneous flow of the patient's associations was the method of choice. After the preliminary interview at which a patient's capacity to undergo analysis is assessed in terms of diagnosis, prognosis and environmental considerations, there comes the first analytic session. At the outset the patient is asked to begin talking about the symptom he most wishes to be cured of, and to express any thoughts or feelings that come into his mind. This is done in order to enlist some degree of conscious co-operation at the start of analysis. Resistance is interpreted from the earliest moment, though it does

not often assume formidable proportions in early sessions. When in later sessions a serious blockage occurs, as silences or in the form of drifting into intellectual considerations, Hadfield's technique of recalling the patient to return to associations about the symptoms is sometimes adopted. This has the purpose primarily of demonstrating the existence of resistance. It shows to the patient better than any interpretation that he, who should be interested in tracing out the meaning of his complaint, is in fact avoiding it. It imparts at an early stage some sort of sense of direction in which doctor and patient are setting out to travel and which it is the analyst's rôle to hold in view. In a smoothly running analysis this direction by the doctor will hardly be necessary, for all the material will be found relevant.

The tracing out of *symptoms*, whether they be a pain, a feeling of inferiority or a sexual anomaly, seems also from the psychopathological point of view the most logical procedure, for in it are contained the opposing forces of the early conflict, and the mechanisms by which these were ultimately to receive expression in the symptom. The *affective* quality of the symptom, even where its form has changed under the influence of the various mechanisms, remains remarkably constant and serves us as a kind of Ariadne's thread through the maze of detail with which it is historically connected, until at last we reach back to the level of its formation. Then the affect begins to split up into its components or earlier determinants, which in turn become new "symptoms," to be traced out in precisely the same way. It is these new, therapeutically produced symptoms which frequently emerge in transference form, although in the easier cases even these new feelings will already have become connected in the patient's mind with the original objects of hate or love. After permitting the fullest possible expression of these feelings we resort to the same process of tracing them back to their origins, for the patient will already have learnt by the earlier procedure to regard what emerges in the analysis as being part of the process of re-living, and retains for the most part just that shred of insight which makes the analysis of any transference feelings relatively trouble-free and rapid. Here again the "reference back" to the main line of analysis is easy when this method has been consistently used.

It will be seen that the analyst does *not* in any way suggest content, but merely directs the flow of associations towards the

point at which content is, or was at the previous session, emerging; notably towards a painstaking working-through of infantile experiences, whether real or phantastic, and their emotional contents. Under this regime very little interpretation is required, and for the analyst's speculation and intuition is substituted as far as possible the patient's own realization.

The same preference for the patient's *own* contribution is also maintained in the understanding of *dreams* (which after all are also supplementary symptoms). There seems nothing so productive of resistance, of the shifting of analysis from the associative to the intellectual level, than the arbitrary interpretation of dreams according to one or other of the schools of symbolism. The dream, while undoubtedly subject to the laws of unconscious functioning as described by psychoanalysis, very seldom is an expression merely of proscribed impulses or "wishes," nor can any stereotyped formula of decoding do justice to the highly individual symbolic language in which the content is clothed, because of the uniqueness of the patient's mind and antecedent experiences in forming affective similarities and analogies.

Most frequently, in my experience, dreams are a cartoon-like representation of a situation or a problem in analysis or in real life, relating to a past experience now under analysis, or to a fusion of such an episode with a present contingency which has aroused analogous feelings, and may thus, for example, express a transference situation.

Of particular interest are the earliest dreams related at the beginning of treatment. Again and again one has had complete, admirably condensed summaries of the entire psychopathology of the patient's illness in a few dreams brought up at the first or second interview. It would perhaps be correct to say that the dream often represents the struggle of some instinctive impulse to gain access to consciousness, but that reactive elements are also brought into play, e.g., punishment or the threat of punishment—in fact the whole conflict; and the human objects which are significant for the neurosis or at least for the particular aspect of it under analytic review are portrayed in the dream. At times the dream is solely concerned with resistance or with the attitude of the patient towards the analysis, as when an elderly man early in his treatment by a youthful doctor dreamt he was being chased round the Underground by a small boy!

There is to my mind also no question that *some* dreams may be only explicable in terms of a progressive, rather than a reductive, point of view, *á la* Jung, serving then as a valuable index of the progress of the therapy. We will content ourselves with one example:

A mother-fixated young man with an anxiety hysteria has a series of dreams towards the end of a successful analysis.

The first dream: "The analyst and I are at the mouth of a tunnel whose entrance is barred by my mother in a threatening attitude. Nevertheless he takes my hand and I follow him, crawling through the slimy tunnel, and emerge at the other end."

Surely, a *re-birth* away from, and in spite of, mother. The ideas of liberation are further shown in

The second dream: "I am at home, in the squalid neighbourhood where I grew up. All the ugly little houses which had shut out the view are on fire." Similarly,

The third dream: "I am in a chapel where my mother used to drag me as a boy on Sundays. Suddenly the chancel end falls in and the clear blue sky is showing through."

The fourth dream: "I am standing on a cliff overlooking the sea—a vast horizon—a lovely day. The shape of a temple-like edifice is forming in the sky, while on one side stands the shrivelled tiny wooden statue of a Madonna."

In brief, then, the dream should be approached with the same catholicity of outlook as the owner's mind in general, and the only reliable guide to its meaning are the patient's associations. Even the so-called stock dreams, such as that of falling from heights, are often over-determined, and while in some cases their meaning is in accord with Freudian doctrine, in others they will only make sense if viewed from the point of view of Adlar's power psychology.

In our method, then, *interpretation* of dreams as of phantasy-material is kept to a minimum, and used mostly as a way of clarifying ideas that are becoming conscious in the patient's mind, as a method of paraphrasing subjective thought in rational terms, as well as a relating to the experiences of others or to typical reactions of childhood. Occasionally a "shot in the dark" has to be risked which will generally bring in reply the true meaning from the patient.

Perhaps enough has been said to indicate, to those in a position to criticize, the type of approach employed in the investigation of the disorders with which the present book is concerned. The foregoing discussion of technique is not intended as a guide to practice.

The latter cannot be learnt from books or lectures; but while recognizing this truth, one feels that so much in psychopathology would sound more convincing if one knew by what road the discoverers had arrived at their conclusions, and with what premisses they had set out to evaluate their data. It is solely with this object in view that a brief sketch of the writer's methods has been presented.

One further point occurs here. It concerns the inestimable value of intimate contact with young children, as a corroborative method for the discoveries in the analytic consulting-room. Much that would sound improbable in the phantasies and other clinical manifestations of neurosis in the adult is in the child seen in its natural and harmless setting and becomes at once more real and more accessible to our understanding. So when we meet with the morbid survivals and distortions of what was once good and normal, we are able to place them back into their proper perspective and restore them into functional harmony with the rest of the individual's psychic life. In terms of training for psychotherapy this means experience in child guidance clinics as well as with normal children.

Lastly, it must be strongly emphasized that those are best fitted for short therapy who have served their apprenticeship as analysts and have first-hand insight into psychopathology.

CHAPTER II

ANXIETY STATES

Of all clinical manifestations in psychological medicine Anxiety is the most widespread. For reasons which will be set out in the argument of these pages, it is to be regarded as the most powerful determinant of pathological adaptation, as well as its commonest expression.

Before plunging into an investigation of the morbid states which it produces it would be as well to consider its relation to its normal counterpart—Fear.

Anxiety may be described as the reaction of the ego to any threat of obliteration or defeat by external or internal forces, where the normal motor outlet of fight or flight has been dammed up owing either to actual helplessness of the individual or to inhibition by endopsychic sanctions of the super-ego type, producing a condition of psychic helplessness. Anxiety thus would seem to be *always* pathological, except perhaps in the earliest months of life, in the sense that it is an arrested, aim-inhibited, side-tracked expression of the tendency to flight and self-preservation. Let us dispose at once of the physiological side of the problem by reminding ourselves of the action of the sympathetic nervous system and of adrenalin in the emotional states of fear and rage, as shown by Cannon. If as the result of the arousing of fear—or rage—no marked voluntary motor expression follows, the vaso-motor and other visceral changes initiated by the sympathetic-adrenal mechanism are probably exaggerated. An injection of adrenalin into a normal person gives rise to a transient state of feeling which very closely simulates psychically evoked anxiety. We also know that infections activate the adrenal defence mechanism to a marked degree, which may account for the importance of sepsis in the aggravation of anxiety states. Nevertheless, there are far more people with anxiety states than people with focal infections; also the majority of anxiety conditions I have seen have never had evidence of toxic foci, or have had these radically treated without affecting the anxiety as a subjective feeling.

The next point which arises is the important query as to

whether the feeling of anxiety is specific to a thwarting or petrification of fear, or whether other strong feelings can be directly transformed into anxiety, for example, rage and sexual excitement. Both feelings lead normally (primitively) to very definite—the former to extreme—motor expression, and would thus be associated with adrenalin excess in the bloodstream. I do not think we can answer this query definitely. Freud used to regard anxiety as the direct transformation of libido into fear, and would, logically, regard rage as being capable of the same alteration. This, indeed, was his sole explanation of the "true anxiety neurosis" of sexually unsatisfied people.

A consciously experienced state of fear, rage or sexual excitement, if not acted upon appropriately, may as it dies away give place to a feeling of temporary exhaustion, possibly due to the fall in adrenalin concentration after prolonged stimulation. An emotion of that kind, not even allowed access into consciousness may have the same effect, but here the situation is complicated by the nature of the barrier. In the case of consciously experienced emotion there must have been conflict, but this was eventually solved one way or the other by conscious choice. In the case we are now considering, such a conflict is *never solved,* because the ego is intolerant of the very existence of the feeling. We can say that the ego has interposed a resistance, censor or whatever we like to call it—and so all that can be manifest is the bodily repercussion of the frustrated feeling in the form of its effect on the adrenal-sympathetic mechanism with anxiety as the result, or exhaustion, if the affect itself has played itself out. This must have been Freud's earlier point of view. Yet in his works he makes it clear that anxiety—the unconscious fear of castration, etc.—is itself one of the opposing forces in conflict.

Ernest Jones and the majority of psychoanalytic writers have gone farther, to the point of differing from Freud, and definitely regard anxiety as a manifestation of *fear,* rather than as the direct transformation of libido. This brings us at once to the chief significance of anxiety in psychopathology—namely that of a danger signal to the ego. To all unwelcome instinctive forces trying to break through into consciousness the ego responds with anxiety if its other defences have failed. In our view anxiety is always protective in function, albeit the mechanism is a very archaic one and can only fulfil its rôle at the price of great suffering to the patient and of

varying degrees of emotional regression to significant fixation points in early childhood, from which the symptoms in which the anxiety clothes itself receive their special flavour. These symptoms are often diagnostic of a certain infantile phase, while sometimes they are highly individual and refer to actual traumatic events of that patient's life, yet at other times they are purely symbolic.

It will be observed that I am inclined to take sides with Ernest Jones in the answer to the query, for it seems to me that we are dealing here with a fundamental problem in the causation of psychoneuroses, namely *the source of their endopsychic conflict.* The Freudian School rightly regard the persistence of infantile sexual tendencies in the unconscious as the origin and content of psychopathological states. But they seemed for a long time not to apprehend a very important correlation, viz., the reason for that arrest, the reason for and the drive behind the new adaptations which are said to occur especially at the passing of the Oedipus phase, when the super-ego arises by the identification with one or other of the parents. I refer, of course, *to fear.* Not that fear has not been described from the beginning, but rather that it has perhaps not been correctly valued as a separate and primal instinctive factor in the aetiology of many forms of psychic abnormality. Fear, to me, is the obverse of that elementary craving for dependence and security whose satisfaction is found ultimately in the symbiotic association with the mother—the only guarantee of survival for our species.

It has, in other words, taken the Freudian observers many years to attach due value to the fact that a child begins life completely helpless and dependent, and that it responds with every expression of terror to certain situations which can all be summed up by the term "loss of the mother." Among the most important of these are: loss of the nipple in feeding, prolonged absence of the mother, especially when feeds are due, loneliness in darkness, and withdrawal of support whether in an actual fall or not. To this class must be added sudden loud noises, pressure, threatened suffocation, anger on the part of the mother, and illnesses where the mother is unable to help, to mention but a few of the factors one has actually observed, or which one has laid bare in analysis of cases. These events are the universal experience of human beings, and to a varying degree we are therefore all inoculated with anxiety. It is likely that when they loom large in a patient's phantasies, they are a

screen behind which a deeper lack of love and emotional warmth are hidden.

We may at this point add that *anxiety is seen to be the infantile form of fear,* in so far as the babe is quite unable to give adequate motor expression to its feeling of dread, which consequently overflows mainly into visceral sensations. The useless anxiety component of adult fear is probably due to reactivation of this early feeling under conditions where a purposive adaptation to the stimulus is not possible. We shall find that these matters lie at the root of most anxiety states, which thus have a component reaching back into the dim past; and also that the actual forms the anxiety symptoms take are often direct reanimations of these early manifestations, and only to be explained as such and cured when they are so related back.

It may be said with some justice that the psychic fate of an individual is determined by the resources at his command for allaying this early fundamental dread of loss of the mother as she appears for the infant. If for one of the above-mentioned reasons the individual has been made to suffer excessive anxiety for his self-preservation, and especially if he has felt from the beginning a sense of unwantedness or lack of warmth and affection, or has passed through a prolonged illness as a baby, the first conditions for the development of a psychoneurosis, quite apart from any inherited predisposition, are already fulfilled.[1] The resources which the child may or may not possess must be understood to include his inherited equipment such as general intelligence and temperament, as well as environmental aids in the shape of friendly human figures in later stages of his development. The point is that there is for every individual a degree of insecurity, which, if exceeded, will set certain infantile defence mechanisms in motion.

There is another condition of early childhood which may predispose to an exaggeration of the tendency towards anxiety, and that is spoiling and over-fussing in the handling of the infant, who will then interpret any *relative* withdrawal of attention as loss of love and react with fear. This merely means that the child is accustomed to a higher norm of interest taken in it so that there is

[1] Long after these words were written, Dr. Karin Stephen gave a paper on "Danger Situations Underlying Anxiety" before the Medical Section of the British Psychological Society (June 1938), which seemed to show complete agreement of at least one distinguished psychoanalyst with the views expressed in these pages. Many other Freudians have since followed suit.

really no essential difference between this type of anxiety and the situations we mentioned earlier. This will be the more readily understood if we recall that the fussy, spoiling mother is probably always an ambivalent, insecure parent, sometimes up to the point of "killing by kindness."

The result of these conditions, which usually begin and are established in the first eighteen months of life, will be to emphasize the child's dependence on the mother, to discourage the passing into later phases, and to exaggerate the significance of any conflicts which inevitably arise later in life with agencies and forces inside and outside the mind.

The later psychological fate of the individual will depend upon the nature of subsequent conflicts as well as on the period at which these occur, and I think it is in this sense only that we can use the term "the choice of neurosis," which by these factors is fairly rigidly predetermined. In this and the following chapters it is hoped to convey some outline of the main varieties of abnormal solutions to which the ego is driven in its struggle to protect itself against recurrences of anxiety. This outline, it will be realized, will be the story of various types of psychopathies as reconstructed from their analyses. As is so frequently the case in medicine, we can only understand the various functions and structures involved in a given process after these have broken down under stress or attack, when they reveal that which had so far been successfully hidden.

Anxiety emerges whenever compensations have broken down, quite irrespective of the clinical type to which we may assign the condition of illness which results therefrom. Anxiety disappears under our eyes when new compensations are established—witness the formation of a hysterical conversion symptom, to give a pathological instance, or the effects of a changed ego-ideal and affect-tolerance as the result of treatment.

So far we have spoken of anxiety as a mental phenomenon, as a thing in itself, and we conclude that it constitutes the common denominator, the currency, of all neurosis and of most character traits. We must now pass to a consideration of the structure, or structures, of that large class of psychoneurosis—the *anxiety states,* which include *the phobias.* It need hardly be said that the structure of a neurosis is not identical with the mechanism of any given symptom in that neurosis. It will be difficult to keep the traditional distinctions between hysteria, anxiety states, obsessional

neuroses, and sex perversions clear, as there is every degree of blending and overlap, but when all this is admitted, there still remain good psychopathological grounds, quite apart from descriptive advantages, for regarding these distinctions as justifiable.

At the beginning of our exploration of the neurotic syndromes, it may be useful to focus the reader's mind on the notion that the major forms of psycho-neurosis are merely different ways in which the feeling of infantile anxiety has been countered by various individuals who were hampered in the secure establishment of affective relationships, and to which the individual reverts when for any reason this later and insecure adaptation fails. Disregarding levels of development and confining ourselves to the factor of anxiety-binding, we may say on the basis of clinical experience that

(1) In *hysteria* anxiety is masked by the mechanism of conversion, which enables the contending forces of the conflict to remain interlocked, the patient remaining unconscious of the nature and content of the wishes and needs motivating his symptoms.

(2) In the *obsessional neurosis* the emotion becomes detached from the idea which would arouse anxiety. The idea or a substitute gains expression in consciousness in the form of a compulsion, alien and incomprehensible to the ego.

(3) In the *sex perversions* anxiety is countered by a compulsion to carry out infantile sexual activities in more or less disguised and elaborated form.

(4) In the *phobias* a dangerous inner situation is displaced onto a symbolic outer object or situation.

(5) In the *anxiety state* rejected unconscious impulses are directly countered by a feeling of anxiety—in the absence of the other possibilities.

The anxiety state is thus, in my opinion, the least complicated of the psychoneuroses, which would account both for its frequency and its relatively easier curability. Somewhere, Freud has stated that he regards it as a hopeful step in the treatment of obsessional neuroses to have succeeded in turning the case into an anxiety state. This is some confirmation of my own impression both of the simpler, one might say, more direct, nature of anxiety states as compared with other conditions, and also of the fundamental, underlying rôle of anxiety in the structure of any neurosis.

Anxiety Hysteria

Concerning the structure of an anxiety state, which would be the anxiety hysteria of Freud, views have undergone considerable change since the comfortable days of the Oedipus complex with its *inevitable castration anxiety*. Anxiety hysteria was then the return of the Oedipus conflict with its reactions in consciousness as guilt, anxiety and inferiority to persons who would fulfil the rôle of the parent of the opposite sex, augmented perhaps by sexual disturbances and such symptoms as fears of heights, of falling, of thunder, or even more specific phobias having more narrowly personal symbolic contents. Such cases do undoubtedly occur, and led the Freudian school to a premature generalization which has of late been partly withdrawn. A classical example was the following:

CASE NO. 1. An educated man aged 34, happily married, came for analysis on account of a sense of intolerable anxiety and inferiority in the presence of a certain masterful man who was his superior at work, and whom he could only face after fortifying himself with large doses of bromide. Analysis soon revealed the father-substitute rôle this man was filling in the patient's mind, which other men in similar positions had filled before. The patient's phantasies at the times of meeting with this man were of an oppressive, disgusting awareness of the chief's genitals, or of a kind of shame of his own genitals. Associations led back through a series of memories of sexual interests and incidents, including sisters and animals, and culminated in a number of dreams, of which two are worth quoting: "I am in a garden, picking tomatoes, and suddenly see three Indians, in long white robes, one of whom threatened me with a long sword, saying, 'You and I are after the same thing.' I was put to flight, and when at a safe distance found myself pointing at them with a revolver, which I felt was a superior weapon but which did not go off. I then saw myself digging in a manure heap."

The associations to the dream were as follows: Tomatoes; my favourite fruit, luscious, one can get one's teeth into—breasts—female genitals—sister's or mother's. The Indian (the multiplication is a favourite dream mechanism of emphasis or intensification) suggested (*a*) a childhood scare of black men—associated with stories of thugs and native risings—for years he had lived in fear of a black man suddenly jumping from behind at him; (*b*) child marriage; (*c*) the robes suggested at once his father's old-fashioned nightshirt; (*d*) the sword—produced a sudden visual image of a huge penis. The revolver and flight were explained more indirectly later on as representing the futile attempt to resist his father and the giving in to *force majeure* in this struggle, while the poking about in the manure heap referred to certain regressive excretory interests and vague sexual curiosity which had dominated the patient's emotional life after the Oedipus phase—from 5 to 8 or so.

A second dream, the following night, was of an old man cutting off the patient's penis with a lancet, and it enabled one to interpret the first dream,

and indeed the patient's symptoms, with confidence, even if there had not followed elaborate associations of a scene in which the patient was playing with his mother's breasts, and the angry father burst in, complete in the aforementioned nightshirt, threw him off, proceeded to have coitus, and the patient's screams of rage remained unheeded save for mocking derision on the father's part. Then the patient played his last card and soiled the bed (this is a common and significant expression of hatred and revenge in these early phantasies), with purposeful malice and a feeling of tremendous, uncontrolled anger, and wanted to smash and crush his father and his genitals. This proved a complete fiasco, and was followed by anger and disapproval by both parents, leading to associations of guilt, inferiority and self-pitying remorse. The symptoms were much alleviated after all this had emerged. Historically, this patient's father had been a rough, patriarchal Presbyterian given to much beating, while the patient knows that he was breast-fed until an incredibly late age, and even at the age of 5 was once made to empty the maternal breast which was too well-filled for the needs of a younger child.

The material suggests that in this case there was the following structure of the anxiety state: exaggeration of sexual interest in the mother; exaggeration of fear of the father conflicting with this interest, which, nevertheless, the patient refuses to give up; a sense of defeat and impotence towards father and his substitutes with death and castration wishes towards him that have to be repressed —a persistence of sodomistic phantasies, displacements from the mother, keeping alive the sense of guilt and anxiety before patriarchal men liable to attack him. It need hardly be added how very abbreviated and incomplete this account has been. The purpose was merely to illustrate a case of gross castration anxiety.

Apart from the confirmation of the classical psychopathology of Freud, consideration of such a case opens out, as does nearly every case, some fundamental problems with regard to psychopathology in general, and anxiety in particular. Let us consider, for example, the composite dream-figure of the Indian who, in addition to being a clear father symbol, was at the same time the opposite, namely a wish symbol: the association with child-marriage actually dominated the patient's mind for a time; again, the black man, from previous dreams, the patient connected with ideas of his *own* primitive, animal side. The threat, therefore, is almost as much from his own sexual and aggressive tendencies as from the father.

CASE No. 2. Another patient, with an anxiety state, partly expressed in a stammer, had to convince himself nightly even at the age of 28 that there was not a burglar behind his wardrobe or under the bed. His father, he recalled, had had several fights with burglars. Turning off taps and closing doors were associated anxiety symptoms, and these link in his mind with

fears of being observed in masturbatory and in urethral-erotic practices as a boy, against which he had strong conscious inhibitions.

We are thus led by instances which might be indefinitely multiplied, into the questions: Is it external forces, or internal strivings which cause conflict, in the pathological sense; and in another form: Is it by external agents that these anxieties, leading to conflict, repression and adoption of a new attitude, are caused, or is there a possibility of purely endogenous anxiety, a fear of invasion of the ego by too powerful instinctive forces themselves?

This is manifestly an important problem, because if perchance the reactions in the mind leading to neurosis are the interplay of unconscious tendencies scarcely affected by outside events and influences, but inexorably following their course, as is held by many Freudians and others, then education and prophylaxis are impotent. On the other hand, those that lean to the conditioning school regard the child as a sort of *tabula rasa,* on which events, words and actions of the environment produce impressions. This point of view also has its limitations, in that it pays no respect to the amazingly different reactions on the part of children to what appear identical situations, which must be dependent to some extent on the strength and distribution of native, congenital dispositions, such as placidity, assertiveness or sensuousness, in conformity with endocrine and other factors which as yet are not fully worked out (the economic factor of Freud).

It seems to me that in practice one is constantly meeting with examples of both exogenous and endogenous conflicts. We must not be misled by thinking that the early childhood incidents we are told in the course of free association are invariably facts; neither can we always assign them to the realm of phantasy, as every now and again one gets striking subsequent confirmation of the accuracy of even very early memories. Thus:

CASE No. 3. A man of 40 with a severe anxiety state, taking the form of claustrophobia, a sense of impending disaster and nocturnal attacks of dyspnoea, eventually recovered impressions of lying in a cot, coughing and nearly suffocated, in a condition of helpless anxiety, and at the same time furious with his mother, who stood there unable to help. This associated itself in his mind with all his present symptoms, to his great relief, and as the scene became more fully worked out, additional details, such as a tent over his cot, forcible giving of medicine, etc., made it certain that we were dealing with an actual memory of respiratory illness. It was ascertained that at about eighteen months he had had an attack of broncho-pneumonia.

As I read the case, there resulted a certain pattern of reaction to ideas of "shut-in-ness" and thoracic oppression, which from the concrete are gradually transferred to the abstract by the formation of a phobic displacement-symbol. Just how this happens we can only reconstruct from inner experience and "feeling-into" the associative material of patients.

He lies there, struggling for breath, in a state of terror and distress, unable to give vent to his anger at the way in which his mother treats him and at her evident helplessness. The need for the mother's protection vies with the furious aggressive impulses. The struggle is resolved with the feeling of rejecting the useless longings of dependence which lead nowhere, and a self-assertive rebellious over-compensatory phase replaces it.

The next development in this case is the birth of a younger brother (patient being the eldest), and the family now encouraging him to be the big boy: he is not only the eldest son of his father, but the eldest among all his cousins. He is very proud and independent, extremely intolerant of correction, but always ready to side with authority against his younger brothers and cousins, whom he bullies and leads. Sitting in church, with dim lights and Gothic arches (representing to him the bronchitis tent), he gets an attack of anxiety at the age of 7. This is a mixture of the reaction to having to sit still and the reanimation of the original pattern. This memory provides an excellent illustration of the merging of the two themes. He does well at school and becomes the typical prefect. His next attack of anxiety is as a freshman at 'varsity, where he is suddenly "nobody." In a lecture room in an ancient building, another claustrophobia, with extreme restlessness, occurs. "He cannot stick the confinement, etc." He avoids lectures or has to sit next to the door or gangway. The War gives plenty of scope for his assertive qualities—he becomes a battalion commander, and is decorated at a very early age. No trouble until demobilization when he again finds himself a nobody. A distinguished career in colonial administration follows, again with plenty of outlet for his need to be the boss, but he cannot agree to government policy, and resigns on "principle"—the powers that be are too liberal. He is the typical "die-hard." He comes home and lives in a little suburban house and decides to take up a new profession, starting once again as a novice. This leads to his severest attack of all—so severe that he is driven to try "this damned psychology stuff."

One could cite many almost identical cases, in which there is this strong power psychology masking an underlying sense of insecurity, in which the type of anxiety is quite different from that seen in the "Oedipal" cases, being much "earlier," more infantile, in character. The case has been quoted in some detail because it illustrates better than any general remarks the structure of the neurosis. Let us say at once that in this case there also were castration phantasies: thus this man had dreams of being the neophyte

in a ritual in which white-robed priests were slitting open his abdomen, and he also had dreams of having his throat cut across, and of a little green man pursuing him and tearing out his heart. Apart from the profound symbolic interest which these images held, however, and which were accompanied by masochistic feeling, there was very little, if any, link between these ideas and the general content of his neurosis. I have purposely mentioned *this* case, because it *did* have some castration symbolism, which has also occurred in others, while some of these people with a power-security problem have shown no clearer fear of castration than phobias of falling from heights or of being attacked.

And this is precisely the point we started to elaborate a little earlier when I said that we could no longer make anxiety states synonymous with castration complexes. In this connection the psychoanalysts have stretched the meaning of terms until castration fear has come to mean almost *any* fear of punishment or loss of love, which has no sexual significance whatever. Whence, then, the castration symbolism in our last-mentioned case?

There is no anxiety state I have ever seen, and no other psychoneurotic except perhaps one, who has not on analysis also shown some traces of disturbed sex-life. It is wise here to take up a position different from the old Freudian one, but possibly nearer to their more modern standpoint, one, moreover, which does not fail to include the tenets of Individual Psychology as I read them. To appreciate this point of view we must have experienced early childhood feelings and emotions in analysis. Human instinctual trends are, as we will agree, very much despecialized, very fluid and adaptable. The notion of owning, disposing of, loving and dominating mother are all bound up with the notion of penis, trampling on her, micturating over her, in general being able to do what one likes with her—and among the things one likes doing best are such things as passing water in a fine stream, or more lovingly, dissolvingly, relaxing one's sphincters, but also pressing one's penis close to her body—or into her navel (these are very common images). These activities, in my experience, are exceedingly difficult to press neatly into stages of development, with the proviso, that they are certainly different in feeling from the oral stage of development, which is much more distinct. They are characterized by a sense of thrust, of some sort of attack, and it is for this reason, perhaps, that in the phantasies of people all forms of the exercise of power

and domination tend to be linked with sexual images, even in women.

CASE No. 4. As an illustration of the fusion and blending of feelings of sex, dependence and power in a child, we may take the associations of a man with anxiety hysteria who, during a crucial stage of analysis, imagined himself in his cot pressing lovingly close to mother's body and squeezing his own penis. Mother comes and finds him, he is angry and furious when she stops him, calling him a dirty little boy. She now tries to comfort and soothe him—that makes him feel very pleasant as though being overpowered (note the masochistic passive feeling) and so he turns away and kicks and struggles, intending for his mother to " woo " him all the harder—but she fails to understand this, and thrusts him away—" get away then, you nasty little demon." Now he has the feelings which are to dominate all his life—of fear and anxiety at being abandoned and cast out; but he is still furious and seems to form the idea of " all right, then—I'll show you I can do without you," still in the demonstrative, pathetic sense of thereby compelling his mother to win him back.

Outwardly he thus became at that stage a rebel—which condition lasted until the age of 6, when he attacked his mother with a knife, and became so terrified that he would lose her altogether that he now finally repressed his aggression. He becomes good and holy—indeed a missionary—while his power drive becomes partly absorbed into the ego-ideal of being a great power of love and religion, and partly remains as an infantile querulousness and temper, i.e. a symptom. The whole life of this man was dominated by a wish to be great and important, yet without any ability to assert himself; ridden with anxiety; dreading insanity—which was the fear of losing control and killing mother; tortured by giddiness, almost a conversion symptom, but technically an anxiety symptom related to fear of falling from heights, etc., which he linked to his early efforts at walking. He was alone with mother—" my walks were a private matter "—feeling very strong and confident—when his uncle walked in. The latter was amused, and thoroughly put the patient off his stroke—" he wanted me to fall "—his attention faltered, he reeled and fell. Now he felt that his uncle had seen he wasn't a man. He cried with rage; his uncle said, " Cry-baby," his mother comforted him, saying it had all been Uncle Charlie's fault, but secretly he knew he had been afraid and felt ashamed at not being a man. This threatened his phantasy of being the strong little man who monopolized mother.

Is this, or is this not, castration? It does not matter—if we can feel ourselves into these conflicts, and not take their imagery as the sole criterion of their meaning. They are certainly sometimes as much concerned with significance and power in a general sense as with sex, because these are not separate compartments, but dynamic, interpenetrating trends. What seems essential is that the anxiety reaction may be evoked at different stages in develop-

ment, and being itself an expression of the tendency to *self*-preservation, not of *genital*-preservation only, it is the reply to *any* form of excessive emotional stimulus in the child.

It is manifestly in the thwarting of all "dangerous" impulses, whether in connection with a sexually toned wish or not, that the crux of anxiety states lies. This relative strength of impulses and the level of development are chiefly of importance in determining the *degree of power at the ego's command to deal with pressure from the instinctive tendencies,* and so to avoid the recurrence of the dreaded anxiety response. For a fuller appreciation of this statement we must wait until after we have dealt with all the psychoneurotic conditions, because therein lies their chief distinction, and especially that between anxiety hysteria and the obsessional neurosis.

The sriking thing about the "ego-ideal," or if we care to call it so, the "fictive goal" of Adler, in anxiety hysteria is that it is often one of omnipotence in one form or another, but always in a guise in which it is acceptable to one or other of the parents. Freud describes a number of permutations and combinations in which the Oedipus situation with its castration anxiety may be resolved through the formation of the ego-ideal or super-ego, arrived at by introjection of, or identification with, either or both parents, depending on various circumstances obtaining at that important phase in the life of the individual. Indeed the analysis of this nuclear experience is one of the most important in the treatment of neurosis, especially if it is complicated by partial identifications with other significant people in the life of the child, which may precede or succeed the central event. In analysis the genesis of the ego-ideal is often brought up as the climax or culmination—sometimes as the anti-climax—of some experience of great emotional intensity, and occasionally this development seems less determined by actual threats or influences of adults at the time, as by the general trends and atmosphere prevailing around the child, which he had previously absorbed by identification and which now crystallize as a permanent attitude towards himself, towards the offending impulses and feelings, and towards his world. The period at which the ego-ideal is formed seems to vary considerably, but is mostly between three and five years. In the case of anxiety states, I have found this to be so—always with the proviso that we are dealing with the patients' estimates of their age at the

time of significant episodes, but verified to some extent by what is learnt through child-study and analysis.

W. R. D. Fairbairn[1] has lately put forward some ideas which throw light on the relationship between repressed impulse and introjection of significant persons. According to his views, still in process of verification and by no means orthodox, impulse can never be considered apart from the object towards which it is directed. Repression, therefore, is not directed at mere impulses, but at *relationships*. He views personality structure in terms of such repressed or introjected relationships which function as "partial egos." Not only the super-ego (already conceded to be such a dynamic internalized structure), but the underlying forces of a conflict are viewed as split-off, dissociated portions of a primary basic unit of psychic organisation, which Fairbairn calls the "Central Ego," and which represses these subsidiary egos, because they seek relationship with unattainable or bad objects, themselves repressed also.

Though at the time when the cases, which form the clinical material of this book, were analysed, these concepts had not been published, there is much that is interesting and illuminating in Fairbairn's views. An attempt could well be made to re-discuss the material in his terms, here only hinted at.

We have, then, a patient feeling himself barred from giving expression to a strong assertive impulse (e.g., "I want to smash Father," or "I want to struggle free") by reason of its conflict with fear and anxiety, leading most often to a sense of impotence and inferiority. The child is at an impasse, at the end of his resources—this sort of thing cannot go on. Anxiety for continued approval, fear of actual punishment, the need for coming to terms with the world, and the sense of uselessness and ineffectiveness of his wishes in varying proportion and combination motivate the taking over of the parental attitude. In the simplest case this results in the wish to be approved of, with repression of the entire conflict. More often elements of the original impulse are incorporated into the ego-ideal as phantasies of greatness, success or perfection, but modified through the action of identification into a pattern conforming to the parental standard. The demand is not always "you must be a good little boy," it is as often "you are a big boy now

[1] "Endopsychic Structure Considered in Terms of Object Relationships," *Int. J. Psycho-Anal.*, xxii, 1944, p. 1, *et seq.*

and we want you to be sensible and clever,you cannot have mummy doing everything for you."

Often the child adopts an ego-ideal, contrasting strongly with the accomplishments of those who thwart it, even in opposition to its own nature, so frequently resembling that of the parents.

CASE No. 5. A girl of distinctly emotional-intuitive temperament, under the stress of an Oedipus situation, adopts the ego-ideal of being sensible, rational and aloof—never wanting anything or minding about anything, never showing any feeling, after a scene in which she has been feeling active sexual excitement and love while her father was playing with her. The mother, who is jealous, comes in and stops all the fun, the child gets furious, mother shakes her and paralyses her with fear. The symptoms emerge just in that form when she falls in love: a sense of maddening inadequacy, haughty, contrary, forbidding behaviour in the presence of the man; and paralysed, frozen horror at his least advance completely ruin the relationship, while at night she gets dreams of a ghost who freezes her up.

In the deepest layer of this girl's conflict we found a repressed love-wish for the mother, which, unsatisfied there, was transferred in exaggerated form to the father with very strong hostility towards the mother. The ego-ideal was motivated from fear of the mother, fear of the sex feelings she had which only found representation as a sort of "horrid thrill"; from fear of her own wishes to love and to yield herself, all repressed by the attitude, "I am big and sensible, and ask for nothing. Look! my whole life shows I am not making a fuss, I don't even know how to accept love." The hostile element was represented by "Look what you have done to me, abject and miserable that I am," and the mother-identification made her look upon herself really in that light, hating herself, as it were, through her mother's eyes, while the conflict continued its subterranean existence at the same level of development at which the repression took place.

The outbreak of symptoms may occur, therefore, in situations which recall the nuclear experience or in which emotions or impulses like the one repressed are stimulated. Such situations we would call "precipitating causes" of the neurosis. Precipitating causes may play the chief part in war situations in which even outwardly well-adjusted persons are subjected to a degree of anxiety capable of overwhelming stable defences, which would be more than adequate for ordinary living. This tells us that there are certain quantitative limits to human capacity to ward off the return of the repressed.

We can now face the problem as to whether rage or sexual emotion is directly transformed into anxiety armed with some knowledge of the structures and forces involved in anxiety hysteria. We see that certain situations in life threaten the precious ego-ideal of the neurotic, and so anxiety develops. This, of course, sounds like Adlerian teaching; yet, looked at from a deeper point of view, it is the censor, the signal from the super-ego, which precipitates anxiety. "If I give way to such feelings terrible consequences will happen," or "if I am placed in such a position of unimportance, I shall perish."

At this point it becomes essential to clarify our use of the psychoanalytic terms and concepts of the "ego-ideal," the "super-ego," and such notions as Adler's "guiding fiction" or "fictive goal." Freud originally (in *The Ego and the Id*) did not distinguish the two former notions, but appplied them as synonyms to the endopsychic institution created by the introjection of one or both the parents, and henceforth destined to function as the censor of instinct excitations as between the id proper and the conscious ego, in short, as a "moral principle." The relationships between the ego and this new inner authority would thus be based on the originally external relations that the child felt existed between itself and its parents for the sake of whose approval some instinctual demands on these same parents had to be repressed.

It soon became clear, however, that a distinction had to be made as between a conscious "regulative principle" (Roback) of a social-ethical sort which we accept as our standard of conduct and as a worth-while norm of personal achievement, and the blind, unconscious "categorical imperative" which institutes and maintains the processes of repression and other "automatic" mechanisms by which the personality defends itself against the emergence of its crude archaic drives. It is to the former that I like to apply the term of "ego-ideal," whereas to the latter I give the name of the "super-ego." In people free from any marked neurotic conflicts it seems as if the original tyrannical super-ego gradually dissolved, making way for a reasonable ego-ideal modifiable by experience and by the assimilation of later values derived from the example of admired personalities or qualities. In the neurotic, on the other hand, it is difficult to differentiate between the conscious ego-ideal and the unconscious super-ego. It is as if the ego-ideal were but a puppet of the hidden tyrant, cravenly doing his bidding, and incapable of

modification. Such an individual can never cease from striving to play a rôle of which the parents of his childhood would approve, perhaps in complete contrast to his real instinctual needs and endowments.

The degree to which such a morbidly persistent super ego is consciously perceived by patients is very variable, and this may have led Hadfield to solve the terminological problem by subsuming both the wholly unconscious censoring super-ego and its representative in the ego under the title of "the false ego-ideal," while Adler, who claimed not to recognize distinctions between conscious and unconscious, and who was struck by the theatrical aspect of the phantastic element of such ego-ideals, called them "the fictive goal." What Adler failed to make clear was the grim unconscious necessity of psychic reality that had forced a child into this mental strait-jacket.

Further points in relation to the origin and nature of the super-ego and its derivative functions in the conscious will emerge in the succeeding chapters. Here we will only say that in our view the anxiety situations which lead to the formation of a severe super-ego do not seem to be solely determined by conflict over sexual impulses, but can be equally, and even more unfortunately, aroused by aggressive feelings linked to the Oedipus situation in varying degrees of clearness, but always involving object-relations.

We can verify again and again the reluctance of the pathological ego-ideal to yield, its utter intolerance of certain emotions as forming part of the self, the way in which the individual clings tenaciously to a certain view of himself, very often an excellent view, but motivated through fear, sustained by distortions of power wishes and hostility, which at the time of its formation seemed the only guarantee and promise of continued worth in the world. That it is also capable of giving some secret satisfaction to the particular instinctual demands it is meant to ward off, is a point which will be elaborated in Chapter IV.

Our picture of the structure of an anxiety state, as here outlined, I am becoming more and more convinced, is valid also in respect of other psychoneuroses, and in what follows we shall have occasion to refer back to these findings.

CHAPTER III

SPECIAL FORMS OF ANXIETY SYMPTOMS

PHOBIAS

THE picture of anxiety states would not be complete without some further study of the forms which the symptoms may assume in more specialized cases.

We have already seen that the situation provoking anxiety may be highly specific—e.g., in the man who feared certain types of patriarchal figures, or in the girl who only developed anxiety in circumstances of flirting. We are, however, aware that anxiety may take very different paths of expression from these, and may present itself in the shape of purely physical distress, which in the above-mentioned types was not at all marked. I have already alluded to the *physiological effects* of adrenal and sympathetic excitation, and this fact will help to explain the genesis of the many circulatory, gastro-intestinal and other symptoms which may form the entire content of an anxiety state on first examination, but to which the patient may attach symbolic significance in addition.

The psychological aspect of the matter lies, briefly, in the use which the patient makes of the mechanism of displacement either in order to divert his attention from the real conflict or because he is unaware of the true source of his symptom. He thus fits the anxiety into a definite and quasi-intelligible channel.

CASE No. 6. A man of 34 was suffering from a form of cardio-respiratory distress of the effort syndrome type which began as follows: He had a strong over-compensation to a sense of inferiority towards his father and brother, in a phantasy of masculine perfection, originating rather like that of Case 4. After the War he found himself resuming his studies among a crowd of young men, many of whom did much better than himself. One day he had a piece of test-work rejected by his professor. On the same day he was told he would not do for the Rugger team, after strenuous passing and sprinting practice, which tried him. He is disgusted with himself, and in despair buys a cigar to which he is not accustomed. Arriving home, still smoking his cigar, he feels dizzy and has palpitations. He faints, his mother fusses round him, and he is conscious of the thought, " I wonder if this heart trouble will put an end to my career." Well, it did.

We learn from this case the fact that physical symptoms, in themselves merely the somatic expression of "nervous tension," may become *reconstellated* to serve the ends of the patient's neurosis, which was based on the fear of the breakdown of his ego-ideal, yet also enabling him to retire "with honour" from the competition into a regression to dependence he had never inwardly relinquished. At this end of the scale the anxiety symptom merges into the hysterical conversion symptom, distinguished, however, by the fact of anxiety being present or very near the surface.

"Neurasthenia"

There is no doubt that such a patient as the one just described would until recently have received Beard's label "neurasthenic" at the hands of the medical profession. Neurasthenia is a conception which has done much to confuse aetiological thinking in regard to the anxiety states with a predominantly somatic expression, for the term connotes obviously an obscure nutritional or perhaps electro-chemical change in nerve tissues, in consequence of which the patient is supposed to have no energy for his ordinary activities in life. If "neurasthenia" were used knowingly, as a convenient label, no great harm would result, but the implication that a real diagnosis has been achieved when this label has been attached perpetuates the error of physical therapy for cases which most often fall into the group of anxiety hysteria. In this respect the most misleading are patients who feel themselves to be "without energy," and their symptom is then apt to be taken at its face value. The psychopathology of a typical case will, I hope, make clear my point.

Case No. 7. A skilled artisan, aged 46, employed by a large public authority, was admitted for treatment complaining of severe lack of energy, abnormal fatigue after the least exertion, aches and pains in his body, pressure feelings in his head and a host of other symptoms typical of "neurasthenia." He was a valetudinarian, an abstainer from all good things—even marital intercourse—"in case it weakened him." The condition, which had lasted some months, had necessitated sick-leave, and had been ushered in by a "fainting attack" while at work. He had had three previous attacks; the first one at 36, when patient had been, in the course of duty, hit on the head by a falling branch. In each case there had been long periods, up to six months, of sick-leave.

On the physical side, the only findings were a low blood-pressure and a raised leucocyte count, for which "toxaemia" due to tonsillar sepsis was blamed. The patient attributed his troubles to over-work and conscientiousness. He was now threatened with compulsory retirement.

As an experiment, the tonsils were left alone, and analytical treatment given. Briefly, the following story emerged.

The patient had been very ambitious and successful, and was pleased with himself to the point of conceit. On each occasion when he developed "neurasthenia" he had been in emotional difficulties, chiefly through conflict with his superiors.

Although the original injury by the branch had been trifling, yet the headache he had each time was located over the site of this blow.

As a child he had been extremely backward and had been for that reason regarded as the disgrace of the large working-class family to which he belonged. The present attack occurred as the result of a severe—and apparently unjust—reprimand by a superior when the patient was already distraught by a number of domestic misfortunes. Following on the "row" he recalled leaving his office in a state of intense excitement. At this point of his narrative we stumbled upon a complete amnesia covering some hours, for his next memory was of being delivered at his front door—some 10 miles away, by a friendly lorry-driver. Under hypnosis the patient reassociated and abreacted violent emotions of distress, crying, "Mummy, mummy!" and was able to relate that he had broken down by the roadside in a paroxysm of thwarted rage and self-pity. In this condition he was at last picked up by his friend. He was ordered by the analyst to remember this scene on waking. At the following visit he reported himself cured. He resumed work almost at once, and had no further recurrences up to 8 years later.

Further analysis of the emotions produced revealed that they were concerned with dread of his brutal and drunken father, whose punishments were recalled very vividly. At first he hid behind his mother, but later he became ashamed of his dependence on her, repressed his fear and over-compensated by adopting an attitude of self-assertion and independence. Determined to "outdo them all," he left home very early, and up to a point achieved his purpose. He became his mother's only support and realized this was done to excel his father. He also saw that his superiors had been for him father figures, so that his reaction to them was *a priori* one of resentment and rebellion. Any situation in which he was blamed or criticized was associated with so much distress because he had to combat the old anxiety which was thus being evoked. When repression failed, he resorted to the more violent mechanism of dissociation. The traumatic effect of the falling branch was conditioned by a childhood experience when he narrowly missed being killed in a quarry.

Here, then, was a very typical case of "traumatic neurosis," a "neurasthenic," very common in industrial medicine; it turned out to have the structure of an anxiety hysteria, with a history of a psychologically traumatic Oedipus phase of great severity if we appproach it from the angle of Freud, or an inferiority complex with over-compensation from the view-point of Adler. The most significant conflict of feelings was between rage and anxiety. A marked secondary gain motive was present, of importance in the

assessment of most industrial cases, in this case mostly concerned with resentment—blaming his authorities, for whom he had laboured so devotedly and without due recognition of his merit, for his illness: they, again, were symbols of his cruel father.

The interest of this case, apart from the amnesia which will be referred to in a later chapter, lies in the problem of the mechanism of psychogenic fatigue-sense.

We referred earlier on to the possibility that the exhaustion which follows a prolonged state of emotional excitation may be due to a temporary fall in the blood-adrenalin, with all that this implies. From the facts of this case, however, it would seem much more likely that the lack of energy and the easily induced fatigue were due to a damming-up of the flow of energy proper to the aggressive instinct, owing to repression and dissociation, so that the stimulus connecting this function (presumably localized in the hypothalamus) with the sympathetic-adrenal mechanism was not working until released from its inhibition, when it was reinstated practically at once.

There is, however, another consideration which seems relevant to the discussion of lack of energy. The patient who displays this symptom usually finds no difficulty in maintaining the utmost vigour and concentration when talking about, or brooding, on his sensations or bodily functions—to the point of exhausting his doctors. In other words, there is, as suggested by psychoanalysts, a withdrawal of energy-investment from the objective world, and an increase in ego-cathexis, i.e. a regression to narcissism. While, no doubt, part of this can be credited to the hysterical motive of wishing to be the self-sacrificing martyr, who works on in spite of his handicap (the sort of thing that Adler would emphasize), part at least is due to a regressive reanimation of infantile anxiety, in our view inherent in the instinct of self-preservation and dependence. In those who receive severe physical injuries, this ego-cathexis is able to find an outlet to the damaged part of the body; moreover, there is in such cases enough " mothering " in the genuine sympathy and medical attention which is bestowed to satisfy its demands. They have, therefore, less need for that indeterminate, generalized regression to narcissism which characterizes the anxiety hysteric of this type.

It may be objected that the case just described is not typical of the true neurasthenia of Freud, which with the true " anxiety neurosis "

(which is, as it were, the opposite pole to neurasthenia) he originally described as "actual-neuroses," possessing no psychopathology, hence as not being amenable to psychotherapy.

This error in Freudian theory has been corrected lately, but the attribution of the neurasthenic syndrome to excessive masturbation is still to be found in Fenichel's textbook of recent date. Presumably, in granting that masturbation in adults was a symptom that all was not well with the personality, the psychoanalysts had to admit that neurasthenia *had* a psychopathology. But there does not seem to be much evidence that masturbation is an important cause of the neurasthenic feeling: thus in a number of patients, who suffer from sexual perversions bordering on schizophrenic states, one finds extremely frequent masturbation, e.g., once or twice a day over a period of fifteen years. One such especially, during analysis, acquired a very great access of physical and mental energy with the liberation of a conflict over agression in childhood, whereas his sexual practices were left as yet unaltered. In contrast, one recalls a man of fifty, who had the typical exhaustion syndrome, in whom the sex-life consisted of narcissism in the literal sense of looking in the mirror, but without sexual relief, which he was careful to avoid. At any rate, psychoanalysis appears to have abandoned the essentially chemical theory of toxic products of sexual activity, to account for both of the so-called "actual neuroses." These entities, one feels sure, will presently disappear and become merged in the great moiety of anxiety states.

It might be well, however, to devote a little attention to the organic aspects of exhaustion. The patient in Case No. 7 had admittedly bad tonsils, and even a leucocytosis. Contrary to the expectations of some hopeful animists, these tonsils did not settle down in a clinical sense, although they were powerless to induce fatigue. It would seem possible, as in numberless cases of Graves's Disease, that an infection may act in much the same way as a chronic unsolved emotional conflict, i.e., by calling upon the defence mechanism of the adrenal and its sympathetic connections. It is significant that a very high proportion of anxiety patients who are seen at the Tavistock Clinic have a high and/or abnormal type of blood-sugar curve (as determined by Dr. J. Fine).

The rapid improvement which may follow the removal of a toxic focus makes it likely that some of the exhaustion sense may be produced by peripheral irritation rather than by true poisoning

(Crookshank's view); this must certainly be taken to account for the cures obtained by dealing with uninfected impacted wisdom-teeth, or with previously undiscovered errors of refraction. There would be, in all these cases, a "subliminal" attention (analogous to the conscious experience of a raspberry pip between the teeth which may entirely ruin a concert or a lecture for us), draining away energy from other cathexes, as if the organism was intent on removing the foreign or noxious matter—which seems biologically sound: "All hands to the pump," as it were. This might, indeed, be the reason for the picture of "debility" resulting from prolonged illness, especially of an infectious nature.

Another mechanism involved in such "detoxication" cures must not be forgotten. It is seen in the thirst for operations which some neurotics display. The rationale is to be found in the satisfaction of an unconscious sense of guilt. The guilt may be related to the presence of a repressed "bad object" which is forbiddenly cherished, but which is sacrificed symbolically in the removal of some part of their anatomy. The surgeon thus saves them the pain of continued self-punishment. The "bad object" is removed, the "castration" is suffered and the individual permits himself to feel well again—for a time.

Where the exhaustion state continues well beyond the normal duration of convalescence for a given illness, we should become suspicious of secondary psychological factors and have to ask ourselves: What unconscious motives are keeping this patient in a state of invalidism? Why does he need to remain narcissistic? Whom does he wish to dominate, or whom compel to solicitude? Sometimes it must be granted, a real and long-continued fear of death may be directly responsible for a "perseveration-neurosis," with much regression to the level of dependence and unconscious craving for maternal protection.

One has to agree with those observers who see in the anxiety states a direct challenge to the instinct of self-preservation, a response to any threat of obliteration. The ego, itself normal, may be threatened by disease or danger from the outside; or by forces from its own unconscious, which are too strong for it (as, for example, in the tragedies of modern industrial monotony, in which there is a conflict between the need for self-expression and the need for economic security).

Nevertheless, in the majority of cases that come to the medical

psychologist, the ego-development itself is abnormal, and intolerant of a degree of instinctual pressure such as would in a normal person lead to some positive step in the world of reality to try and redress the balance. A precarious and false security has been attained by the adoption of an ego-ideal of power and superiority, to surrender which would be to such a person equivalent to obliteration. Examples of this adaptation we met with in Cases Nos. 3 and 6. Such patients are afraid of fear itself, or of the betrayal of weakness, inferiority or dependence. Thus, a patient who had for some years occupied an important position in colonial administration, was "axed" through no fault of his own, and had to accept a very small post in England. He developed acute claustrophobia almost immediately, having his first attack when lunching in a common refectory "with a lot of little clerks and typists." His symptoms disappeared on interpreting the nature of his ego-ideal of false self-inflation, after two talks.

It is just in this type of case, too, that we so constantly meet with *the fear of heights*, whether as a phobia of waking life or merely in dream form. Here we are dealing with a variant of the anxiety response which has acquired some symbolic revaluation. In the analysis of the symptom, which may prove quite difficult, patients will generally produce early childhood situations of insecurity, of actual danger of falling, as well as associations which prove the phobia to be a metaphoric way of expressing their fear of "coming off the pedestal"; additionally it may also signify "falling" in the moral sense. One case must serve as an example of what is my frequent experience.

CASE No. 8. A divorced woman in the late thirties complained of active homosexuality, fear of speed and fear of heights. The genesis of the neurosis lay in the relation to the mother who under-valued her female child and lavished all attention on the son and heir born two or three years later, whom the patient envied and despised. The patient from earliest times was encouraged to behave and dress as a boy—her usual attire at the age of 5 and upwards was the full-dress uniform of the Grenadier Guards.

The child's attempts at making love advances to her mother were repulsed, and there were scenes in which the patient saw herself blindly furious, wanting to kill her mother. This proved to be the emotion responsible for the fear of speed, which disappeared on realization of this connection.

The fear of heights was traced backwards to an occasion at 5 or 6, when the mother made the little girl mount a large, fierce bull on their estate in front of a group of visitors, and ride round the paddock. When the child hesitated, the mother said, "What! I won't have any child of mine a

coward!" The feelings of the patient while sitting on the bull need no description, but are of interest as showing the fusion of ordinary fear of being perched on this fierce brute's bare back with the anxiety of not losing her mother's esteem—which later accounted for her "masculine" power pyschology and various daring homosexual adventures.

Into this pattern there constantly intruded fears, also implanted by mother, that the patient was delicate and not up to the mark, needing special care. The patient's compensation for lovelessness had been mainly sexual ones, derivations of early masturbation, and she used to "go the pace" with money, cars, and male and female lovers. A few years ago she developed an acute illness, and during her convalescence, partly under the impulsion of these fears, but partly, I think, as the result of sheer growth, she turned over a new leaf, and decided she would do something useful and stop her riotous living. It is from this time only that she had her symptom of fear of heights. She very quickly saw its further symbolic significance, and it proved, in addition to the meanings we have already mentioned, to stand for moral fall, i.e. the symptom had a defensive value against her earlier mode of life. Her greatest fear was of walking down a steep path, and on being on top of ladders, the sexual import of which she realized.

This phobia is, incidentally, an example of what is called *over-determination* of a symptom or a symbol, which is one of the most troublesome things in psychopathology. It is a special instance of the mechanism of condensation.

Phobias

In assigning the phobias to a special sub-division of anxiety states, one is moved by clinical rather than psychopathological considerations. The specificity of the fear-arousing situation or object excepted, the state into which the patient is thrown by the stimulus is very similar to the other anxiety states. The anxiety, moreover, tends gradually to invade further territories only loosely connected with the original actiology, as we saw, for example, in Case No. 7.

If from the anxiety states we subtract all the varieties of phobias, then there remain only the so-called organ-neuroses, i.e. those states (e.g., Case No. 6) where an organic sensation, originally a "somatic resonance" of anxiety, has been elevated into the illness itself, surrounded by a fringe of fear based on what the patient may know of anatomy and medicine. It is permissible to call even such anxiety reactions as impotence, or self-consciousness before strangers, phobias, in so far as here, too, the anxiety is aroused by a specific situation.

It is perhaps mostly through usage that we are limiting the name to a number of somewhat stereotyped clinical pictures, the notable ones being (*a*) phobias of situation (e.g., claustro-, agora-, nycto-phobia); (*b*) phobias of objects (e.g., of people, animals and insects, dirt, etc.); (*c*) phobias of subjective conations (e.g., of uttering obscene words, of injuring others, etc.). As it appears to me, these three types of phobias have significantly different structures and are concerned with different, or at least differently complex or mature, forces in the unconscious. One might almost say that these three divisions are, in miniature, a reflection of the three main psychoneuroses. Type (*a*) corresponds to the anxiety state proper; type (*b*) to hysteria; while type (*c*) undoubtedly has close affinities with the obsessional and depressive states.

The phobia, then, does not seem to be a unitary conception, but a purely superficial label for a variety of syndromes, based on certain resemblances. In content, instinctive drive and defence mechanism, age-level of the instinct involved, as well as in prognosis, what is there in common between, let is say, the mouse phobia of an engaged girl and the fear of strangling his wife in a man of thirty-five?

Of the first type, fairly representative examples have already been discussed under Cases Nos. 3 and 8—the man who feared to be in Gothic buildings, and the woman who dreaded speed and heights. With the hysterical phobia we shall be dealing shortly, while the obsessional type of phobia will be dealt with in Chapter IV.

It is, however, interesting to observe, at the risk of contradicting what has just been said, that a number of phobias in my experience, especially in women, tend to be exceedingly complex in their structure, so as to occupy a truly intermediate or intersecting position between all three conditions. In these conditions, as in certain character-developments and in some of the sexual abnormalities, it is especially helpful to bear in mind Glover's conception of classification[1] in terms of early nuclear "themes" and fixation points, according to which a given disorder, while belonging predominantly to a certain phase of development, may draw on earlier as well as later clusters of motive and mechanism, thus giving rise to a "mixed" psychopathology. So far as the "anxiety" phobias

[1] GLOVER, E., "A Psycho-analytic Approach to the Classification of Mental Disorders," *J. Ment. Sci.*, vol. lxxviii, No. 323, Oct. 1932, p. 819.

(or type (*a*)) are concerned, this appears to be particularly relevant, and perhaps some clinical examples will best illustrate this idea of intersection with several of the neuroses.

CASE No. 9. A woman aged 35, wife of a professional man and mother of several children, came for analysis on account of a very severe phobia of being alone in the open, out of sight of houses and people. Additionally, she was sexually frigid and had frequency of micturition without organic cause. She was very neat and tidy, prim and "lady-like," yet a communist and a pacifist in her politics.

Her history was that she was the younger of two sisters, and had been expected to be a boy by parents who were always living apart as long as she could remember. The mother was powerful in character, elegant, independent, and made up for her narcissistic lack of real interest in her children by financial lavishness. She taught her daughter to despise the gentle, ineffective father, who, moreover, was "in trade" and so of no social value either. The child, who was passionately devoted to this beautiful mother, was sent from pillar to post and never had a home; only memories of kind relatives here and there.

At 7 to 9 years of age the patient recalls having passed through a phase of indulging in sexually coloured beating games, with children as well as maids, and twice she was caught doing so. Then followed a phase of intense religious fervour and cant during her stay in a convent school where shrouds were worn for bathing. It was soon after puberty that she had transient symptoms of claustrophobia, and remembers an episode of intense (heterosexual) erotic excitement which she suppressed with all her might.

After leaving school, she became apparently of more interest to her mother, who now joined up with her. After a period of living together, during which the patient's identification with the "blonde beast" ideal of her mother was further strengthened, she became engaged, with very strong re-animation of lurid sexual phantasies. Unfortunately the marriage proved sexually disappointing, whether by comparison with phantasy, or because she had married a very gentle and at that time somewhat anxious man. She had no genital satisfaction, and in other respects also she felt isolated on account of the remoteness of her husband's professional life and his mildly asocial tendencies.

About eight years after marriage, during which she had remained frigid, but a dutiful wife and mother, she happened to be travelling in a train, occupied with day-dreams of a pleasant day away from the monotony of home-life, when she was seized with a violent claustrophobia. This formed both the starting-point of her increasing disability, and of the analytical investigation which revealed the following sequence, greatly condensed here.

The patient was really frightened at phantasies of navvies and "cave-men" which were associated with leaving the shelter of her home and violently sexual-masochistic in content. From this the analysis led back to the beating games in childhood, and the emergence of anal (buttock) erotism as being more attractive than genital approaches, as well as severe guilt, with

identification with her mother's reproaches when discovered: no lady ever was coarse or vulgar.

Presently, the buttocks were associated with biting into peaches, and so a link was made with oral pleasures, which, however, could not be taken further at this stage. It also emerged that she could experience orgasm if *surprised,* e.g., in sleep. This related back to the inability to "let herself go," in contrast to the pleasant idea of being taken or carried off by force—like the relentless motion of a non-stop train, where one was in someone else's power and so could be free from guilt and responsibility for one's sexuality.

So far, then, there is a marked genital, so to speak, hysterical element in the picture, but with a very obvious pre-genital, anal nucleus which, as we shall see, was an essential link in the chain.

Apart from an episode at puberty when she wetted herself involuntarily before a boy she was in love with, there now emerged memories of early phantasies, between 5 and 6. During this time she stayed with an uncle and aunt in an old-fashioned house with an out-door lavatory at the end of a narrow alley-way. She recalled desperate curiosity and coitus phantasies about them, when she imagined uncle using much force, and the image of a broom-stick (cf. folk-lore) moving up and down was persistently in her mind, and realized as her conception of his penis. Then she remembered the fascinated terror she felt for an old friend of the family who had a sword concealed in a walking-stick. Then of a friend's father who used to beat his little girl with a stick. The patient wanted to be beaten and tied up but make a show as if to resist. She saw that these were her ideas of coitus, linking up with cave-men of her recent day-dreams which so terrified her.

At her uncle's house she used to retire to the little shut-away lavatory to indulge undisturbedly her phantasies of parental coitus, and realized that the shut-in condition, like that of being held tight, was pleasurable as well as terrifying.

After this phase of the analysis, which brought some relief but not much, the patient became more aggressive in transference, to her great surprise. It was at this point that she was able to produce early oral-aggressive pictures, with guilt and squeamishness. She was now extremely distressed, so much so that she had to be placed in a nursing-home. She developed an intensely negative transference, cursing the analyst for abandoning her there for whole days without help or relief. This feeling was directed back to the picture of the breast. It leapt from there to an incident at 8 when her mother had left her alone all day in a flat, and forbade her to call on friendly neighbours. The dread was now extreme, and revealed itself as due to precisely the beating phantasies which were crowding in on her when she was left to herself, and against which her mother (at that stage but imperfectly internalized as the ego-ideal) was her only reassurance.

We were now at once able to get to the main themes of her neurosis. The aggression against the breast—at first friendly sensuous and playful—was intensified to fury when mother did not tolerate her mauling of it. She was taken off and *abandoned,* imperfectly satisfied, terrified and angry. She must keep still lest worse befall. But she will revenge herself and in turn steal father's penis from mother and *swallow it,* so

triumphing over mother. With the emergence of this curious composite phantasy came enormous and lasting relief, and much improved capacity for genital response. It now appeared that the concealment in her throat of this forbidden precious object had led to two symptoms which became momentarily aggravated in analysis: an explosive cough, and a fear of choking. The former was a displacement of aggression of the oral type, as it were saying, "Ha, ha! to you" to mother. The latter was evidently a displacement upwards of genital wishes, for a day or two after the swallowing phantasy emerged the patient described that she had experienced an orgasm *in her throat* during coitus.

The fear of the open now became prominent as a residual symptom. This again proved to have a multiple determination. It associated itself with phantasies of flying away with father after her mother had proved so harsh and unloving, but the father "let her down" through fear of mother. More historically, she recalled wanting to go out and be made love to by one of her many temporary foster-fathers, but his wife somehow seemed forbidding, so she had just to content herself with the wish to masturbate and pass water on the open common near the house—a most exciting thing, taking the place of what she was not allowed to do.

This account, while displaying clearly the sequence of psychic events which converged into the phobia, has done no justice to the various interesting characterological aspects of the case, such as the motivations in dress, political creed, etc., which were illustrated in the course of the analysis. It will, perhaps, be granted that the chief content and structure of this neurosis was hysterical. It seems very clear, however, that the essential frustration and threat to this patient's security lay in the unsatisfactory mother, which aroused very early hostility that had to be checked with a reaction of hemming in of all strong affect—"swallowing" it as well as internalizing the object of one's hate and affection, the nipple-penis, which mother owns and will not surrender. This shows a strong oral nucleus.

The transference to the father is unsatisfactory for reasons already mentioned, and so full genitality is never established, the sexual life remaining at (or regressing to?) a stage which is characterized by displacements and interplay from the oral to the anal. The trauma of a genital disappointment in marriage (which as it happens was *real,* as the husband's history is known) revives the whole theme again, the claustrophobia and the phobia of being alone referring both to the *danger* of sexual phantasies unless protected by a mother who forbids them, and at the same time serving as substitute gratifications—especially in the case of the train-phobia. The essential mechanism, like in Case No. 3, appears to be

a displacement from an inner feeling—e.g., of "being carried away" to an outer, concrete symbolization of that feeling—the train which carries you willy-nilly. The capacity so to externalize an inner danger appears to be the specific hall-mark of the phobic mechanism, and since it is also a characteristic of hysteria, one would be justified in classing such a phobia with the hysterical group.

Clinically, the personalities of phobic patients, therefore, are marked by the inability to "let themselves go," or to achieve spontaneity and self-forgetfulness, essentially not different from the anxiety states proper, in which there is usually a dread of some impending "organic" disaster: fear of collapse, of heart-failure and so on. In the case just described this was clearly symbolized by the persistent image of a nightmare, in which the patient was hanging on a balcony and was being urged to let herself drop. It is clear, that it is just this liberation that the unconscious is striving to achieve, so that the symptoms are in a real sense an attempt at restoring a lost capacity to the personality, against the resistance of a false ego-ideal frequently characterized by extreme correctness, "lady-likeness" and rigidity. It is also noteworthy, how often such a patient will choose a mate best calculated to re-enact the love deprivation. The more ardent and robust type is taboo because it is too likely to arouse the forbidden feelings in one's self.

The type of mother appears to be also of real significance in the genesis of the phobia in women. In my records are a number of such cases who all give a very similar account of their mother, as that in Case No. 9, and in a few instances one has been able to identify the type through meeting them or hearing collateral evidence. It would seem that they are noxious not only because they are cold and narcissistic, but also because, being narcissistic, they inspire admiration and therefore identification in their young daughters, who consequently are for ever imprisoned in the personality of the overwhelming mother. But whether such a finding is accidental, or if not, whether it is specific to this type of case, is an open question. It may, however, be of real psychopathological and sociological value to investigate systematically the types of parent and their relationship to each other in conjunction with the various psychogenic disorders. The records of child-guidance clinics ought to provide ample material for such an inquiry.

As if in contrast, there presents itself to mind the case of a

girl, in whose life the mother was a relative nonentity, whereas the father loomed very large in her analysis. The patient's condition was superficially like that of Case No. 9, and affords interesting comparisons with the latter.

CASE No. 10. An unmarried lady of 28, the only child of a gifted man of some note, and extremely loved by him. The personality of the father was of importance; he was very unstable, and had bouts of alcoholism. The daughter was always treated as a baby, and felt that the father had a sort of "part-object" fascination for her. She was cuddled and spoilt, but never felt that either parent had any regard for her as a person. The mother was kept down and was terrified of her husband when in his cups. Violence would be followed by abject and tearful contrition the next day. The daughter received most of his tenderness and, one suspects, a good deal of his sexuality.

The parental attitude to her was that while she was wonderful, she must not be allowed to go and do anything, e.g., train for the stage, for which she had a marked talent and craving, or still less must any young man be allowed to "hang around."

The patient had completely accepted this state of affairs and lived in an unconscious identification with the rôle made for her by her father, as his charming plaything, acutely anxious when men approached her even in the most harmless way, just living as the daughter of the house, with mild artistic pursuits, sharing in all the tensions of the home.

Then, eventually, the façade gave way, and one night in a theatre the patient was seized with an acute attack of claustrophobia, feeling as if the eyes of the whole audience were upon her, and that she was about to lose control, collapse and scream. Thereafter she could not leave the house alone, or go anywhere.

Analysis revealed that the fears started over a threatened appendicectomy. After this they were replaced by the claustrophobia, which in detail meant that she might be sick, or pass water, or have to make some such explosive exhibition of herself. Apart from these panics, she felt herself a prey to sexual phantasies, when she wanted to attack men and pull at their genitals; or she felt de-realized and a veil between herself and things, or thirdly, that things were too vivid and close, and then she had a sense of impending catastrophe, which meant an explosion in her head when "all would be finished." The sexual phantasies culminated always in a urinary orgasm—and she saw that the dread of this happening in public was therefore a fear of sexual experience as she knew it. From this point she was able to go out alone. She next recalled a number of sexual experiences: a homosexual episode at 14, resulting in discovery and shame, with subsequent guilt-laden masturbation; and notably an incident where an elderly uncle handled her sexually when she was about 10. At first she abreacted the fear and pain she then felt, especially as he was a grown-up who forbade such things—a cold paralysis like her present-day attitude towards men. Then she recalled the forgotten pleasure ele-

ment—of a markedly urethal flavour; still later a third feeling—that of sexual *inadequacy*, of being a helpless little girl, which made her furious with herself. The fact that he happened to hurt her became the means of escaping from this intolerable conflict between a compulsion to go on and the sense of maddening inadequacy and guilt.

Next we entered upon a long working-through of how the guilt came to be there, in terms of incidents of soiling, wetting and vomiting, and these ultimately associated with feelings of *masculinity*, aggression and destruction: something we called "opening fire from all orifices," which she said just expressed the feeling. This was her response to a constant feeling of being passed over, made to feel small and of no account. It was her only way of expressing the tension she felt inside. Evidently it was her idea of father's power, for she now related her dread of those "explosions" to *his* opening fire, his flatus and other body-noises, all of which terrified her. At this stage she became free from social anxiety, all her self-consciousness now centring around her father once more. Her fear of him became very acute: she had a typical nightmare in which she and mother (an identification) barricaded themselves against him, but he burst in and she felt he would dig a trident into her back. She now abreacted much early fear of her father's tempers, especially when he smashed a doll of hers, and in the analytic session she felt as if this were happening to herself. This proved to be the meaning of her head-bursting phobia.

Now she passed suddenly into a much more masochistic, one may say, feminine stage, of pleasure at being taken (but fear of it too) to a doctor to operate on her hand; this when interpreted led to great relief, and the sense that she had "touched bottom" in her analysis and was a little girl again. Next she produced memories of frustrations at a more Oedipal level—of wanting to be loved and valued by father, but never "getting there." The acme of affection always resulted in the wish to run away and pass water. Then emerged an equivalent frustration at the breast—the wish and inability to snuggle into father—no! mother and her bosom —fury and dread when this did not succeed. This was referred back to the father situation. She showed remarkably good general insight, and realized how completely wrapped up with parental emotions she had been. She began to take steps to train for an independent career, to the real horror of her father.

Continuing, we now came upon a very traumatic incident at 5 or so, when in her quest for being loved *as she wanted to*, she clambered about on her father's body with great pleasure, and was suddenly rebuffed—"*as if he became afraid* of my feelings." She recoils and experiences the most intense fury—again in terms of "firing from all orifices," but this she must conceal, as the pressure of destructive aggression might kill father: she wants to kill and castrate, but dare not: she has no means, she is so small; so she identifies herself with this prohibition, which becomes her permanent ego-ideal of herself in matters of the affective life.

The clinical result of these discoveries was very gratifying.

The phobia, therefore, as in the preceding case, was an over-

determined expression of the fear of displaying love, sexuality and aggression. The idea of imprisonment is the symbol of a conception which the parents have built up of her, so that her real instinctual needs remain incarcerated at the infantile level; the blending of defence mechanism with libidinal elements (as in the micturition feelings) is analogous to the finding in Case No. 9.

The chief contrast was perhaps the much greater predominance of pre-genital trends, notably of an excretory type, in the phantasy life. Whereas in Case No. 9 we were, I think, dealing with a hysterical displacement upwards from vagina to throat, in this case the "power" element of the anal-urethral-phallic complex was much more evident, as it is now showing in her post-analytic character development of ambition, power of organizing and of artistic self-display, in which she is finding her true vocation. This expressed itself partly as a compulsive element in her symptoms, the need for appreciation and intimacy taking the form of a desire to whisper "Fiddle with my a-a" to people, whereas the aggressive tendency was embodied in the wish to attack men. The *form* of the symptom—the dread of being observed giving way to her primitive feelings—was derived from a childhood scene when she had a temper tantrum while surrounded by a group of adults, including her parents, with all eyes on her; just as the form of the phobia in Case No. 9 was derived from being left alone in a flat, a prey to her phantasies against which she felt helpless.

The instinctual forces participating in a phobic development are seen to be rooted in various stages of early life. The essential mechanism is that of a localized symbolic displacement outwards (i.e., on to objects or situations) of an intolerable tension in the psyche, leading to the avoidance of any *situations* in which there might be a flare-up of the original conflict between offending impulse and defensive anxiety stimulated through reminiscence or through analogy. The offending impulse is sometimes early fear itself—a conditioned response to experiences at the level of dependence ("id anxiety"), whereas the dread of the recurrence of such an intolerable degree of nameless fear has led the individual at last to protect himself by an ego-ideal which excluded such feelings from the concert of psychic processes ("ego anxiety"). This is simply the "fear of fear." The ego-ideal of patients with the anxiety-phobia (which we called type (*a*)), is therefore always one of considerable rigidity and conventionality, much poorer than the

"real person" might be, with a good deal of similarity to that of the obsessional, and far removed from that of the true hysteric. For a fuller appreciation of the differences between the three conditions, we shall have to wait until we have studied the two last-named disorders, when the "buffer" rôle of the phobia, intermediate and shading into hysteria at one end and obsessional neurosis at the other, will become apparent.

Conclusion

In this and the preceding chapter we have tried to put forward a view of anxiety as a biological phenomenon, and to describe it as the archaic form of fear response of the infant. In this view it is first and foremost the expression of the instinct of self-preservation or security and closely related in its operation to the complete dependence upon the mother. Any disturbance in the harmonious physical and psychic relationship between infant and mother will be the signal for the release of this feeling. Unable to find outlet through appropriate and co-ordinated action, much of the energy of this feeling discharges itself into visceral and "inner" channels and so gives rise to painful tensions.

Psychopathology begins where insecurity in human relationships becomes an established pattern of apprehending the universe, either through an unfavourable external environment or through the operation of other feelings, notably aggression and/or infantile libidinal trends, which are too powerful to be dealt with—psychically digested—by the baby. The first conflict seems to arise in this way, anxiety being now mobilized as the only defence at the helpless ego's disposal, and representing in reality an appeal for maternal protection.

I regard anxiety as the fundamental factor in psychogenic mental illness because its appearance in the child's awareness means a threat to existence, and this is equivalent in phantasy to a withdrawal of the mother's love. Leaving aside the mechanisms reported as occurring at this early stage in those who develop psychoses in later life, the next stage would be represented by a conditioning of the child to actual or implied parental disapproval of some of its instinctual activities—and presently of the psychical dispositions towards those activities also, even if pleasurable. This brings into operation the mechanism of repression, and finally a new endopsychic institution—the super-ego, which functions as the

permanent guardian of the *status quo* at any rate with respect to the conflict in question.

The view was put forward that such a situation might arise not only from the classical Oedipus system, but from other causes at various levels, individually determined, to which perhaps some typical Oedipal phantasy material had become attached without, however, forming the causal nucleus of the neurosis. We must emphasize also that in symptomatology one has to distinguish between very early infantile dread, frequently linked to organic sensations ("id anxiety"),[1] and anxiety already in the service of the defences against other impulses ("ego anxiety").

In anxiety hysteria the *mechanisms* are of a relatively simple kind; repression and displacement being the most common. The displacement may take place either to an organ function with subsequent symbolic elaboration, or to situations which acquire casual or symbolic connections with the fundamental conflict. The latter is the hall-mark of the phobia.

It is noteworthy that in the phobias of the anxiety type the feeling most feared is precisely infantile anxiety itself. We therefore find in the *ego-development* compensatory attitudes of the aggressive, self-assured, or "hail-fellow-well-met" type, and the anxiety which is allowed into consciousness is ego anxiety, mobilized to ward off the eruption of a much more intolerable feeling—the nameless catastrophe which these patients fear, and which ultimately always represents some danger of bodily disruption.

[1] Horney's "basic anxiety", *loc. cit.*

CHAPTER IV

OBSESSIONAL STATES

In the preceding chapter we considered some case material illustrating the genesis of phobias, and advanced the point of view that these states were, in effect, special modifications of the three great psychoneuroses; the morbid process in each case having become encysted, as it were, and so delimited. But as so often happens in organic disease also, the defensive zone of delimitation does not succeed in holding the confined but still potent focus in check, and so a phobia tends to spread, like a "tubercle" or a gumma, and invade fresh territories.

It is likely that, the more aggression and hate such forces contain, the more intense will be the reaction against them on the part of the ego, as soon as it has new resources and mechanisms at its command to reinforce the primitive anxiety response, by which alone the very young and helpless ego seems able to react. The nearer a clinical picture approaches to the obsessional neurosis, the more certainly do we discover increasing charges of aggression and hate impulses to be responsible for the reaction and the more desperate the defence of the ego becomes.

The obsessional neurosis, in its full-blown form, may make its appearance only after a prolonged anxiety state has existed for some time, and it is then permissible to regard it as a mobilization, under duress, of an old reaction pattern which, for its adequate understanding, requires the help of phylogenetic concepts. In this neurosis, more than in any other, there would seem to be a drawing on the store of our racial past, with its strange animistic and totemistic cults and symbolisms, its magic and its rituals, as well as its strict proscription of the individual who dared to transgress the law of the tribe, or raise an assertive hand against authority.

We are then tempted to assume that the child at a certain stage, confronted by the vast and terrifying forces of nature in its destructive aspect—now, however, perceived as largely *within* the mind—retains the capacity to counter them with the same weapons that his ancestors and his cousins in the jungle and the native preserve found as a way out of their impasse. In the course of this chapter

we shall hope to illustrate these points as well as to touch a little upon the genesis of the phobias of supernatural or monstrous things, ill-equipped though we are anthropologically for such a task.

In dealing with the obsessional patient one cannot for long escape the feeling that his mind is haunted by something much more remote and inexorable than in the case of the other conditions we have discussed, as if in order to combat his own impulses he had surrendered his present-day modes of thinking and was back in the days of magic.

We will now return to the clinical method of approach, by way of a case which will link up easily with the phobias of which we have spoken in the last chapter, for among the symptoms encountered was one we have already met but not dealt with very fully—namely the phobia of enuresis. At the same time it will illustrate many points of importance that one associates with the psychopathology of obsessional conditions, as well as providing again an example of the maxim I regard as so fundamental—the basis of excessive anxiety in infancy for the formation of every psychic distortion.

CASE No. 11. A girl aged 27, when first seen, came with the complaint of depression, fears of being left alone, of going out, also of insanity amounting almost to conviction, and an intolerable screwed-up feeling in her head, the latter occupying her attention all the time. She was the youngest by about ten years of a family of boys, headed by a sister some fifteen years older than herself; she was probably unwanted, and grew up under a mixture of religious narrowness and of a sentimental "we must all love one another" sort of feeling, very much spoilt, fussed and worried over, as well as hopelessly inferior to the giants around her; with the result that she adopted an attitude of being the little helpless child, while the assertive tendencies throve on phantasies of the "he-man" type, and found expression in tantrums and purposeful non-co-operation, e.g., she did badly at school to show she was a duffer and could not compete. As early as she could remember she used to get screwed-up feelings of anxiety.

At 8 she had rheumatic fever and had since, owing to bad cardiological diagnosis, been regarded as an invalid, thus further curtailing her freedom and exaggerating her dependence. She revelled in being waited upon hand and foot and being, as she put it the "village idiot." Actually she had a well-compensated healed mitral leak of no great medical importance. She had a strong ambivalency towards her big sister, who, after her mother's death, took charge of the household and perpetuated into patient's adulthood the approach of grown-up to child.

On the sexual side, the patient after the first interview suddenly recalled a scene when she was 3 or 4 in which there was mutual masturba-

tion and exposure with a big girl in a shed—suddenly interrupted by the entry of a maid. The recital of this incident was deferred by her until five months after the beginning of treatment. The patient had the most severe taboo about everything of sexual import, including the nomenclature, I have ever seen. The rest of the story was that she developed normal sex curiosity about 10, but dared not ask her mother. At 14 she was chased by a man and badly frightened. At 17 she learnt the facts of sex and birth, but would not accept them, preferring to think the Almighty created children and somehow conjured them into people's hands. She summoned all her courage and asked her mother, who confirmed the facts, but was shocked that her baby daughter should be interested in such things. This led to the first appearance of obsessional doubt as between the infantile theory and the biological facts in her mind.

She next went to a film called "The Sheikh," with Rudolf Valentino in the title rôle, and during a passionate and suggestive episode in the picture felt "horrible sensations," and knew it was all true. She had a breakdown, became apathetic, refused food and was entirely engrossed with compulsive thoughts and feelings of sex, mostly with a wish to touch herself and quench a very strong local excitation in her genitals. The whole world now looked different, the compulsive thoughts involved everybody in a morbid curiosity and wonder that "all these decent-looking folk should be doing such wicked things."

Eventually the pressure eased off, and though not free, the patient went in for nursing to try and work off her trouble. Even at the time of midwifery training she still had obsessional doubts about the origin of children. About this time she was told that 75 per cent of lunatics owed their illnesses to sex troubles. This made a deep impression and linked up with the sayings of various maiden aunts in her childhood—that she would have trouble when she grew up because she was so self-willed.

She apparently went on in a quiet way, working as a defence against compulsive sexual thoughts, with frequent feelings of getting her head screwed up. Some months before being seen she met a man on a pleasure cruise and had the first and only love-affair of her life. She was happy and free from obsessions. Upon landing, she was invited to meet his people, after which the relationship was broken off.

She went on a motor tour to try and distract her mind, but feelings of depression and compulsive regressive sex thoughts crowded in on her, and at one stage while coming down a steep mountain road, she got into a state of extreme anxiety—something went snap in her head—she knew now she had gone insane. All the sexual thoughts left her, in fact all feeling left her—except the constant presence in her mind of her head and the knowledge she was insane and wanted to be locked up. In this state she was first seen by me, and she had certainly not a few features in common with a case of melancholia: the expressionless face, the sense of "all being now finished"; the stereotypy of her remarks; the self-accusation, "I used to have horrible ideas," "I was the most wicked person ever," etc. Yet, fortunately, there were also the other features, more of an anxiety character, which ensured the possibility of a successful analysis. It should

be noted that she always hid her face with her arm in my presence, and that she never addressed a single "private" remark to me.

Only a condensed account of the chief points of interest and importance relating to her mechanisms of dealing with intolerable instinctual drives is given here. These drives were two in this case, and from first to last they have remained separate: firstly, sexual impulses; and, secondly, feelings of hatred against her mother and sister, and extreme self-will.

There was no doubt that the episode in the shed aroused very strongly the patient's sex feelings: the peculiar flavour of that feeling was intense curiosity to touch, as well as to see more, and to expose herself more fully in a spirit of abandon, a sort of orgiastic feeling. This was interrupted by the coming of a maid who, in the patient's mind, was a mother-substitute. They had to sit very still, holding down the powerful feelings, with knickers off, in a terrible fear lest she would ask them to get up. The maid's gaze was searching, and penetrated the patient's soul. This was the origin of not being able to look people in the face. She said, "If only I had been able to finish what we were doing." She went about in a state of extreme guilt for days, wondering if the maid had understood, and if she had reported to the parents. Later on emerged the element of fury against the maid.

How did this guilt arise? There seems to be some furtiveness and secrecy in her tempter's behaviour which the patient would absorb by identification. Is it possible that guilt can arise purely endogenously? Such a possibility cannot be excluded, but in this case the answer comes from another quarter:

After a year's analysis the patient started to make use, in her resistance phenomena, of an intolerable desire to pass water—so bad that she could think of nothing else, and could only clamour to let her go. On quietly continuing, the most intense feelings of fury were provoked, up to the confessed wish to kill me. Analysis of the symptom revealed that she had been troubled with a compulsion to micturate ever since her breakdown over the love-affair. Further, this element was obviously associated with far more guilt and shame even than the more genital sexual compulsions and thoughts. Apparently at 11 or 12 the patient had been through a period of bed-wetting and was able to associate very distinct masturbatory phantasies with them. She readily saw the identity of her type of sex feeling with the tension-relief of micturition.

It was clear that we were dealing with what Freud has called *urethral erotism*, to which the patient's interest had regressed after its brief rising to a more adult level on the ship. Only now, to the great relief, incidentally, of patient's head symptom, did she produce the memory that while in the shed an important part of the pleasure had been that the big girl had poured water over patient's perinaeum and had asked her to do the

same. The guilt was thus traced to the usual excretory prohibitions which in the *milieu* in which she grew up were severe.

The phobia of enuresis had thus the significance of (*a*) the wish to masturbate, which she had never given up since the episode in the shed, (*b*) the guilt of having this wish, (*c*) the wish (in analysis) to compel me to stop—witness the fury when this manoeuvre did not succeed, i.e., it was an expression of aggression and power: to destroy with her hot stream, (*d*) it was an expression of the wish to return to childhood: during the period at twelve when she was wetting the bed, she only did so when sleeping in her mother's room with phantasies of being looked after and sat upon the chamber by solicitous nurses, which would give her nice, safe feelings.

At this stage the patient associated back to two dreams, one she had at 22, when a thing like a polyp seemed to be attached to the "lower part of her body," and another recent one when a thing she could only draw (an unmistakable penis) came out of her mouth, to her great disgust and shame.

After this she was dwelling on the wish to be a boy, and there was, in short, every evidence of the emotional connection between her urethral erotism and a *phallic,* thrusting, outward-going, active, hence termed masculine, sex interest in this girl. This was the level from which evidently the obsessional formation acquired its motive force, and I have several other cases of obsessional neurosis in women, who have shown a more or less similar substratum. The patient we are discussing brought out also exhibitionist feelings as well as wishes to abandon herself to riotous living, sexual and alcoholic orgies, and to become the prostitute she felt she was—a blend of two motives: the instinctive, primary one, and the wish to degrade herself as self-punishment.

This brings us to the second fundamental point, the source of the *self-hatred* and self-accusation—obviously a problem in which melancholia and the obsessional neurosis touch, as indeed we have seen that they do clinically. The need for self-punishment was in fact the most conspicuous thing about this patient, as it is known to be of obsessionals—and there are some, like Alexander, who would hold it to be one of the fundamental motives in all psychopathology. In the obsessional it is one of the ways of dealing with the intolerable impulse. How does this come about? What is its purpose?

The tendency was manifested in various ways in the present case—but chiefly in three. The first and most obvious was the constant and monotonous reiteration, instead of the associations which were actually in her mind, of self-depreciatory remarks in criticism of her mental content. These had about them at times the obvious intonation of the nurse or admonishing mother. Often she would admit that she did it to prevent my thinking her horrible, as, by and by, I became the sole representative of that authority before which she thought it necessary to show the wish for self-punishment. The analyst had obviously taken on a rôle which was, before the treatment, an internal function, since she never expressed herself to anyone on the subject. This re-projection of the super-ego in the transference is an important mechanism in the cure.

The second symptom, which turned out to have a self-punishing significance among others, was the head sensation. Whenever marked libidinal elements were emerging this sensation would come and interfere with their expression in the analysis; more recently (before its disappearance) it would also follow, with mathematical certainty, the ventilation or realization of some sexual or aggressive impulse during the previous session.

On analysis of the terrible state in which she found herself during her motor trip, when the final picture of her neurosis emerged, she brought out the intense pressure of sexual phantasies, her hatred of herself for them, her resentment and fury against her sister, who, as an entirely conventional extrovert, could not understand what was troubling her, and who yet dominated her—the welter of emotion fused with the rapid downward motion of the car—everything was slipping—she was about to lose control and wanted to throw herself about and scream—then came both, "how beastly of you, you wicked person," and "you will go mad." The head sensation becomes the sign of insanity—the wages of sexual sin—she now accomplishes the most typical manoeuvre in the obsessional picture. She displaces the entire anxiety about her sex feelings on to this set of ideas—she also manages to direct her thirst for punishment into this identical channel. The wish to be insane turns out ultimately also to be the wish to give free vent and full rein to her orgiastic wishes, to kick and scream, to strip naked and get drunk and masturbate, all without the sense of guilt —for the insane are not responsible.

This patient, in common with all obsessionals, has a raging tyrannical super-ego, which betrays in every sentence its introjected parent-nature, its archaic character (since the conscious ego of the patient wished for a reasonable life), with its monotonous, irrational

self-directed aggression, reminiscent of melancholia. The self-punishing tendency of the obsessional has yet another component. This appeared in the patient in connection with her wish to be the dunce. It was at the same time her *revenge* on her family for interfering with her self-assertion and her wish to be a tomboy. It is thus an example of the turning of agressiveness against oneself—of that same mechanism as the one which gives rise to the compulsion to slash oneself with a knife. The further we progressed with this analysis the more clearly marked became the hostile tendencies directed against her family—always followed by self-punishment, and often with urgent requests for me to confirm the wickedness of those impulses.

The covering of her eyes turned out to be also a reaction-formation against her exhibitionistic tendencies, the evidence for which came from dreams and phantasies. She had strikingly lovely auburn hair, and was altogether rather a Titianesque-looking person, and in addition to the more primitive impulses already referred to, had always wanted to dress gaily and be attractive, but owing to the puritanism of her home and teasing about her "carrot" hair, also on account of their sexual implications, had repressed these desires. It meant "I want you to think me lovely and look at me—I want to strip before you—I am wicked to want to do it—you will be able to see in my eyes what my thoughts are." Later still, the symptom proved to be a last stand against the world of reality of which I was representative, and which, if she faced and accepted it, would mean the loss of her phantasies.

In this case, then, we may trace the following development: (1) exaggeration of anxiety and dependence on her mother, (2) exaggeration of urethral and exhibitionist sexual impulses as well as of aggressiveness, repressed owing to fear of loss of mother's love, (3) identification with the mother and finally introjection of the parental code into a correspondingly exaggerated super-ego. At first she appears to have been able to deal with those impulses by an anxiety symptom—the screwed-up feelings—and it was not until adolescence that obsessional features emerged, although their foundations were laid much earlier:

At 6 or 7 she made a noisy angry scene, following which her mother had a heart attack, and the patient was assured she had killed or would kill her mother: this produced very severe guilt and began the self-punishment symptoms, i.e. in analysis we found her giving way to the most in-

tense remorse and guilt as she stood convicted of her death wishes, and her submission to her super-ego was now completed.

At 11 she still had conscious urethral phantasies. At 17 she received a further trauma from her mother in connection with her sexual curiosity, and we now witness the typical obsessional mechanism of dissociation of affect—the compulsion to wonder and brood over sexual matters without recognition that such thoughts represent one's own wishes—the banishment of the forbidden impulses outside the ego, with the experience of anxiety and self-punishing tendencies, as if the super-ego knew all the time.

We need not now be in any doubt as to the differences between guilt and anxiety. The latter we know to be the affective danger signal of the ego; the former we recognize as the voice and the characteristic hall-mark of the super-ego's thirst for expiation. There is reason to think that the super-ego of the obsessional is one of greater severity than in other psychoneuroses. The reason for this would appear to be that it is, as far as my experience goes, always formed under circumstances when the patient's aggressive feelings are aroused: witness the components of the super-ego derived from moments of intense exhibitionistic and urethral excitement and, especially later, of fury at being thwarted by the maid; and also from the episode when the mother had her heart attack.

It is impossible to say certainly whether this absorption of fury into the super-ego is entirely endogenous, or whether it is partly derived from outer relationships—the anger and disgust of the elders with the child, which the latter introjects and turns against itself via an intermediate phase of identification. I am inclined towards both explanations: that the former is the same phenomenon as the thwarted rage of children which, finding no other object, makes them bite their own arm or hit their own head against the wall—" to hurt something, to hurt the poor weak thing that I am for I can't stand up against any of these big people." A further aspect of this endogenous reaction will appear when we come to another case later on. It is only if we bear both the sources of introjected fury in mind that we shall be able to deal fully with this essential aspect of obsessional neuroses.

Mutatis mutandis, all the foregoing observations will apply to such typical obsessional symptoms as the compulsion to knife or strangle people, to use obscene or blasphemous words, and so on, which may be accompanied by varying degrees of conscious anxiety. A characteristic feature of all of them is the dual nature of

the symptom, as illustrated, for example, by the obsessional wish to be insane. It is both the forbidden impulse and the punishment for that impulse. There is thus manifest a certain conspiracy, a sort of collusion, between the instinctive drive and the super-ego—a clinical fact which Alexander calls the *corruptibility* of the super-ego, comparable to the behaviour of a child who allows himself to be beaten and then feels he can be naughty again, or of the primitive Catholic who gets his absolution for the week, and in no way modifies his conduct for the future, knowing he can again practice expiation and obtain forgiveness.

We thus find in advanced obsessionals a gradual schematization and increasing automatism of the expiatory act, more and more empty of feeling, as both impulse and punishment become completely dissociated from their affect. In the *tic* this has reached its logical conclusion. The parallel with ceremonial formalism in the degeneration of religion is close enough to have appeared more than a coincidence to psychologists. The tendency to ritualistic expiation, or else neutralization of the offending impulse is, in my opinion, only to be explained on the basis of ontogenetic recapitulation of racial traits.

CASE No. 12. A striking example is that of a professional man of 29 who came for treatment in a state which to lay observers seemed nothing short of insanity. He had a most elaborate ritual of raising his folded hands to his forehead as if in prayer whenever he left his house or entered another house, as well as bowing several times; also the compulsion to gaze into florists' shops to make sure that someone was minding the place, that someone was to be seen direct and not through glass (cf. popular superstition re the moon).

Most interesting, from our point of view, was his ceremonial about not leaving anything belonging to him behind in offices, or posting letters which would be " floating about " all night; he took the greatest care to dispose of his cigarette ends, used matches, food remains and even cut hair and nails, in a manner exactly similar to tribal taboos described by Frazer in the *Golden Bough*. The analysis revealed a fairly typical story of early masturbation guilt, with a strong sado-masochistic component, and a phase of washing compulsion at puberty.

The illness overwhelmed him as a defence against a phobia of dying which appeared after an attack of tonsilitis. He felt faint in a theatre and this revived the old dread of having damaged himself. The florists' shops (a displacement from undertakers) symbolized funeral wreaths, and so coffins. Ultimately the person in the shop was the avenging father, whom he had wished to kill, and who was now, half-mythically, threatening to destroy him, transformed into Fate or Death.

The rituals connected with his food remains, nails, and even letters, stopped after interpretation on anthropological lines, referring them back to the magical practices of primitive man, who feared lest an evil sorcerer would be able to cast a death-dealing spell on these objects which by "sympathetic magic" were part of his personality and so "magically" connected with him.

The inability to write cheques, or to send letters which would lie about in sorting offices overnight, were precautions against dying in the night and so leaving anything uncompleted. He had many compulsions connected with numbers and counting, mostly sublimated in his work. The need for restitution and symmetry and for balancing all opposites and accounts meant that by some old act (and in magical thinking the wish is an act) he had committed a crime which by his second act he could annul, or cancel out, or balance.

We see, therefore, that an obsessional system of this type amounts to a private "religion," individual and bizarre until we apply to it the key of the doctrine of phylogenetic recapitulation.

A similar ritual, but on a much less comprehensive scale, was reported by a business man of 40, suffering from multiple phobiae of the "obsessional" type, who recalled that his need for meticulous symmetry and order was directly associated with his mother's strictness in matters of morality and religion; "my orderliness was a sort of fear of the Almighty," he said. "a superstition by which I could guard myself against evil and punishment."

This patient, in common with Case No. 12, responded well therapeutically to an interpretation which related rituals with the common obsessional play of childhood. Both recalled, as no doubt most of us could, a phase of "gambling with fate." "If I step on the cracks in the pavement, then something unpleasant will happen," or, "unless I reach the corner before a car appears, or before I count ten, etc., etc., then I shall be ill, or my parents will die; if I succeed then I shall have saved the world and all will be well."

Both patients admitted that this was at first, in childhood, just a mildly exciting game, and of no great consequence even if they lost the "gamble," the satisfaction consisting in the sense of adventure and of magical omnipotence, as it were, in the play with great forces.

It would seem reasonable to regard this childhood play in the light of a preparation, a sort of rehearsing of a reassurance mechanism, against weakness and inferiority, just as in one sense the excitement or anxious anticipation of failure before a test situation

may be a rehearsal in phantasy, to ensure calmness when the situation is upon us. This, indeed, we find to be the case with so many phobic and obsessional people, who *never* fail, but have always prepared themselves for the impending collapse or failure in the phobic situation. From this success against the phantom-failure, they even derive a considerable access of self-regard. In this sense there appears to be some truth in the Adlerian approach to these phenomena.

It would seem as if in the obsessional neurosis the patient resuscitated this old possibility of fencing with the "great powers," only this time in grim earnest, so that we must surmise that in such cases the early magical method of mastering anxiety had never been given up. That being granted, the ritual adopted, especially the final elaborate form of it, may be almost anything, and is often highly individual, determined by personal experience.

There are, however, certain stereotyped and common forms, among which one would mention (*a*) washing and cleansing ceremonials, and (*b*) the tendency to count or arrange things in numbers, often in threes or fours. The former we have learnt to interpret with confidence as the reaction formation against an ambivalent contamination phobia based on excretory or on masturbation guilt, with complete fixation and absorption of all anxiety in the ritual. In one case recently under my care, a washing compulsion started when the patient had to use a semi-public lavatory, with the idea that she might thus have caught syphilis, which latter phobia was itself an ambivalent fear-wish for anal-erotic and homosexual experiences. The counting compulsion I believe to be a primary displacement mechanism not susceptible of further reduction, although every now and again one meets with fairly simple explanations of a fortuitous character.

For an example of the immediate connection between anal erotism and number compulsions I am indebted to Dr. E. Lucas, who was able to observe in a small boy the substitution of an excretory ceremonial connected with lavatories and water taps by a counting ritual, which absorbed all the energy of the original compulsion. The connection in his mind was provided by the name "No. 2" sometimes used in the nursery for defaecation. From this activity he also passed on to various word compulsions. There is, however, no further evidence to show how this happens; we have to regard this mechanism as immediate and primitive, as the direct

displacement of energy attaching to anal interest to mental and vocal ruminations of number.

This nursery observation also provides a link with cases of obsessional chatter of the coprolalic (direct or veiled) type, which in turn connects with the distressing cases of obsessional phobia of uttering obscene and blasphemous words. The original conflict here would seem to be a dread of making "rude noises," the prototypes of which are to be found on the one hand in the cheerful, enormously energetic "blowing bubbles" of the late oral stage, and on the other in the passage of flatus, eructation and so forth, analogous in unconscious significance to the "opening fire from all orifices" which was discussed in the preceding chapter.

It is possible, however, that the beginnings of a capacity to appreciate numbers and a desire to count coincide in time of development with that of excretory interest, and the interchangeability is one of juxtaposition, rather than of essential linking—the child revels in one newly found occupation as in the other, and the number compulsion gives it a greater sense of magical power and less disapproval; hence the displacement is readily made.

Returning to magical, and rationally almost incomprehensible compulsive acts in general, explicable only in the child mind and the primitive mind, it is appropriate to quote

CASE No. 13. A public-school boy of 15 had since earliest days had a multitude of such symptoms as touching, the wish to push his finger down his throat so as to make himself sick, to swallow pins, feelings of guilt over cheating at cards, which he never does, scrupulousness, a pathological fear of roughness and cruelty in any form, at various times the compulsion to count and read everything, and to arrange things in threes in his mind. He was the most meek, perfectly mannered, stiff little gentleman I have ever met, described by his mother as "too sweet to live, and always thoughtful of others."

Very soon in analysis we uncovered incidents of early childhood concerning which he felt guilt. They were without exception connected with outbursts of fury and rage on his part. At 7 he hit his larger and older brother so that he bled. This was his own interpretation of the origin of his horror of cruelty. His guilt feelings in general he traced back to much earlier scenes of being thwarted and held down by a doctor at 2 or 3, when he felt oppressed and impotent and experienced murderous rage. He had bronchitis and felt all choked and blocked—he wants to break his throat as this appears to be the source of his weakness and affliction (this is the wish to push his finger down) —again an example of the tendency for anger to turn back on to the ego—he is left exhausted, furious with all that shuts him in and limits him—tremendous feelings of omnipotence surge up.

For the sake of brevity a long series of pictures (which by way of a test, brought enormous therapeutic relief of his symptoms) is condensed into one connected story.

One of his symptoms, which he reported a little later, was a sense of *oppressiveness,* only felt at home, and especially on Sundays, if thwarted in some plan or game. From this feeling arose the need to do compulsive acts, an uncontrollable restlessness which made him want to smash something. The following is an excerpt from notes on the analysis of an incident at 3 years old, when he felt held back into a pram—not by straps, but by an injunction: "I felt madly furious—anything might happen if I didn't get out—I *would be sick* [a form of revenge on his mother], I felt a black cloud descending and closing in on me [cf. the oppressive feeling], *everything would be blotted out*—this was my fear of my own omnipotent anger—it seemed to recoil on myself—I was not so furious against any one person as against my whole condition—my helplessness. I would do anything—anything." This was followed by dejection and misery. "It is a sense of revolt at boredom which starts the sense of oppression—a thwarting of omnipotent feelings." This he links to the earlier scene, and progressively the thundercloud takes human shape, even acquires a voice, etc.—an interesting commentary on the degeneration of the human hostile figure into the monstrous or even inanimate phobic symbol.

Next we come to the part which is especially interesting as an explanation of the touching compulsion.

"The thundercloud is my overwhelming anger which tries to blot me out—like a supernatural force." (He reports various dreams of witches and men trying to attack him, which also have this interpretation, with the same feeling tone of sinister, weird, supernatural fear—like the prevalent religious feelings of primitive man.) Against this he reacts with what he calls his own anger—trying to smash it and *counteract* it. (*Note the line of dissociative cleavage appearing within the instinct.*) This he can only direct against the four walls that shut him in—his pram: he tries to smash through. He senses it to be a substitute for those people who prevented him—the parental images who limited his omnipotence. He experiences next a *third* anger—at his own impotence. At this point in the analytic session he suddenly felt an impulse to touch a picture hanging on the wall—and it became clear to him that the touching had a *magical* significance just like "touching wood" as a reassurance—he called it "omnipotence attacked with its own weapons." Next he realized, there and then, that most of his tricks had just that purpose—to side-track this overwhelming feeling—a sort of lightning-conductor effect. He also sees that the touch is a truncated, abbreviated, symbolic code method substituted for the violent smashing action itself, a *relief of oppressive tension.*

Again we notice the ambivalent fusion of charge and countercharge in the symbolic act.

Here comes to mind another example of the same mechanism, from a case which will be referred to later under sex perversions. The patient here saw himself in a blazing rage wanting to bite, claw and tear his mother's breast, but the action froze under the feeling of her overwhelming majesty and power into a *very gentle* caress—he *just* touched her, but all his fury, he said, expressed itself in this act, and through his eyes.

Returning to the previous case, the boy came to realize the fear of his own hatred and anger, causing feelings of guilt and apology, a sense of disapproval. This is the answer to a question we asked earlier—whether guilt can arise endogenously? It is clear that a child can feel threatened by its own overwhelming emotions, and feel helpless in the face of them. The first step—as in this case—is their projection into a phobic symbol. The next step in the reaction formation is illustrated in another fragment from the boy's associations:

> " I feel an anger which at first is under control and later breaks its bounds —then I want to turn to anything to counteract it—any loophole—a lot of plans and thoughts overwhelm me—a feeling of wanting to smash through —stampede—then a desperate impotent feeling—*the touching comes almost as a victory,* followed by calm and rest."

Here we see the whole essence of ritual as used by the savage and by the child—impotence becomes omnipotent *in magic,* and anxiety is allayed. The core of it is a delusional belief in " egoic " omnipotence used to neutralize " id " omnipotence—evidently a typical feeling of the child in the second main stage of development between 1½ and 3 or 4 years of age.

This example also illustrates the splitting of aggressiveness into two parts: one remains primitive and is repressed as a forbidden impulse, while the other enters into the dynamic sphere of, and is used by, the super-ego to reinforce the repression, the whole process taking place in the unconscious at about the age of 3. The original aggressive impulse (which this patient had many adequate reasons to feel intensely in his environment) can only manifest as the sense of oppressiveness (the thundercloud) and restlessness (partly due to anxiety aroused)—and then both it and the ego's counter-charge result in the compulsion to touch, blink, count, etc., whereas the guilt sense over uncommitted unimportant crimes is a displacement from the intolerable to the more tolerable. Freudians would perhaps postulate that the omnipotence feelings would need to be related also

to some sexual impulse—especially to the wish to touch his penis (omnipotent masturbation phantasies)—and it is true that this boy may have had considerable conflict over this matter, of which he had no conscious memory. We also know that he was abruptly weaned as the result of milk failure, and " bit his mother to pieces," as she put it. But granted the possibility of such further components of omnipotence, these would not invalidate the essential psychopathology as above described but would enrich its content, and might throw light on the symbolism of the " three " compulsion (if we concede the psychoanalytic meaning), and suggest that some of the aggressiveness as well as the anxiety date back to earlier levels, for as already discussed, the polynuclear structure of neurotic impulses need not be in doubt.

From what has been said concerning the magical value of thought-processes—counting and the like—in the defence against feelings which are too strong for the child, it will be easy to pass to a brief consideration of those cases in which the compulsion takes the character of more abstract thought, of *philosophical doubt or speculaton,* which, in the nature of the case, is never solved or finished.

In my experience, there are two types of compulsive thinkers. The first and prognostically more serious one is that in which the individual intellectualizes all his responses to the world, thereby denuding them of any feeling. These are people who are for ever examining themselves, analysing their motives, inhibiting their spontaneity, proof against all surprise attack from the instinctual levels. Often enough they are aware of this state of affairs, and then, by means of a further intellectual *tour de force* they attempt to conjure up a false façade of emotional life. One such case will be referred to in the chapter on sexual maladjustments; it goes without saying that it is in this type that impotence frequently occurs, the thought-process having absorbed all libido and becoming " genitalized." It is permissible to group this type with schizophrenia rather than psychoneurosis, so severe is their loss of affect and their splitting of personality. Graham Howe has given an admirable description of this type,[1] in which there is no longer any question of an isolated symptom, but an involvement of the whole personality.

[1] HOWE, E. GRAHAM, " Compulsive Thinking as a Castration Equivalent," *Brit. J. Med. Psych.*, vol. ix, 1929, p. 159 *et seq.*

The second, more benign form exhibits the typical obsessional ritual, in which thinking out a philosophical problem takes the place of an act of expiation or magical defence: there has been a displacement from the motor into the intellectual sphere. An illustrative case of this type, also distinguished by Howe, will show the steps by which this displacement is accomplished quite early in childhood—analogously to the jump from excretory play to counting compulsions.

CASE No. 14. A university graduate of 23 came for analysis on account of a distressing preoccupation with the problem of survival after death, which had bothered him during his whole undergraduate life, spent in the study of philosophy. The proposition he could not solve was as follows: "If there is no survival after death then I shall be wiped out, and this is too terrifying to face. If there is survival—then I shall have to go on and on through eternity—and this also I cannot face. So whichever is true—the prospect is equally intolerable, and gives rise to unreasoning terror."

The symptom had been present in less crystallized form since childhood as a fear of unending time, which would attack him especially when lying in bed in the dark. It had become accentuated since he had become engaged to a very suitable girl.

He was strong, intelligent and a good athlete, a healthy rebel in matters of politics and religion, the youngest child of a tolerant and progressive father and a very indulgent mother.

Frequently when the obsession was upon him, he would feel an impulse to call "Mummy."

He was said to have been a very frightened baby, artificially fed. He recalled three traumatic fear-producing incidents. At 3 or 4 he was taken to the hairdresser's and was terrified in the extreme, for the dummy heads with wigs in the barber's window suggested that his own would be cut off. At 4 he fell while climbing and ripped his leg open; he saw his flesh hang. At 8 or 9, after evensong in the country, he was obsessed and terrified by the phrase of a psalm: "Lest I sleep the sleep of death," as he was walking home in the dark. He arrived in tears. At 13 he had appendicectomy.

He volunteered that he was a mother's boy and had pleasant memories of her. His relation to her was ambivalent, for she always caused him intense irritation. His sister, eight years older, was unable to deal with him and would resort to vague threats of terrible consequences if he were disobedient. His older brother resented the patient being petted by the mother.

Presently he also recalled his experiences of air raids, when he felt more excited than scared, but thought, "This may be my last night on earth." His conscious sexual interests were awakened at 5 or 6 by seeing a tramp masturbate. He was enlightened very early by his mother about "the facts of life," but failed to connect them with his own sex organs or functions until he went to public school when they burst in as a fresh discovery. During puberty he had severe masturbation guilt, obsessing him with the feeling

that he was unlike other boys. The love-making with his fiancée, which was of a violent order, caused much guilt and depression.

Deeper levels were reached with the analysis of a dream: " I am in the loft at home and facing a trap-door in the floor, opposite me was a very fierce animal taking various shapes—at one time a serpent and ultimately our own cat, but ferocious. I struggled with it and threw it through the trap-door. Then I saw how stupid I had been: it was only our poor old Tibby who never did any harm, and she was pregnant; how I might have hurt her." The associations were such as to enable one to interpret this as the conflict over sexuality, in the shape of penis as well as of maternal animal, attempting to intrude into his " higher mind " (loft), his repression of it (trap-door), and the recognition by his own unconscious of the groudlessness of such a proceeding.

This interpretation produced much material, especially relating to his mother, who was very Calvinistic. He recalled his circumcision and her phrase, " Those parts are sacred." With her he had a constant sense of guilt, and felt he was always giving himself away. She used to say: " I can forgive you—but will God? "

His whole childhood was spent in a struggle to appear uninterested in smut, in adventures or " ragging." The picture was of a healthy, but self-conscious, over-conscientious boy who should have been " a little devil," but was afraid. A further dream concerning a French and an English train was easily seen as symbolic portrayal of sensuality versus conventional morality, with a sneaking preference for the French.

He now plunged into castration anxiety related to the circumcision as well as to the removal of a small cyst on his scrotum at 4 or 5. A dread of *anaesthetics* was clearly realized by the patient to be associated with his fear of sexual mutilation and loomed large in the analysis. After this had been worked out he began to be able to display his phallic and urethral omnipotence; he became cheeky and bumptious in transference, his imagery became preoccupied with big guns, fire-hoses, the Eiffel tower and smutty jokes, as well as the consciousness of various sadistic preoccupations such as picking spots and biting nails. The analysis was largely conducted through the associations with phantastic imagery, kaleidoscopic in complexity. The feelings of eternity began to centre round a sensation of circles in motion somewhere before his eyes: a whirlpool of water running out of the bath where he was masturbating, and the breasts before him were his associations to this image.

He now recalled furious tempers which we were able to trace to phantasies of savage attacks on his mother's breast where he saw himself frustrated and put away hungry and depressed, turning to his penis for solace. He wants to scoop out the breast—destroy it—he gets a persistent image of an axe—this becomes " the axe laid at the root of the tree "—it slips and turns against himself—he dreads castration quite consciously now. This feeling blends with the intense fear of anaesthetics—*slipping away into timelessness.* The thought occurs " All right, then—I will do it myself ": in a desperate defiance of his tormentors he would castrate himself.

There was also an anal-sadistic element in the fury and rebellion which

were evoked in him by enemata which his mother used to give him in early childhood, and which he again interpreted as a castration-attack upon him: the nozzle of the syringe was analogous to the hostile nipple. He then recalled a period of intense anal interest with much guilt, to which he easily related a passing phase of washing compulsion. He also saw the connection between the fear of his *own* anal explosions and air-raids: the equation of outer with inner danger of excessive aggression.

These feelings were related to the present; it appeared that he was practising self-punishment for the sexual episodes with his girl friend.

Towards the end of treatment he was conscious that the intellectual compulsion appeared whenever he was annoyed, " sexy " or witnessed scenes of violence in the cinema.

His ego-ideal was typically obsessional, that of a truthful, harmless, dear little boy, by which he hoped to conform to the requirements of his ethically severe mother and keep her indulgence. In this case the super-ego was based much more on the maternal pattern than the paternal.

Commentary on this case is almost superfluous. It illustrates the way in which a whole career may be influenced by the need to secure oneself against the onslaught of destructive impulses by thought which functions both as self-punishment and as a substitutive gratification (e.g., the pleasant feeling in the bath after masturbation) in the typical obsessional way. The splitting of aggression, with introjection of one part into the super-ego (as symbolized by the axe), is again clearly demonstrated.

Conclusion

Certain things have emerged from this brief sketch of the most complicated of the psychoneuroses. The characteristics distinctive of the obsessional neurosis would appear to be the following:

(*A*) *In respect of the instinctive impulses*: these derive predominantly from the second, aggressive phase of infancy, and may ultimately be reduced to (*a*) pure aggression, (*b*) aggressive, thrusting sexual feelings of the excretory and phallic levels of interest, with a thread or two relating back to still earlier oral levels; (*c*) active curiosity and exhibitionist tendencies. It would appear, however, that even with regard to (*b*) and (*c*) the aggression aroused as the result of frustration is the most important factor in initiating the compulsive development, while in the process the sexual impulses, because frustrated, remain arrested at the level at which the traumatic events occurred.

(*B*) *In respect of dealing with these instinctive drives.* (1) The

impulse itself appears either in undisguised or in symbolic, codified form, without its accompanying emotion, or at least only with the anxiety attendant on the original experience of the impulse in childhood. (2) There is repression of the emotion proper of the impulse—or if preferred, dissociation of the emotion—which, persisting in the unconscious, owing to its aggressive character, lends the symptom its compulsive force. (3) We note the capacity for substitution and displacement from the significant and unbearable to the trivial and bearable, a feature also common to other psychoneuroses, but in obsessional cases mostly derived from the normal magical thinking of early childhood. (4) There is consequently an alien, "unrelated" feeling about the symptom. (5) The patient makes regressive use of such magical thinking as a reaction-formation against the impulse, leading to compulsive rituals, acts and mental activities of all degrees of elaborateness, from the tic to systems of philosophy—maybe even of psychopathology!—in a manner resembling the thought-processes of primitive man.

(C) *In respect of ego-development.* We observe the following: (1) the fortification of the helpless ego by this omnipotent magic: (2) the hypertrophy of the super-ego through a fusion with part of the original aggressiveness now turned to punish the ego and spur it to ever-increasing vigilance, as shown by scrupulousness, self-consciousness and an ever-present sense of guilt. (3) The assumption of an ego-ideal of meekness and goodness.

The classical picture of an obsessional neurosis is one in which the defensive ritual holds the stage (be it work or some more obviously pathological compulsion), and where, only when this defence against the impulse has failed, the underlying actual ideas are able to break through, to the accompaniment of anxiety normally checked by the ritual, which may be said to constitute the front line of defence. The second line of defence—deeper from the point of view of original genesis—is the dissociation of affect, rendering the impulse isolated and logic-proof, almost the promptings of a second personality, not infrequently perceived with hallucinatory vividness.

The anxiety is of the essence of the condition—being the manifestation of the fear of loss of parental love, by this time (in the obsessional) a function of the super-ego, and so originally responsible for the banishment of the offending impulse, as it is now keeping it in banishment, determining acceptance and continual service to the rigid pattern and standard set by the supreme authority with its

liberal admixture of hatred now turned against the ego, preventing the expansion of the infantile into the mature ego-ideal.

The dichotomy of feeling is very characteristic of the obsessional, and is seen both in the fate of the aggressive tendency which we have studied, and in the ever-present *ambivalencies* towards objects. This follows naturally from the impossible position of the child when it finds itself literally biting the hand that feeds it. It is only another aspect of the fundamental conflict between hostile, aggressive, rebellious feelings against the very people whose love and approval is all-important, and the fear of what would happen if we gave way to them. No wonder that the ego-ideal, on the one hand, becomes all love and sweet submission, and on the other (in its super-ego aspect) borrows all the fury it can from the id, exaggerating the punishing, threatening parent images into veritable tyrants, and enthroning them permanently within the self as the all-seeing eye.

No wonder that there exists an enormously strong barrier to the recognition of this hostility, which can allow a patient to say, "I can never remember feeling angry with anyone—I was so fond of mother and tried to be so good," the day after the recital of a scene of murderous rage against the self-same parent, or after an outburst of fury against the doctor.

It is in this dichotomy and inviolability of façade that there lies the power of the resistance to cure in the more severe obsessional cases: the hostility of the id against the doctor who as parent-substitute is wanting to attack the patient's omnipotence phantasies, and the hostility of the patient's super-ego, in the later stages also unloaded on to the doctor, which will not allow the realization of those dreaded impulses.

Hence, I think, it comes about that there remains about the obsessional neurosis a sense of the unfathomable, ancient and elusive. Much further research will have to be done both on the structure and on the handling of this disorder before we can hope to produce cures in well-established cases.

CHAPTER V

HYSTERIA

THE psychopathology of hysteria is said to be the best understood of the whole range of psychological illnesses, and it has certainly received the earliest and most thorough attention from both pre-analysts and analysts. Yet as one thinks over this protean disorder, one wonders whether it is possible to reduce its manifestations to one or perhaps a few valid basic principles that will serve to guide us in therapy. The temptation is, as everywhere in psychology, to look down various approaches, all of which seem to contain some of the truth, and to doubt the ability of a thorough-going adherent of some single school to establish a convincing pathology of this disease.

Perhaps our best plan would be to look at hysteria, as we did at the obsessional neurosis, from the three points of view of (1) the instinctive forces and developmental levels involved, (2) the methods and mechanisms the patient has used in order to deal with them, and (3) the state of the ego. In the course of this we shall have to consider certain other notions—such as suggestibility, capacity for dissociation and conversion, which we have not met before in these discussions.

1. *Instinct Levels*

In the second chapter it was indicated how the anxiety state might be regarded as the point of departure for several more complex developments, of which Hysteria is one, and perhaps the commonest. Much of what was then said concerning the levels and instinctual drivers involved, obviously holds good in the case of hysteria proper; i.e., that the Oedipal, sexual content of the neurosis while frequently crucial is not always the main feature of the case. We must take for granted a certain familiarity with psychoanalytic views of the structure and conflicts of hysteria. The views put forward in this chapter will be, in a sense, supplementary to the Freudian conceptions, while also confirming many psychoanalytic discoveries.

The most obvious clinical fact about hysterics are (1) that they

wish to draw attention and sympathy to themselves, and (2) that consciously they behave as if nothing was further from their minds. That is to say, the wish for sympathy is wholly or largely unconscious, and there is no need to describe the lengths to which the patient will go in order to conquer the environment by his illness. Incidentally, when we have said that, we have summed up all that Adler has been able to teach us on the subject.

As psychopathologists we must attempt to find the instinctual basis for this unconscious goal of " power through weakness," which at first sight seems to have little in common with the view of hysteria taken by the Freudian school, who nevertheless admit the notion of a " secondary " gain through illness. In the remarks that follow it will be seen that frequently this gain or goal appears to be a *primary* one, based on a need which psychoanalysis has not yet accepted on a footing of equality with libido and aggression.

Let us look at some clinical examples, and see whether from them we get an answer to the question, " What is the emotional need behind the hysterical symptom? " They will probably also answer our other points. The first case to be cited will conform closely to the Freudian psychopathology:

CASE NO. 15. A young professional woman, aged 25 when first seen, a university graduate and highly intelligent, was the younger of two children, the elder being a backward boy. She complained of terrible exhaustion, " neuritis " of the right arm, and attacks of headache and vomiting, none of which had yielded to diverse methods of physiotherapy. Her periods were irregular, suggesting defect in the direction of hypogonadism for which ovarian extract had proved useless. The analysis, which took over a year, revealed no notable traumatic events in the outer life, which was uneventful and usual. The chief factor in the environment was the father: impatient, exacting and bad-tempered. He lived in mystical high-church phantasies and " gave his family hell."

The child early identified herself primarily with her long-suffering mother. Memories of this went back to before the age of 2. She slept in a room adjoining the parents', and could observe all that occurred there. Early recollections revealed an ambivalent feeling towards the father's penis, as seen during micturition: it was threatening and disgusting, just as he was, nasty and dirty, and we soon found that the vomiting, as a symptom, had its origin in car-sickness which occurred only when driving with her father, i.e., when he had her in his complete control. It was her way of rejecting him and the penis, and the Oedipal feminine rôle altogether. At a deeper level, however, she was also attracted to him, and a great part of the analysis was devoted to working out the Oedipal, strongly sexualized, love for him.

Primarily these feelings emerged in the analysis of coitus scenes between

the parents, where the child felt very strongly masochistically identified with the mother; there were also other phantasies and feelings of wanting to be in her mother's place, and to be entirely absorbed by the father, who on and off would make a fuss of her, but mostly misunderstood and rejected her advances. He became the terrible, attractive monster-hero, and, unable to attain him, she secondarily identified herself with him, i.e., she formed a masculine ego-ideal or goal, and at this level had sadistically coloured phantasies of torturing her very prudish mother by forcing enemas into her—the basis of a later homosexual trend, as a defence against the Oedipal impulses.

She wants to be a man, but in after-life cannot; but her mother stands between her father and herself in a feminine rôle for which she also feels so inadequate and little, and father, moreover, so disgusting and terrible, that she cannot accept femininity either. He also stands between her and mother and stresses her inferiority to him in all departments of life; lastly, he also stands between her and other men, taking away her femininity, partly because she must be loyal to him, partly because she has resolved to be a man herself. These were the main themes of the analysis.

To keep her mother's love she becomes the little sweet pure girl—a further discordant element in her ego-ideal. To achieve her father's admiration she emulates him in learning and cleverness and religion, but always with a feeling of inadequacy since she is not as he is. At her Honours exam., for which she has swatted with increasing anxiety, she breaks down with the "neuritis," which she subsequently employs at all critical junctures as a means of escape.

The "neuritis" as a symptom only cleared up when we analysed some birth phantasies which indicated an impacted shoulder, with the pain clearly relating to this. This shows the depths to which hysterical symptoms may need to be traced—a flight very far back. The impaction symbolized the general arrest from which she suffered, in addition to a possible interpretation as a displaced castration image. It was also her Adlerian "if only I had not this affliction I could be like my father." We may speculate on the lines of cabbalistic symbolism in which Right is active and male, Left passive and female and say that she wished to paralyse that masculine Right side in an attempt to find her true profoundly feminine nature. But essentially it was a regressive recapitulation of a danger situation, and so an appeal to the parents to come to the rescue, to sympathize. After the analysis of this symptom the vomiting was recognized as a conversion symbolizing the whole underlying structure of the conflict resulting from the unrealizable wish to be loved by both parents. This led to her having to reject the father as an object of desire, inadequately dealt with by a partial identification with him. The need to be a woman, which had become impacted on this rock, was thus repressed.

The main structure of the neurosis follows that of other conditions we have studied: an instinctive (in this case libidinal) tendency is repressed through fear—here quite properly called castration fear—and a pathological ego-ideal is formed by identification with, or introjection of, the father, under the threat of loss of love. This ego-ideal determines her virginal, scholastic career, and her anxiety to live up to the tyrant's standard.

Under the test of an examination this false adaptation breaks down, and the repressed feminine side, the need for adult love-life and for sexual satisfaction present themselves; they are still of the same Oedipal character as when they were originally repressed, and so arouse the same feeling of disgust. The vomiting is the defence, the smoke indicating the hidden fire of intensely yielding, passive sexual love-wishes underneath the "masculine protest." But the vomiting as the primitive expression of disgust was also a rejection of the father and all that belonged to him, owing to the ambivalency which was based on his actual conduct in the home.

Allowing for great condensation of the case material, we may say at once that *this* patient exhibited the "classical" Freudian psychopathology of hysteria.

The impulse which lay at the root of her desires against which her hysterical symptoms were a defence, was a fully formed yielding feminine sexuality, experienced first by identification with her mother in primal scenes which we had reason to believe were really witnessed between 3 and 5 years of age, and later reinforced by the sort of sensual fuss which the father made of her and which constituted his only method of showing approval or liking for her. The wish for this love was exaggerated largely on account of the constant doubt whether he really valued her.

One or two points require further comment. The first one is that in this case the father himself is felt as the prohibitor of love. Secondly, we have to note again that endogenous feeling of *genital inadequacy* which we met with before in Case No. 10—of the girl with a theatre phobia—in which also the father was felt ambivalently as the lover and the punisher. In the present case the mother becomes an object for identification, and *later* for aggression, and functions as a carrier of super-ego guilt *only* in respect of that later aggression (the guilt of being like father), although the aggression takes a form reminding us that in hysteria, too, we may meet with motives derived from earlier, anal-aggressive components (the attack

on mother with an enema), in accordance with Glover's views, which function as a defensive regression from the dangerous genital wishes.

The motive of inadequacy—of being too small for such a powerful experience—comes to function in the adult neurosis as a strong defence against sexuality and is, doubtless, responsible for the feeling of being "only a helpless little child" which is so successfully dramatized in the whole unconscious behaviour of the hysteric. It must remain an open question, what part was played by hypogonadism in this particular case, which recovered fully.

Last but not least, the symptoms as a whole were a way of saying, "Look what you have brought your poor little girl to," although this element was not so well brought out in this case as in two others, the first of whom was a girl of the same age and even physical type as the girl just described. They were also trying to "prove themselves" to their parents in a non-sexual masculine rôle, but were unconsciously intensely masochistic, alternating between the poles of self-pity and self-immolation, "wanting nothing for themselves."

CASE No. 16. In this patient there was a traumatic basis in sexual assault by an older brother and some other boys at 6 or 7, the feelings of which had to be repressed and reacted to by adopting a masculine role.

This very able and very feminine girl was a daughter of the people, who had a brother four years older. She had won her way by scholarships, and at the time of her breakdown was on the staff of a very superior girls' school. She resented the fact that her father never gave her praise but took her successes for granted, and she hated the fact that her mother had to work as well as he. Yet she had accepted her social "inferiority" with great frankness and dignity, so that this Adlerian motive did not arise in her case. During her schooldays she had suffered from frequent headaches and tiredness attributed to overwork.

Her hysterical illness began soon after a colleague "went hysterical on her" and she began to dread that she would break down too, for she prided herself on being in perfect self-control and able to hide her feelings. Her friend's example proved too strong, and she developed a neurosis.

On her first visit the picture was that of a very excited girl flapping her arms and uttering hissing sounds of "sh-sh," complaining of extreme exhaustion and pain in the back, which had a certain anatomical basis, as she had had a bad fall recently. Even during this first interview she related, with much distress, the episode of having been exposed by her brother and other boys, when she was 6 or 7. She admitted that she was two persons, one always having to say "sh-sh" to the other. It emerged that up to the age of 11, the brother had on several occcasions practically had coitus with her,

which she allowed without resistance. Later in treatment the sexual feelings aroused by these episodes emerged, and a strong remaining erotic attachment to the brother was revealed; she resented his recent marriage and feared she would remain an old maid. This latter dread was more and more brought home to her by the life amongst her colleagues, and it contributed to the unconscious revolt culminating in her breakdown.

She envied her brother's strength and knowledge of sex and the world, and it was no consolation to her that she was cleverer than he. She abreacted rage and humiliating feelings of inferiority to him and to men, including the father, who were always bullying and depreciating women; she felt herself identified with various heroic women as well as with "poor helpless people," and saw that the need to be calm was part of an ego-ideal derived from her mother. These feelings had their origin in what might be called the nuclear incident of her development: on one of the occasions when her brother and she were having sexual play, she was very conscious of being the "helpless victim," dreading his penis. At that moment, after anxiously listening for it, she hears her mother's knock on the door. She tries to do up her knickers, but her mother sees her, standing there. She then has a peculiar reaction: "It is all out of my hands now; all my fear and tension goes—my fear goes into my limbs, which feel heavy and tired. My mind feels free. I now see myself as my mother would see me—a silly little girl with my knickers down." She saw that this was the final identification with her mother, by which she had repressed her feelings of sexual anxiety and adopted that self-control and self-observation by which she had kept her emotional life in abeyance. Henceforth she would be the good and clever little girl.

Another incident significant in illustrating her ego-ideal occurred at 12, when she happened to observe a couple in sexual intimacy. She felt a vivid thrill which she immediately suppressed with disgust, and raised her eyes to the starry heavens. She would only pursue the higher, mental pleasures and forswear the sordid earth, trying to ignore even the revolting fact of her menstruation, which had just then begun.

The next phase in analysis began with her resentment at the formal and unsympathetic attitude of the physician who had been treating her spinal injury. This feeling was followed by a dream in which her father was initiating her into sexual life. A nice stranger called, but the father said: "She is not yet ready for you." In short her Oedipal feelings emerged, partly as transference guilt, with the reiteration, "I must not make a fuss."

She now recalled the earliest incident which it was necessary to deal with in this case; this concerned her rage with her mother for interfering with a phantasy game, at the age of 4. The mother would not understand, but calmly watched her tantrum, saying "Sh-sh, you naughty little girl," and ultimately put her into a room by herself, where she realized the hopelessness of her assertion against mother, and again saw herself through her mother's eyes as the silly baby. She cannot do without her mother's love, and decides to become good and sensible. This material could now be related to the father situation, in which her mother played the part of a critic of the fuss which she and father used used to make of each other, and expressed disapproval of the patient's sitting on his knee, etc.

A notable feature of the patient's self-awareness was the following statement: "I feel in three layers: a top one which is the cork that has now blown off; a middle one which I observe myself with, and a bottom one in which are only my fears, sex interests and hates."

Another interesting development towards the end of her treatment, which was very successful, was the appearance of a series of anagogic dreams similar to those mentioned in the Introduction. These dreams, while not directly concerned with our theme, are quoted, on account of the "prophetic" element in them.

(1) "I see a tree, standing bare and isolated above a town which is unattractive and dull."

(2) A few weeks later: "I again dreamt of my tree, but now it has leaves on it and is standing amongst other trees." *Associations*: "It is the tree of my life—I am no longer afraid and isolated."

(3) A few days later: "I am sitting behind a hedge. I have a green powder-puff and after using it I throw it to the winds over a hedge. A charming young man comes along—he has picked it up and gives it back to me. Then we begin making love ever so happily." *Associations:* "The powder-puff is my feminity, and its colour is like that of my tree of life—budding, green and inexperienced. I used never to use cosmetics—I scorned them. Now I am ready to tell the world that I can live and love and be attractive."

The young man came into her life in fact three days later at a dance, and the patient was married to him after a few months: she reports great happiness and fullness of life four years later, with her baby 18 months old.

Again commentary seems almost superfluous, as the account of the analysis itself reveals the structure and the forces concerned in the neurosis. The instinctive drive is provided by a typically feminine, yielding sexuality, aroused in the years between 4 and 12, in which it is gradually displaced from father to brother. It is in conflict with anxiety—the dread of loss of mother's love. The mother therefore has to be placated, and this is achieved by identification with her. The ego-ideal gets further coloured by the sense of inadequacy and feminine inferiority, leading to a striving for achievement and a career; in this she is helped by possessing a first-rate intellect.

So far as typical hysterical mechanisms are concerned, we note the appearance of a dissociation of personality, in the incident when she and her brother were discovered by the mother. The affect is, as it were, directly displaced from her ego to her limbs; this state of affairs persists, for now she can remain calm and unmoved by sexual and other feeling, but she suffers from tiredness and exhaustion. This is an example, therefore, of the mechanism of *conversion*,

which frees the mind from anxiety. Furthermore, the patient also experienced a sense of *detachment* from herself as viewed from the angle of her mother-identification: the process of formation of a double personality is hinted at. The dissociative cleavage, however, was not so severe as in the case of the artisan (Case No. 7) whom we found to have resorted to a true amnesic fugue. Nevertheless, the "sh-sh" person was clearly talking to and trying to suppress an infantile, naughty sexual personality which, until her breakdown, had remained below the threshold of consciousness.

The essential process in determining this, as other neuroses, was the need to retain the parental love and regard enshrined in the super-ego, and to this demand the true personality of the patient had to be sacrificed.

The same psychopathological data, grossly exaggerated and overdrawn, clearly emerge from the analysis of the third patient of the series, once again the daughter of an authoritarian father. This case cannot be quoted in any detail, as the material obtained was very copious, but the essentials will suffice for our argument.

CASE No. 17. This able woman, aged 38 when first seen (like Case No. 15), had obtained her degree under the conditions of "absence through illness" during her finals, and thereafter pursued a distinguished career with constant over-work, no amusement, few friends, and shunning of male society. Her medical history was one of repeated "breakdowns" attributed to over-work, with symptoms of exhaustion, insomnia, nausea, palpitations, etc., etc. On the last occasion her breakdown was precipitated by differences of opinion with her authorities—especially an elderly chairman—who had blamed her for something of which she was in fact innocent. Her most troublesome symptoms were *screams,* which she would utter whenever startled by sudden noise.

She was the fifth of eight children, and the eldest of the girls. Her four brothers and she had their early tuition from the father, who was unquestionably a sadist of the first order. This gave her conflicts, as well as her symptoms, a much more serious character.

The nuclear experiences in the genesis of her neurosis may be summarized as follows:

(1) Beating games with an older brother which aroused both masochistic sexual feelings and anxiety and guilt, as the game was constructed around his seeing whether her knickers were soiled or not. From this time dated the sexual significance of beating.

(2) A cruel "birching" by her father for actually having soiled herself and trying to conceal the fact. This incident took a very long time to work through, and was the most traumatic of all. On the one hand she brought out a great deal of aggression, up to the wish to kill him. "I won't be beaten —I won't be crushed"—screaming and wriggling. This aspect she saw to be

responsible for her attitude to her authorities as well as for her negative transference.

On the other hand she re-experienced a profound masochistic sexual excitement at the idea of being beaten, which was practically identical with orgasm, accompanied by polypnoea, flushing, and every sign of transport as well as pain over the back and buttocks. At this stage she wrote the following remarks in a letter: "Go on with your slating—do your utmost until there is nothing left of me to appeal or plead for mercy." "I was afraid to say 'forgive me' [she meant for having made a noise in my consulting-room and generally exhibiting strong hostility]—can't you assure me that you are friendly . . . but I feel you despise me and . . . look on me as an absolute worm, and then you expect me to open my mouth and say more for you to turn and rend me again. . . . But why should you or anyone else be sympathetic towards me in my naughtiness. You don't know how much I want to win back your good will which I did have once. . . . I don't want you to demean yourself by shaking hands with me. . . . Doctor, do make me humble myself till I can no further." With her father there was no forgiveness, and, moreover, after the beating she had to return straightway to the schoolroom and pretend that nothing had happened. The whole of these two powerful emotions had to be smothered, and so they had remained until their outbreak in a neurosis.

(3) At various times she had seen the father birch her several brothers in the schoolroom for offences against Latin grammar, for such was his love of the classics. Here she would again feel an ambivalency: (*a*) Identification with the victim, even envying him the manly privileges of a good "hiding," whereas the parent would not deem her, as a girl, worthy of even that much attention. She wishes she could be a boy. Each stripe is a suppressed scream —she visualizes amid great excitement each weal on the brother's body; (*b*) Identification with the father—she felt all his sternness and power pass through her—traits she has extensively used in her own subsequent administrative career, in which she would be a veritable tyrant and disciplinarian, hard to imagine in the wriggling, panting heap of masochism on the couch or, more often, the floor of the consulting-room.

The hyperaesthesia to noise was related to another incident in which her father surprised her being "maltreated" by her brother: the latter is slapping her face, and each time she gives a little yell. Then suddenly the father springs at her from behind, and clouting her says, "I'll give you something to cry for!" Here, the yells were a form of playfully feminine coquetry, which the father, of course, would not tolerate, and so this aspect of the patient's life also had to be stifled, forming an additional stream of motivation converging on to her main symptom. In transference, this kittenish playfulness was one of the first things to be exhibited, evidently with a view to testing the analyst's capacity to tolerate the child in her.

It should be clearly understood that the unearthly cry, and the other conversion symptoms such as polypnoea, palpitations, flushing, tingling pain in the lower part of the back, weakness and

fainting attacks, were at first entirely dissociated from the above-described memories and phantasies.

The only conscious link with this content was to be found in an antagonism to the father, whom she had not visited for many years, and in a horror of all matters appertaining to sex as well as extreme shyness in her dealings with me. Her ego-ideal had incorporated some of the earlier submissive trends in her devotion to duty, but in the main it was expressive of an identification with her authoritarian father, who in this way was still able to continue his punishments of any manifestation of "weakness," i.e. femininity. Yet, preconsciously she thought of herself as a frail, uprooted, wilted little flower, and displayed every sign of intense self-pity.

Her father identification took a form which bore some resemblance to melancholia, including a half-hearted suicidal attempt, as one might theoretically expect: reiterated self-depreciatory ideas and feelings of worthlessness, which by and by became projected to me in transference, which thereafter was markedly hostile and aggressive. This patient was very clearly and undisguisably obstructing and punishing me by lying on the floor, refusing to go at the end of the session by shrieking and squirming at every interpretation, so much as to merit the name of "Kicking Kate" which my neighbour in the house bestowed on her. She seemed to say: "Look at me—your poor victim—now trample on me and see what you have done to me."

Self-pity always had dual roots: both in the feeling of resentment and in the wish to be loved. It was, of course, utterly unconscious at first, and solely appeared in these dissociated acts, which were on the borderline of hystero-epileptic manifestations.

In this case, in addition to the clear sexual Oedipal longings, we see the exhibitionism which so frequently enters into hysterical symptoms. It seems to be always of the passive kind. This patient associated the display of her buttocks (which she did very nearly in her transports on the couch) with a later scene where some boys pulled her out of bed and examined her anatomy in great detail. This type of exhibitionism, "The wish to be seen," is almost the opposite of the sort we found in the active, compulsive curiosity of the phallic phase, "The wish to see," which is linked in neurosis with obsessional formations. We learn that a hysteric needs some sort of audience for symptoms to manifest.

As a matter of observation, we see this state of affairs very

commonly in the child of four to five. The demonstrative, vindictively coloured paroxysm of self-pity when thwarted, readily assumes the form of a pain in some favourite site. "Here you are being hard on me, and all the time I am a poor ill little girl, and nobody cares." I have no doubt in my mind of the identity of this feeling of self-conscious "unlovedness" with its homologues in hysteria, all the more as in point of age-level it certainly corresponds with the genital Oedipal phase of Freud. The three examples quoted are all illustrations of the correctness of the psychoanalytic teaching that the dynamic aspect of hysteria comes from this level of libidinal organization.

As a specialized type of masochistic drive we may refer back to the underlying phantasies in Case No. 9—the woman with a phobia of travelling in public conveyances and of being alone. This patient went through a phase of beating herself with sexual excitement when sexually frustrated. This proved to have been the result of an introjection of the breast after an oral frustration with the formation of a super-ego forbidding sexual gratification. The train of associations represented an inversion of her own aggression against the breast into a wish for rape. It is suggested that somewhere between the anal and the genital phases an active aggression is replaced by masochism as a mechanism for dealing with excessive charges of hate. It seems as if the bad object is finally introjected.

The phobia, it will be remembered, began in a train carrying her away from the cares of the home, and had this primary libidinal content: "Freedom from responsibility—the train carries me away —I can't control it—I am quite unable to help myself—being carried off—rape—coitus scenes between uncle and aunt—he uses force—my aunt is held down—I want to be in her position—he-men—cave-men. If I can be taken without responsibility I would be blameless." The phobia is a compromise between the wish to be raped (something her husband did not give her)—the wish to be guilt-free in the matter, moreover, and the feeling of guilt itself, derived from the phantasies of the Oedipal phase (the scenes were dated to the age of 5 or 6) which equate all sexual activity of the father figure with rape. The beating was, unlike that of the previous case, symbolic of certain persisting anal and breast ideas associated with exhibitionistic play and recollections of a girl whose father used to beat her with a big stick. This case links up the fear of sex with the wish for it, as in the little girl's phantasies it means being overcome with violence;

hence often the sense of loss of personality and self-esteem that lead, in a general sense, to masculine over-compensations on the part of hysterically disposed women. The phobia had the same value as the shrieking of our previous case and the vomiting of the first case.

The feeling tone of the hysterical symptom is what we may call forbidden dependent, passive, *submissive* feeling, in contrast to the obsessional motive, which as we saw derived mainly from a conflict between *aggressive* tendencies and fear. There, as here, we see that both may be either the detached echoes of actual traumata, which have acquired symbolic value, or be entirely primarily symbolic: in the one of aggressive motives, in the other of submissive and dependent motives. Needless to say, these distinctions are not often so clear-cut as I have made them for the purposes of theoretical discussion.

Returning to our study of the child in a fit of self-pity, we find that we have to note several more points of value to our inquiry. Manifestly, not every tantrum of the child in the hysterical phase is concerned with sexual motives, and quite as manifestly to all but official Freudian eyes, not every case of clinical hysteria turns out to have a dynamic basis in sexual wishes. Because a number of cases have it, inferences tend to be made from established theory in all subsequent cases which then fit into that theory; especially does this become stretched beyond legitimate boundaries when we remember that everybody is supposed to have passed through the Oedipus stage, and would presumably show traces of this phase in analysis.

There are, I feel, cases of hysteria which aetiologically have very little to do with a primary sexual basis, and are almost entirely concerned with the motive of monopolization or domination of the environment in order to remain dependent, a pattern which may be summarized in the words: "Power through weakness." These are the children who will not be left alone and who become anxious, or petulant and bullying or develop some ache when nobody occupies themselves with them; and if occasion arises in later life when they experience real or imaginary deprivation of love or human interest, they will make use of the same method again, under suitable disguise.

CASE No. 18. A hale and hearty woman of 62, who came with the symptoms of throbbing headache, insomnia for twenty years and various

other complaints, showed the following genesis of her neurosis. She was an only child, but unwanted in so far as her parents wished for a boy and let her know it. Since childhood she learnt to use various complaints unconsciously to obtain sympathy, under the disguise of a masculine ego-ideal. After a financial crash of her father, she had to go out into the world at eighteen, and promptly developed headaches. She contracted a marriage of convenience with a social inferior who was always engrossed in his work. So she joined the Women's Freedom League, and after a still-born child refused to have any more pregnancies.

Some years ago they retired from London into the country, where her compensatory activities found no outlet. Her headaches returned. She resented that no one took them seriously. Then she developed such a tender scalp that her husband had to do her hair. She lost all her strength and her husband had to do everything, and when she was awake he had to be too. Previously, she said, "I had to bear my burden alone"—then with a laugh, "now he is getting it too!" I will add here that the patient had a somewhat raised blood-pressure, but it was not complicated by arterial or renal charges, and the condition was exactly like that at eighteen. Even granted the organic basis, this patient was using her symptom in order to obtain sympathy and attention, and succeeded when she became ill enough.

Such examples are, of course, very common, and the sexual issue is, I submit, clinically largely irrelevant. We are bound to admit the existence, independently from the sexual instinct, of a tendency to seek love and security such as I have frequently indicated, in order to account reasonably for this type of patient's condition. It is a tendency which is unlike aggressiveness, although it also seeks to dominate, in that its aim is to submit to someone else's care. *It is this very tendency, in fact, which is found to conflict mainly with the sexual one in cases of hysteria and anxiety hysteria.* The dread of losing the parental love causes a repression of sexual trends or feelings, with the result that the patient must now go on seeking security by remaining a dependent child.

An alternative formulation is possible; namely, that an *earlier phase* of an instinct comes into conflict with a *later phase* of the same instinct, to wit the libido. The ambivalent ("aim-inhibited") feeling towards a "bad" mother, let us say, clashes with the developing "non-aim-inhibited" feeling for the father, and for various reasons wins the battle, but the Oedipal longings are not completely and satisfactorily assimilated and dealt with. On biological, as well as practical clinical grounds, this theory has not appealed to me, and it seems more logical to regard fear and insecurity as the affective aspects of an instinct for seeking safety and

protection, rather than to fit it, by an elaborate theoretical construction, into the libido scheme.

The arguments in favour of separating the dependent tendency from sexuality are well set out in the writings of Suttie and of Hadfield. It seems that if we once abandon some such standpoint as Jung's, who postulates only one general life-force or *Hormé* (his "libido"), then we might as well admit as many "instincts" as seem needful to explain our clinical facts without strain. As already pointed out in an earlier chapter, there is evidence that psychoanalysts are coming to admit this tendency towards security as a separate instinct, referred to as "the dread of loss of love" in the negative sense, and "dependence" in the positive sense, by which the feeling of anxiety would seem to be much more reasonably accounted for than was hitherto the case.

Enough has been said to clarify the nature of the instinctive forces that are seeking satisfaction in the hysterical symptom.

2. *Mechanisms and Methods of Dealing with the Impulses*

Turning now to the methods by which the impulses are dealt with in the unconscious, we shall obviously find some mechanisms that are common to all psychology, some that are found in all the neuroses, and others that seem to be the special property of hysteria. With many of the manoeuvres found in this disease, e.g., repression, displacement, symbolization, and so on, we need therefore hardly concern ourselves, as they do not differ from the phenomena of unconscious functioning in general. We can devote our attention immediately to the last class, the special features of the hysterical armoury, and in this there is much obscurity of essential, real knowledge.

It might be an advantage once again to consider the reactions of small children at the "hysterical" level of development. Here one is struck by (1) imitativeness, (2) capacity for identification, which is perhaps the same thing, and (3) the faculty for substituting a bodily complaint when self-pity has been aroused—to which we alluded earlier on, i.e. conversion.

The small child of 4 or 5 can readily adopt any condition which it has seen in its environment: if it has seen or heard its mother say she was tired, at the next opportunity where its appeal for sympathy demands it—out will come the identical manner, phraseology and mood! In the case of more localized symptoms, not accounted

for by this imitativeness or identification, one can nearly always trace an antecedent physical or mental trauma determining the seat of the hysterical disability. This requires, of course, considerable appreciation of both the mood and behaviour of adults "as whole persons," and of their special solicitude in real illness—in fact a capacity to stand aside and observe effects. Thus a small girl in a fit of rage and self-pity was observed to go before the mirror to see what she looked like in that state. At this age-level, therefore, the "hysterical" behaviour is still integrated, for there is no conflict of its aim with an ego-ideal which would forbid the wish for dependence and so force it to become repressed and dissociated. We learn, incidentally, also whence comes the capacity for self-dramatization, which looms so large in this disease.

In many cases of conversion hysteria, where the sexual significance and symbolism is lacking or very problematical, we can trace a symptom to such humble antecedents (i.e., the need to impress the parents with a striking picture of pathos), granted that an arrest due to severe conflict took place at this level, to which the patient regresses later on. The predisposition may remain latent for so long that in many cases one gains the impression as if the mind could accomplish the same trick for the first time in adult life. Two cases of this kind will serve as examples.

CASE NO. 19. A staunch middle-aged married woman, formerly a trained nurse, expressed her wish for a place in the feelings of her mother-fixed husband, by staging, in blithe innocence, a functional paraplegia, simulating an organic paralysis of her aged mother-in-law.

She had been devotedly nursing the old lady at her own home for months. In this she was following the promptings of her own self-sacrificing and "heroic" ego-ideal by originally agreeing to this dumping of the aged invalid upon her. Gradually the husband's attitude changed: he was solicitous about his old mother, bought her grapes and gave her the best bedroom, while our patient, who after all was not even a relation, received no thanks or recognition for taking sole charge of a very disagreeable nursing job for which their income could have provided professional assistance. Moreover, the husband became *more exacting* than hitherto, criticized his wife, never took her out, etc., and treated her as an adjunct.

In the analysis these resentments of our patient's were made conscious. She recalled especially a walk which she took, feeling a criminal in revolt—for she had absented herself "when she ought not to have left the old lady," and also remembered the painful anxiety of her conflict between wishing the old lady to her grave, wanting her old position back, and the unkindness and weakness of such wishes in one whose life had been free from such petty and feline feelings. In short she was more upset by seeing *in herself*

wishes for significance and love, and aggressive impulses, than about the home situation. It made her feel quite bad and faint (= the anxiety feelings preceding conversion). She had to sit down on a park seat. When she got up—her legs gave way: she was now paralysed. The effect on the husband was electrifying. No effort was to be spared when he saw what he had done. The patient was at ease: *she* was now the invalid, and the equilibrium was restored.

It took comparatively little time to analyse these symptoms and reconstruct the early development: apart from the ego-ideal already mentioned no material became available to justify the assumption that her childhood had been one likely to predispose to hysteria: her "will-to-health" very readily overcame the slight loss of *amour-propre* demanded by insight into the purposive nature of her disability. The assumption that the symptoms formed a compromise between the wish to identify herself with her preferred mother-in-law and self-punishment needs, would do full justice to the case, and probably exhaust its meaning, but leaves us still in the dark as to the "mysterious leap from the mental to the physical," which is the essential mechanism of even this most straightforward case of "gain from the illness."

CASE No. 20. A woman of 55, a former artist, always an anxious and dependent but flamboyant type, had sought shelter from life's threats by marrying a safe, dull man, when she saw that she would not climb to the top of her profession. Lean days came, while her growing daughter claimed the husband's best attentions, and more housework devolved on our narcissistic patient. She went out one day, and after seeing a beggar with a violent tremor of his right arm, forthwith produced the identical disability, so well sustained that an eminent neurologist added to her pride by labelling her a Parkinsonian.

It is easy enough to say that such people have remained at the level of four-year-old children, and have fallen a prey to the facility for imitation and identification possessed by the child of that phase, in order to monopolize attention, but how is such a thing accomplished in their minds? The answer is most unsatisfactory, for it merely introduces the other great unknown—*dissociation.*

Conversion is certainly to be regarded as a special instance of dissociation. In its easier aspects we can follow what happens, by common sense and hypothesis rather than by proven physiological experiment. The simplest type is where a physiological accompaniment of fear becomes reconstellated into a hysterical symptom on account of conflict, as exemplified by the following:

CASE No. 21. A valiant fisherman aged 28, admitted to a general hospital, gave the history that he was thrown against a cabin on his trawler during a gale. He said he did not mind this. The next time he was due to go out in a heavy sea, he developed severe symptoms of duodenal dyspepsia. Full investigation showed no organic lesion. A comparatively superficial analytical approach disclosed the typical hysterical conflict between repressed fear and an ego-ideal of fearlessness, bred in the tradition of his environment. He realized that his epigastric sensations had been those of "wind-up," such as anyone in a state of fear might get.

The next type, again easy to follow, is that in which the site of a physical injury, originally slight, remains the focus of hysterical displacement as a *locus minoris resistentiae.* This is the common state of affairs in the industrial traumatic neuroses, a fairly good example of which was quoted in the headache of Case No. 7, the workman who had an amnesia, or indeed in the pain of the lady in Case No. 17, who had, as it were, never forgotten the gratification of her father's beatings on her back where she still experienced them as pain, although she had *forgotten* what that pain meant.

A third type still is one abundantly illustrated in psychoanalytic literature, where in addition to the above process, there occurs the mechanism of displacement. One instance will suffice:

CASE No. 22. A girl of 24 was treated for pain in her eye, without organic cause. She was in this way not only expressing her wish to escape from uncongenial secretarial work, for she had a narcissistic phantasy of herself as somebody great and artistic, but she was also using this symptom as a displacement of a conflict over masturbation. She had as a child found solace from a difficult home situation (a dissolute father, who preferred a clever older sister) in masturbating by riding astride a wooden gate, which had been a painful as well as sexually gratifying experience. She had developed the fear that she had in this way injured herself and made herself sexually inadequate. This proved to be a concretization of a psychological truth, namely that by her flight from the Oedipus situation into narcissism she had closed the door to falling in love.

Further analysis showed that before her symptoms started she had been wooed by a young man to whom she could not respond although she liked him. One day at the office she had her original pain in the vagina, which frightened her. The pain in the eye then appeared almost as a relief from the much less tolerable pain, the eye having become a symbol of the vagina.

It could not be said that this patient had done anything but *forget* the meaning of her pain and its original site, and the possible stimulus to such a displacement, apart from symbolic revaluation,

might easily have been provided by a *real* pain due to ocular fatigue in one who spent much time in clerical work.

We must not, therefore, omit to mention the fact that in many instances the choice of any particular site or type of hysterical conversion may be governed by accidental, but historically real, experiences in childhood or the recent past, i.e., through some part of the body being a *locus minoris resistentiae,* where the somatic phenomenon was associated with a traumatic psychic situation. This again is part of a general observation on the principle of displacement, to be found in all the neuroses We shall have occasion to refer to it again in our discussion of fetishism, just as we saw it illustrated in the phobias. The later re-appearance of such conversion symptoms must technically be classed with hallucinations.

McDougall equates the processes of dissociation and forgetting, and adduces speculative neurological conceptions of synaptic barriers, and so on, which no doubt must occur; but again, granted such neural events, how do these happen at the behest of a wish? Many have tried the solution of this problem, only to come back to much the same ideas, the essence of which is: return to primitive response, and shutting out of normal associative and perceptual connections in the central nervous system either for an organ or a limb, or a whole system of sentiments or portions of the personality. Pathologically speaking, there does not seem to be an essential difference between the automatism of the paralyzed limb and the co-conscious personality of the Sally Beauchamp type, for both have in common the existence of *amnesia,* one in the motor sphere, the other in the sphere of more widely spread perception.

But quite apart from this failure of innervation, as Ferenczi points out, there are those automatic activities which demand either at least an equal degree or even an increased amount of innervation as compared with the normal. All the motor manifestations of hysteria, whether in voluntary or in unstriped musculature and glands, come under this head—from the purely involuntary cry of our earlier example (Case No. 17) to mucous colitis, hysterical salivation and tremors.

The fakirs of India, and various music-hall artists elsewhere, acquire such control over normally automatic processes as the hysteric's unconscious seems to possess, and which we still see in children—as for example in the almost voluntary vomiting as revenge.

How is " the mysterious leap from the mental to bodily sphere " accomplished? Must we fall back, after all, on to postulating a special type, who never abandons the control over reflex and sympathetic activities which in the course of human phylogenesis has been relegated to subordinate spheres? It is easy enough to disentangle the many determining motives or *purposes* for these kinds of event, but we are here concerned with the deeper knowledge of the process itself whereby mind moulds the movements of bodily functions normally quite inaccessible to its control.

The discussion of this problem lands us inevitably in an as yet largely theoretical field on the fringes of metaphysics, where it is difficult to divest oneself of the traditional dualism with its body-mind antithesis. The importance of taking sides either with dualism or with monism is fortunately not very great when considering the question of conversion and dissociation, for neither philosophy as such makes the solution any easier. The former would assume a mysterious incursion of mind into what are, so to speak, purely somatic affairs, as if the commander-in-chief were to take over the management of the battalion cook-house, there to find the favourite outlets for his talent.

The second view would likewise present one with having to explain a lop-sided failure of integration, highly selective, whereby higher level function comes to be discharged at a lower neurological level. If we regard one of the aspects of mind as the " organ of adaptation " to the environment, then we must agree with Ferenczi's view, that conversion represents a giving up of the alloplastic way of meeting life, by which the individual would seek to mould or modify his environment to gain his ends, and a regression to the autoplastic form of response in which the conative energy discharges itself along inner, bodily pathways, owing to inhibition. This would be especially true of those cases where the symptom is clearly the result of an over-innervation, such as cramp or tremor, where the forces of *ex*pression and of *re*pression seem evenly balanced.

There may be some advantage in comparing the ease with which the hysteric regresses to autoplasty with the readiness of the obsessional personality to lapse into magical and animistic forms of thinking. Both, in their way, may represent " unfinished " products of evolution, partial " throw-backs " in phylogenesis, while nevertheless merely showing the persistence of stages through which

every child of modern Europe still passes. In the hysteric this defect seems to lie in his capacity for integration at a neurological level, while in the obsessional the fault lies in the sphere of adaptation of the "mental" attitude towards the inner and outer environment. Paradoxically enough, therefore, this speculation would place the hysteric at a much more primitive level, as against the position which has been assigned to him in the psychoanalytic scheme by comparison with the obsessional.

We must, therefore, distinguish between a neural level of response, as thus defined, and the age-level at which typical reaction-formations tend to occur. In the study of children we find every degree of overlap between the two phases, although undoubtedly the stage of omnipotence and marked aggression so closely associated with obsessional formations, precedes that of the hysterical tantrum, with its self-pity, its imitativeness and suggestibility and its fleeting conversions.

We know, moreover, that some "organ-neuroses" are much more closely associated with obsessional and phobic formations than with the picture of clinical hysteria, e.g., asthma, some forms of impotence, and some of the disturbances of digestive function, which may indeed be expressions of very early psychotic mechanisms, concerned with the infantile responses to organic sensation. The primitiveness of the autoplastic response, as ancient as the segmented worm, may, therefore, be *made use of* by the hysterical patient when ordinary anxiety mechanisms are not able to deal with a situation, rather than representing a true fixation. The fact still remains, however, that that door is open to only a limited and selected group of people, whom we must, in the absence of deeper knowledge, reluctantly assign to a type, one which Kretschmer would characterize as possessing an abnormal tendency to hyponoic and hypobulic activity. But it must be stated that one would like to regard this statement as a confession of temporary failure in understanding.

As regards *dissociation*, the issue is not exactly simplified by the analogies which have been observed between hypnotic phenomena, suggestibility, and dissociation; for while on the one hand we can, so to speak, unite a dissociated personality under hypnosis, we can also create artificial dissociations. All we can say about it is that a hidden reservoir of mental function exists in various states of complexity in different people—comprising perhaps only one

bodily process, or a whole sector of the personality—which has been segregated from the main stream by a more sudden and even more rigorous and effective force than repression, and that this force can be mobilized when occasion demands, or can be commanded by a hypnotist. At this level, psychic tensions can discharge themselves direct (hypobulically) into motor actions and can interpose barriers to the sensory representation of functions or systems and groups of functions among themselves or between them and that central experiencer—the ego. We may perhaps speak of repression as a horizontal barrier interposed between instinct impulse and its expression in egoic consciousness. Dissociation might then be visualized as a vertical barrier, or perhaps cleavage, within the repressed material itself, especially appearing when the force of repression is for any reason weakened, or inadequate to keep the offending impulses out.

Thus, the woman with the paraplegia recalled that before she was stricken with her paralysis she went for a walk and felt vaguely "fed up," and then had an anxiety condition—palpitations and trembling—which resulted from a repressed conflict "in the act" of becoming conscious, after which the paraplegia had to occur so as to restore a state of mental tranquillity which repression alone could no longer deal with. The ego-ideal was thereby spared from destruction.

Another case which teaches us a great deal on this point is that of the workman (Case No. 7) who was found to have an *amnesia* covering some hours of his life a few months previously. Essentially, this man's ego-ideal was concerned with concealing from himself the wish for help and maternal sympathy, and normally the processes of repression were adequate for this purpose, i.e. his compensatory ego-ideal of being a strong independent man kept his dependence need under control. Only on an occasion of special provocation another cleavage in the continuity of consciousness had to arise to blot out the overwhelming feelings of distress and impotent rage. Then the whole incident including the amnesia is forgotten and only remembered in analysis—there is thus further repression on top of the dissociation which is on top of an unsuccessful repression. The purposive, motivated nature of dissociation, under the same kinds of conflict that one would see in the determining of morbid repression, i.e. super-ego censorship, is well brought out and definitely refutes the mechanical sort of theories,

like those of Janet, that preceded the discovery of unconscious wish and purpose.

More frequently the *amnesic fugue* is the first symptom of a conflict between a dutiful, striving ego and an unconscious need for security. Military psychiatry has made us very familiar with the great variety of hysterical personalities that resort to this method of escape from stress. Civilian practice always provides a sprinkling of these "wanderers with lost memory." The aetiology and psychopathology are on the whole similar to those illustrated in Case No. 7.

I have not met with a case of major multiple personality of undoubted genuineness, but have dealt with one or two interesting *hystero-epileptics,* who would appear to represent a variant.

CASE No. 23. A very tall and powerfully built girl of 19, with the face of a baby, a factory operative, was sent for the treatment of epileptic fits from which she had suffered since the age of 15. She came from a working-class home, and was the youngest child, the others being two brothers. The father had died a year or two earlier as a very old man, who had had a previous marriage. There was no family history of any fits or other neuropathic or psychopathic illness. The girl was suspected of having a pituitary lesion, but investigation to that effect revealed no abnormality, and her growth was ascertained to be typical of her father's family.

The fits were described as follows: they would commence with loss of consciousness after a cry, which followed some hours of change in mood. They would often be tonic, sometimes tonic-clonic, at other times quasi-purposive. Thus she might occasionally be observed to be going through the movements of her trade, or to be apparently fighting or even muttering. From time to time she would wet herself and bite her tongue. The fits were unaffected by sedatives like bromide and luminal. She was treated analytically at first, and revealed the following story:

She had always been very attached to her father, "who could do what he liked with her," whereas she had been rebellious and antagonistic to the mother (a very sensible woman in reality), and jealous of her big brothers. She felt intensely inferior on account of her size and early puberty which had made her the victim of many indecent assaults in the dark streets of her little market-town. At 12 she had been seriously assaulted by a boy in a barn, and had fainted.

At 14, after leaving school and entering a factory, she had come under a strict forewoman towards whom she now displayed her hostility, as the result of which she became a "marked man." One day after getting into trouble she had her first fit. She admitted now that *sometimes* she did not become unconscious, but was aware of all around her but unable to initiate or control her movements. As the fits recurred at her work, she was removed and lived at home, visiting her father's grave daily, and at times having hallucinations of him calling her to join him. At other times she would

brood over his photo until it seemed to come alive and then she would be frightened. At home she was useless, lazy and bad-tempered.

As an experiment, she was hypnotized one day and duly went into a dissociated state, when she became flushed and rigid. She was commanded to recall what she was experiencing and awakened. She related with great horror that she went through the scene of the assault with the boy in the barn, and that his face then changed to that of her father. She was given reassuring interpretation, but failed to keep further appointments. It was ascertained later that she had become very excited and intractable, and had to be admitted to a mental hospital for a few weeks. She made a rapid recovery, and from that time has been free of fits and apparently well, according to follow-ups over three years.

Besides being an illustration of the classical female Oedipus complex as the cause of hysteria, this case offers a valuable commentary on the importance of a psychological approach to epilepsy, even when the fits seem to conform to type, but when they have no ascertainable organic basis. There would appear to be every gradation in the severity of the dissociation from the tantrum to the true "idiopathic" attack. It has seemed to me that the nearer the true epileptic attack the manifestations are, the more primitive aggression is present, so that idiopathic epilepsy may, after all, be a regression to the massive tension-discharge of infantile rage.

Returning to the question of dissociation we are bound to conclude from the above-mentioned case that while there is a distinction in degree, there is no difference in kind or in purpose, between morbid repression and dissociation; both subserve the function of a "cut-out" and will act in either direction—permitting or prohibiting the expression of the offending impulse; only dissociation is the more forcible, and, in a sense, the more naïve manoeuvre. It has been asserted that it is the method of lowly human types. To this it is impossible to agree.

What seems, however, true is that dissociative functioning is a return to the various automatisms that are observed in, for example, a segmented animal, perhaps somewhat analogous to the automatic movements seen in organic upper motor neurone lesions. But it must be clearly understood that the hysteric *uses* this primitive level as a vehicle for the expression of relatively mature drives, and probably always only after the ordinary mechanism of defence by anxiety has proved insufficient.

3. *The Ego Development in Hysteria*

If we revert to the case material examined in this chapter, we notice certain similarities in the ego attitudes of all the patients, determined by their ego-ideals, perhaps best summed up by the term *heroic*. This pattern, at whatever cultural level the patient may stand, is based on the *rejection of dependence* in its broadest sense, including that of feminine sexual feeling with its passive submissive colouring.

The phobic and obsessional *wants* to feel, especially the obsessional woman, in whom it takes much analytic labour to reveal the fixation of the id impulses at a " masculine," pregenital level, while their ego-ideals may be highly feminine. In the hysteric, on the other hand, there is a conscious devaluation of feeling and of softness, and a *masculine* over-compensation, in the direction of exaltation of calm, rational standards of behaviour, culminating at the extreme end of the scale in the classical *belle indifference* of the conversion case.

In the case of both men and women, this ego-ideal appears to have been adopted by identification with the father (and older brothers) whether he was the love-object, or the frustrator, or both in one. The *martyrdom* and resignation, self-pity and pathos, so prominent in the personality of many hysterics as observed by the onlooker, are *unconscious phantasies*, more often belonging to the repressed love-craving than to the ego-ideal, although we know how frequently id impulses may find their way into the ego-ideal in suitable disguise.

This is especially true of *exhibitionism*, from which many traits of the hysterical personality derive their motive force, either as direct, aim-inhibited symptoms, or as the determinant of compensations or sanctions against it. Frequently symptom and ego-ideal partake in equal measure of both sides of the conflict, in the nature of compromises. A typical example of this is the hysterical faint, where there is both the desire to abandon oneself to masochistic pleasure, and the repression of it by the super-ego. The unconscious might be saying, " Look! What a martyr to my high morality I am—you see you are killing me by your prohibition—I would suffer rather than feel horrid sex feelings—— Ah! But the delight of letting go to it—I am yielding—you don't know what I am really feeling! "

Our case material tells us further, that the hysterics with the heroic "masculine protest" sort of ego-ideal usually have strong and well differentiated object-attachments, and that their conflicts are quite frequently associated with real trauma in childhood.

There is, however, quite another and much more serious type of case with hysterical conversions, where the ego is of a *narcissistic* kind, implying deeper frustrations of their need for object-love. Their neuroses are much more often concerned with revenge motives and with the theme of "power through weakness." Their personalities are those of spoilt children, while the ego-ideal may be summed up in the notion, "I am a frail exquisite flower—nothing crude or unpleasant must touch me." The protection of their ego-ideal lies in illness, by which they manage to keep everyone on the run in their service. It is a type not infrequently found among the more inane members of Society, but it occurs also in other strata of the population. It is my opinion that they are practically inaccessible to analysis, although one can get far enough to make psychopathological deductions from the material. From such observations I feel bound to conclude that we are dealing here not with true hysteria, but with a hysterical façade which covers obsessional and schizoid-paranoid formations.

A few typical case-notes will perhaps illustrate these points without need for further discussion:

CASE No. 24. A girl of 26, a professional dancer, was seen in consultation. She was the youngest of three, having two older brothers. Her mother died at her birth, and her father and others had done all in their power "to make it up to her." She was always spoilt and treated as the baby. Whatever she did, the comment was: "Let her—she is only a child." She was surrounded by admirers. She had an unhappy love-affair at 21. She said, "Now my heart is broken—I am through with love and *prefer to be admired.*"

After this episode she developed a right-sided pain, for which a normal appendix was removed, which made no difference to the pain. She was sent to England for a rest from abroad, where she met her brothers after many years. Instead of being pleased to see her, they disapproved of her and were most unbrotherly in the matter of money. One of them apparently struck her—one imagines not without provocation. The outraged patient said, "No one has ever dared do that before," and forthwith developed headaches and trembling fits, and began a lawsuit against him, in which the supposed injury was to be responsible for her pitiful nervous condition. She refused treatment by psychological methods.

CASE No. 25. A very handsome and well-dressed unmarried man of 27 came for analysis on account of multiple anxiety symptoms, palpitations, blushing and breath-holding, in addition to general sexual and social maladjustments.

A great deal of interesting material emerged during a lengthy analysis which, in spite of some improvement, did not succeed in eradicating his main symptoms.

He was the youngest of five children. His mother was a puritan, intolerant of all pleasure, and to judge from her attitude during the progress of the case, both anxious and interfering. His early life was an alternation of spoiling and beating, so that his ego-attitude was both that of a little prince and a poor little crushed fellow who could not keep up with the others. He could never deny himself anything, and had to steal as well as make angry scenes to get his due share of attention if this seemed to flag. His phantasies were concerned with a constant need for security and for revenge when neglected. The latter he found in masturbation, which he practised continually since he could remember. This was accompanied by very agressive omnipotent phantasies. His flushing and breath-holding had ultimately that significance also.

His attitude to his parents was one of hostility, masking a wish to be coaxed back to forgiveness and affection; and the more they coaxed, the more sadistic pleasure he got from remaining stubborn. "My secret plan was to turn all my beatings into sexual pleasure; the more I am bullied, the more anxiety I feel, the greater the pleasure becomes." "I don't care a damn for any of them—I don't need their love—I am a desperate fellow." His attitude to women was derived from this: they were useful to "mess one about," like his nurses, and he would lie passively in their arms, revelling in his secret power by reason of his smallness and his look of helpless innocence, "You sweet baby—we love you—we are not angry with you," etc., etc.

In this case undoubtedly the crop of hysterical symptoms was concealing a very serious emotional arrest at pre-genital levels. The correct diagnosis was probably that of a "psychopathic personality" with schizoid features. The discussion of it will be resumed in Chapter VIII from another angle. It is here introduced to show into what deep waters one gets with the type we labelled as the narcissistic form of hysteria without the therapeutic result which is obtained in the other class.

CASE No. 26. A charming and *bien-soignée* married lady of 41, the only child of a county family, was taken on for psychological investigation at the suggestion of her physicians. The medical history of this patient would fill a volume, or more if the details of the surgical, endocrine, allergic, and vaccine treatments she had received at many temples of healing were to be included. Her illnesses, beginning at adolescence, ranged from (?) intestinal obstruction through cardiac affections, duodenal ulcers, and uterine disorders to angio-neurotic oedema, exhaustion and (?) tetany, until treatment

with an autogenous highly toxic proteose produced another attack of obstruction with complete collapse, thus completing the circle.

Her mother was a severe hysteric who dominated her father by continual scenes in which revolvers and poison bottles were freely employed as the trump cards. The patient, who was brought up in an atmosphere of spoiling and insecurity, came to be the peacemaker between them at the earliest age, and had to repress her violent feelings of rage and fear by a calm exterior. He defence against these was a withdrawal into narcissism and the adoption of an ego-ideal of being the sweet angelic child who would reunite her parents through her love.

At 14, the parents were divorced and their battles continued over her custody, while a traditional stepmother came on the scene and turned the hitherto devoted father against her. She now felt unwanted and lost—and here started the physical troubles. As so often happens, the marriage situation reproduced the home situation, and each crisis was punctuated by a physical illness. She was angelic, the husband cruel and unkind. "But when he saw what he had done he changed—just like mother got much better when I became ill." "Of course I am much too weak to have sex—my husband is most considerate and leaves me alone." "I do so enjoy life when I am well, but I am always under some kind of treatment." The patient did not continue her treatment with me.

The traumatic element in this case was very evident. Her early spoiling had suggested a way of regression for her personality development, while her love-cravings, revenge, and probably her need for punishment were converted into organ dysfunctions.

It is my impression that in this instance the patient was much more sinned against than sinning from the medical point of view, as the appalling procedures and abdominal operations performed on her were enough to produce a vicious circle of acute anxiety, exhaustion and regressive narcissism in anybody; quite apart from any primary psychogenesis which forbade this poor woman to protest, for fear that such emotional conduct would anger the kind parental figures who were bent on checking the only outlet for her feelings.

Before concluding this brief survey of the vast field of hysteria, mention must be made of a third type of hysteric—that which has, properly speaking, no single personality: those are the interesting cases of multiple, dissociated, or co-conscious personalities, of which clinical examples are rare. It is obvious, however, from the accounts of them in the medical Press, and from the few cases seen by some of my friends, that here also the splitting of consciousness obeys the purposive principle. The most superficial personality is colourless, "good" and amenable, a second personality may be

aggressive, hostile or indecent, while at deeper levels still we may find extremely primitive and almost sub-human creatures manifesting, which are disowned even by the intermediate personality. The purpose of the dissociation is, therefore, always to protect the ego (if the waking personality may be so designated) against the experience of its proscribed primitive tendencies.

Conclusion

Hysteria seems in every way the most opposite to obsessional neurosis. In the latter there is also dissociation within the offending complex, but it is the *affect* which is lost, while the idea may be in consciousness. In hysteria affect, or at any rate the somatic accompaniment of affect, appears, whereas the ideational content is split off or repressed. Thus it comes about that hysteria is a much more convincing "real" illness, thanks to the peculiar fate which those bodily concomitants may undergo.

An attempt at the definition of hysteria in terms which bring in all aspects of its psychopathology as they appear to me, would be as follows: It is a neurosis which typically utilizes dissociative mental processes for symbolic ends in the pursuit of security, freedom from anxiety and monopolization of "parental" attention from the environment. Such wishes for dependence frequently arise primarily out of the conflict of the Oedipus situation, at which age-level capacity for identification and conversion is at its maximum. The symptoms represent a compromise between wish-fulfilment and the fear of loss of love.

The ego-ideal rejects or hides this purpose by the assumption of an aggressive, rational, indifferent or heroic attitude.

The hall-mark of hysteria is in the type of its unconscious feeling content—a devouring masochism and exhibitionistic self-pity.

CHAPTER VI

THE PLAY OF OPPOSITES

THIS chapter will be devoted not to any specific morbid states or symptoms but rather to certain phenomena and themes which under various names and interpretations have always been observed in our clinical material and in the human mind generally. I am thinking now of the tendency, broadly speaking, towards dichotomy or splitting into opposites, as well as of the ever-present converse—the tendency towards fusion of incompatibles or opposites, the so-called *ambivalency*—which seems to me to be at the root of much mental difficulty and suffering.

The observation of this state of things goes back to the most venerable antiquity; thus in the *Bhagavad-Gita* of India we read the following passage: "By the delusion of the pairs of opposites sprung from attraction and repulsion, O Bharata, all beings walk this universe wholly deluded." "But those men of pure deeds, freed from the delusive pair of opposites, worship me (Krishna, the Creator of all things)," or again, "He . . . (who is) free from the pairs of opposites is easily set free from bondage."

Jung, in his fascinating study of a Chinese book of Yoga—the ancient science of psychology—illustrated the dualism which is accepted by the Taoists as underlying all nature, including man, symbolized by them as male and female currents of force, the task of man being the finding of the Golden Flower—a unifying centre of great significance and value to the individual. Analogous doctrines are found in old Hebrew treatises, in which the human personality, in correspondence with the structure of the universe, is represented as a Tree of Life, with male and female potencies, thought of as the right and left sides of the body—active and passive. In Greek mythology the same concept is expressed in the figure of Hermes, bearing this very tree of life in his hand as the caduceus, the wand with the two different-coloured serpents, having the same meaning, curling upwards to the golden sphere surmounting the top of the wand. Healing power is associated with this emblem of union, the rod of Aesculapius, the symbol of power and order in the universe.

These ideas have thus greatly exercised the human mind, which has always perceived in itself a duality, a hermaphroditism, portrayed largely in sexual imagery except in Christian philosophy, which such people as Chesterton, perhaps not without foundation, regard as a gigantic guilt-reaction to the preceding era of open sensuality.

Clearly the union of the opposites has been set as the highest goal of human achievement. To suppose that this merely signified coitus would seem to me to miss the entire point. Rather is it a task to be fufilled by the individual within himself—a process of psychological growth and unification—the resolution of conflict, to give it its modern name. The discovery of oneself, the finding of the centre from which we cannot err, of the "still small voice," of the "Golden Flower," of the "Keystone of the Arch," of the "Philosopher's stone," of the "elixir of life," the "thousand-petalled lotus," etc., etc., by whatever names this precious self-realization and acceptance has been called—this is nothing less than the aim of psychotherapy, within the limits of the patient's powers.

We have to treat these expressions of the sense of duality in man and his longing for unification with the utmost seriousness; we need to try to find clinical facts and observations that will perhaps simplify this problem, which pervades practically every aspect of life, and to attempt to bring it within the limits of a single theory which ought, if possible, to be a psycho-dynamic theory. How shall we explain the sense of duality and conflict, its origin whether in individuals or in the race as a whole?

In modern psychology these contrasts appear chiefly in such terms as the following: active and passive, sadism and masochism, superiority and inferiority, extraversion and introversion, and love and hate, and perhaps one should add thinking and feeling.

In the earlier Freudian writings there appeared only one of these—sadism and masochism; and the occurrence of these opposites in the same individual was then linked to the concept of a fundamental *bi-sexuality,* on an anatomical basis. We started life with both sets of genital rudiments and developed one at the expense of the other. Consequently, we have in us the germs of both typical dispositions, the assertiveness of the male and the submissiveness of the female as observed everywhere in Nature, and sadism and masochism are exaggerations of these.

At the passing of the Oedipus phase, and the formation of the super-ego by introjection of the parental images, a number of solutions are possible, and the choice of these, according to Freud, will be determined by the native strength, the biological quantities of maleness and femaleness in the child's make-up. A boy with much femaleness will tend to identify himself with his mother and become masochistic, submissive towards his father and towards life, and so possibly a passive homosexual at the extreme of the scale. Another, with more maleness, will identify himself with his father, become aggressive, authoritative, sadistic towards his environment, and so strengthen still further his essential masculinity. The same may happen to girls, in whom identification with the father will lead to all that Adler has called the masculine protest—a concept which Freud admits into his views, but on the basis of a preceding pre-Oedipus conflict. The opposite tendency in all these situations then undergoes repression, which, if successful, leads to a certain character development, while, if unsuccessful, it emerges as a neurotic symptom at a later stage.

Out of this situation *Jung*, as far as I can follow his mind, traces the development of the persona and the anima, which he conceives as being mutually compensatory and complementary to each other. In the case of masculine alignment, the repressed, or unconscious part of the individual will be feminine, so that a normal man will possess a female anima, a normal woman a male animus. Homosexuality is, in this sense, the pathological reversal of these positions. In seeking their soul-mate and complement, the individuals are really seeking for the lost part of themselves, of which they carry the imago in their ideal of a partner.

For Jung, conflict and anxiety arise through the repression of the "unconscious" which is the natural complement to the conscious attitude, and the patient suffers from the sense of incompleteness, endless seeking and imago-chasing always fruitless so long as it is projected on the outside. The neurosis is the attempt at restitution, at growth; the symptom represents the S O S from the banished languishing *alter ego* longing for unification and participation in the total life of the individual, from which it was excluded by the identification of the child with the collective norm as represented by its parents.

The same conflict—the search for completion—is seen by Jung in another form, that of the opposing attitudes towards the objects

—extraversion and introversion—in which the soul is always striving for the natural complement. The thinker longs for deep feeling, the emotional person for that clear, cool world of reason which always escapes him. As Jung says, "One-sided development must inevitably lead to a reaction, since the repressed inferior functions cannot be indefinitely excluded from common life and development." The time will come when "the cleavage in the individual man must again be resolved ... that the undeveloped may be granted the opportunity to live." This point of view I have found to be extremely helpful for one's work—to regard the *repressed,* that which is symptomatic, as the more real, more truly belonging to the individual, as something which, if admitted into the unity of the personality, would enhance, deepen, loosen, leaven, strengthen, or complete him or her. Each human being is psychically complete (i.e. bi-sexual) in potentiality, albeit differentiated biologically for the purposes of procreation, and socially through specialization in the division of labour necessitated by gregarious living.

One way of describing the therapeutic task is that it should bring about the reconciliation between the self and its forbidden impulses (Freud) or inferior functions (Jung). Fairbairn's recent contributions, briefly alluded to in Chapter II in relation to introjection, would seem to apply particularly to this theme. In his terms the analysis must aim at a restoration to the central ego of the split-off partial egos which play the part of unconscious antagonists in the psyche, derived from ambivalent relationships to the parents and their substitutes, internalized as "good" and "bad" objects.

To mention briefly an example, a patient already described (Case No. 8, Chap. III), a homosexual woman, who as a child was made to wear soldier's uniform, had experienced complete deprivation of maternal love and affection, and severe under-valuation of the feminine rôle in life. Outwardly she was a strong, harsh, hard-bitten creature, "horsy" and masculine. Inside she had no resistance against her own impulses, was dependent, psychic in the sense of being very intuitive and sensitive to other people's opinions of her, all expressions of passivity, inferiority and inner insecurity. Every symptom she had was an expression of her feminine side, in the sense we have used the word: the passive aspect of psychic life. She has fears of heights and of speed—the overbearing masculine attitude will fail and she needs to be protected against it; it is hollow.

Again, she is homosexual—she wants to capture her mother's love which she was not given as a child, even if she has to take it by force. I cannot conceive of this woman's symptoms except as an attempt at synthesis, at reconstruction and change in the progressive sense. The repressed fear of the hurt child will out at last. How much the more inadequate do methods of persuasion, suggestion and exhortation appear in such a light! They remind one of the earlier efforts of physicians to suppress fever, now known to be a valuable factor in the attempt at self-cure.

Contrariwise, we have our obsessional and depressive patients, outwardly meek and mild, suffering from more or less complete self-abasement in the face of the world and of their super-ego, yet boiling inside with colossal fury. They are doubtful and hesitant in their outer adjustment, while inside they have phantasies of hate and omnipotence. Here again the symptom is an attempt at the expression of this split-off aspect of the total human endowment.

The contrast in the obsessional, moreover, generally follows yet another line of cleavage: that between thinking and feeling—usually (though not by Jung) assumed to be respectively male and female ways of functioning. Every spontaneous feeling is intercepted by the critical thinking faculty; in thought, often too plainly of a compulsive, protective and defensive character, in intellectualism and rationalism, does this type attempt to escape from the banished, dangerous inner feeling world.

How can we visualize and understand these broad, major conflicts in terms of instinct-development and pathology?

In the case of the psychoneurotics and allied personality difficulties, there will, axiomatically, always be found the conflict between what Jung calls "persona" and "anima." The persona is the man as he-would-wish-to-appear (the wish often unconscious), and largely identical with the ego-ideal on the one hand and the "fictive goal" of Adler on the other. It is the constant pose, the crystallized attitude before the parents, the absorption of the parental, environmental and cultural authority into this attitude. The anima is the "repressed," and the stricter the super-ego the greater the sense of conflict and duality.

While it is nearly always the feeling values which are repressed in favour of the rational (in view of the greater utility of the latter to society), sometimes it is the other way about, as when an indi-

vidual, more often than not a woman, falls back on being the helpless child, the sentimental or irrational person when her intellect has led to intolerance in childhood. Witness the searching spirit of a girl mentioned in Chapter IV (Case No. 11), who adopted the attitude of the dunce and village idiot; or the type who is in a state of anxiety the moment a decision, an adaptation requiring intelligence, is asked of them. They can take orders, obey, even lead, but are afraid of independent thought. Thought is thus, somehow, allied to the assertion of independence, being our major weapon in the mastery of " nature "—our outer and inner environment.

We have strayed somewhat from the subject with which we began—the development of the bi-sexual theory and its relevance to the facts of sadism and masochism. There seems to be truth in the statement made by Adler that the association of superiority with aggressiveness and inferiority with submissiveness, hence of the idea of masculinity with superiority, are the products of patriarchal culture—themselves, therefore, socially conditioned, rather than biologically given. Furthermore, one meets with the expression of sadistic and aggressive traits and symptoms as frequently in women as in men. In the adaptation to a feminine rôle as demanded by present—or perhaps we should say recently past—culture, girls have to change more than boys, especially in dealing with the rather aggressive sexual phase which Freud terms the phallic phase, of which we have already seen one or two examples in our discussion on obsessional and anxiety conditions.

We saw then also how difficult, in experience rather than in theory, it was to differentiate between sexual and aggressive feelings at that stage and the preceding anal-erotic one. But it is significant that even the Freudian school have had to admit the existence of a *separate* aggressive instinct. Their views have changed round from regarding " sadism " as something primary, as a part of the sexual function—pure culture in exaggeration of the masculine component of the bi-sexual libido—to seeing the prime factor in a general drive towards *aggressiveness* which only *secondarily* may become sexualized. This I feel to be nearer the truth, clinically.

The process of such a fusion of libido and aggression is illustrated, for example, by the case of the woman mentioned previously (Chapter II, Case No. 5), who developed hysterics when

faced with the possibility of sexual advances, experiencing terror and rage.

The genesis of the symptom in the patient's unconscious was analysed thus: she has experienced strong passive sexual stimulation with her father. The mother appears as the frustrator: "It is time to go to bed." The father ceases his game abruptly, the girl is furiously angry—with both of them—and makes a terrific scene, in which she excites herself sexually, with phantasies of the father. Ultimately the mother comes and transfixes her with her eyes and shakes her, holding her rigid—she experiences orgasm which fuses with the feeling of being completely overcome and defeated. Sexual excitement henceforth means rage and hatred of the attacking mother, and this sado-masochistic mother ambivalency is later transferred to her lover. The dread of her mother ultimately wins and determines the establishment of a super-ego that represses and so "fixates" the reaction. She has active and passive beating phantasies relating to her mother as her only sexual activity until she meets the first man of her life at 30; this brings out the latent symptoms.

To mention a male case:

CASE No. 27. In the course of analysis in a man, who is essentially a hysteric, but with homosexual tendencies, we get this situation: he is being punished for masturbation by his father who gets the boy's head under his arm. He has the wish to bite father—to bite his penis off—of stamping on him and making water over him—then sees father lying there helpless, crucified, penis-less—"Then I can do what I like—masturbate." His sexuality remained hereafter an expression of the hatred for his father.

This is typical so-called sadism in the old sense, the aggressiveness of the two to five year old stage; it is pure hate, *pathologically* fused with libido.

We have already seen in Chapter IV how this feeling may become transformed into self-directed hatred which, acting through the super-ego, expresses itself as guilt, inferiority, and submissiveness, what might be called moral masochism, which was what we found in the conscious attitude of this man. It is also capable of expressing itself as suicidal feeling, it is essentially the impulse responsible for self-mutilation, from obsessional ideas of cutting oneself to nail-biting, or picking till something bleeds or hurts. All these activities, therefore, represent *ambivalent* fusions of sexuality (masturbation) with hatred, which, frustrated, has turned against the ego.

CASE No. 28. An example of this mechanism was seen during the analysis of a young man who had an obsessional fear of impotence. Among other things there emerged an extremely ambivalent feeling and behaviour towards his fiancée, a foreign girl (N.B. "the inferior anima" symbol of

Jung!) whom in her absence he ardently loved and desired, but whom when present he mentally dissected like a cadaver at autopsy with consequent horror and loathing.

The crucial point in the analysis was reached when he saw himself rejecting a hostile, withered breast (the final reduction of an unsatisfactory mother-relationship) which, because he could not love and own it, he wanted to destroy. He then felt himself directing the same destructive hatred against his penis, to which he displaced the ambivalency as a wish for self-castration by masturbation. From this we were able to understand the significance of his attitude towards the girl, and his fear of impotence. As the by-product of his insight into this early picture, he found that the earlier compulsion to pull at his penis was now represented in his life by a compulsion, (*a*) to criticize and "pull himself to pieces" mentally, and (*b*) to pick at pimples, etc., till they bled.

The above examples are intended to make clear the point of view I hold with regard to that fusion of sexual impulses with aggression which has been called sadism: namely, that *this fusion is not a normal process* in human infants, but that *it arises as a traumatic event* when the child happens to be in a state of marked sexual excitement which is then frustrated. *The rage thus evoked is* itself a morbid exaggeration if not a *perversion of the normal instinct of aggression.* The satisfaction of the latter has a pleasurable feeling tone of its own which is quite distinct from that seen in any of the above cases, and is, moreover, guilt free and uni-valent. In the *oral* stage, however, this pleasurable aggression is normally associated with biting and clawing, and so has a sensuous flavour.

The association of aggression with the *anal* or excretory stage I feel to be determined by the fact that its appearance in the life of the child coincides with that of the anal-erotic phase of sexual interest, which in itself is not infrequently inconspicuous in normal instances. This aggression often has the quality of pure anger or obstinacy, and far less frequently that of sadism proper, i.e. the experience of sexual pleasure in the infliction of mental or physical pain, or in the phantasies of doing so. It is to this feeling of "sexual pleasure in the infliction of pain" alone that the term "sadism" should be restricted. Any use of the term to include other forms of aggressive feeling is both unjustified and misleading.

We have seen that the symptoms to which the repression of "anal" aggression, usually at the Oedipus stage, gives rise are either compulsions, tempers (which latter are also a compulsive, obsessional phenomenon), or anxiety. The play of opposites is of what might be termed a "molar" character—it is, stated simply,

the fear-determined ego-ideal versus the affect. It is in this type of case that the conflict between masculine and feminine is apt to be experienced as feelings of *superiority* and *inferiority*.

Countless examples occur to one's mind to illustrate this somewhat obscure statement. We think of the boy who, in repressing his aggressiveness and omnipotence under what we may still technically call the castration threat, becomes docile and smug in his attitude, but while unable to prevent himself from acting in that way, experiences intense self-contempt and inferiority; "I feel like a girl," or "I am a moral coward, no real man will have anything to do with me," and so on, always leaving a sense of insufficiency, incompleteness, and lack of spontaneity.

Analysis reveals these feelings to be usually derived from the phase immediately preceding or succeeding the formation of the submissive—i.e. "feminine" ego-ideal, where the child turns its anger from the outer objects, e.g., the father, on to itself for its weakness and helplessness in the face of the aggressor. It seems to be a remainder of the ego-attitude before this repression occurred —where the child is really identified wholeheartedly with its own aggressiveness and feels it is omnipotent. There is as yet no split into opposites. It is unwilling to surrender this attitude, but does so ultimately under fear, and the immediately preceding attitude then persists as a phantasy—the Adlerian phantasy: "I ought to be powerful and strong." This may, in disguised form, be incorporated in the ego-ideal as a partial component—that of constant self-criticism and power-urge, while consciously it is experienced as inferiority or *sentiment d'incomplétude*.

Hence we find, even in the ego-ideal itself, the possibility of cleavage, from which may result such a hybrid as the so-called "Messianic compensation" phantasy, as, for example, in the man mentioned in Chapter II (Case No. 4), who becomes a missionary—the omnipotence wish taking on the colour of goodness and submissiveness to the superior power. From the Jungian point of view we thus see the longing for completeness to be based on a clinical fact—the repression of a component part of the human psyche which, had it developed, would have completed the individual.

Whence comes the capacity to assume the submissive, or docile ego-ideal? We derived it from the early dread of "loss of love," implying the existence in the native equipment of a positive need to be loved, the basis of co-operation and symbiosis with the mother,

the most conspicuous psychic phenomenon of the first year of life, the phase of real and *biologically normal* dependence and passivity. Whenever we succeed in pushing analysis back to the feelings of that stage, we find that this passivity and dependence is not a negative state—a sort of *laissez-faire* on the part of the child towards an active loving mother. On the contrary, there is real emotional satisfaction in being dependent, in being, we are tempted to say, "actively passive." Direct observation, moreover, shows that the infant returns, in a thousand simple ways, this love and affection, otherwise than in the act of sucking of which alone psychoanalysts take note.[1]

Sucking, however, is the most typical of these interplays of love. A patient phantasying himself at the breast, says, "I am waiting there for the sweet warm milk, passive and suspended for the whole intense pleasure feeling to pass through me." Deprive a child of the intense pleasure and satisfaction which the exercise of this dependent symbiosis gives it, on the plane of the physical or of the psychological, and you see the whole subsequent life of it devoted to the effort to recapture this state of being loved and wanted. The formation of the ego-ideal, and particularly of the pathological ego-ideal, at the passing of the aggressive anal and phallic phases of development is the re-assertion of this fundamental need, namely, to re-capture and hold parental love and approval.

In the view of some psycho-analysts this represents a *regression.* True enough, the child is forced to hark back to a phase of its life which should by now be abandoned. But the term regression scarcely does justice to the complicated structure which underlies the top-dressing of a "docile" ego-ideal. An example will illustrate this point:

CASE No. 29. A young married woman with a severe phobia. Omitting all irrelevant data, this patient was living entirely in what she called her "sugar-icing." Beneath this were repressed aggressive, hostile impulses directed against her parents (displaced on to her husband as a wish to castrate him). These in turn were a rebellious reaction which had its origin at the age of 2½ over a feeling of being unloved, and over the anxieties of cleanliness training. Before this she pictured herself as happy and loved, a baby who was well fed and made much of.

The climax to endless tantrums and enuresis came at the age of 4 or 5

[1] This statement concerning psychoanalysts should be modified, since the publication of *Love, Hate and Reparation* by Klein and Rivière, who admit the existence of tender love in infants.

when she kicked her older brother, who was her mother's favourite, and got into a paroxysm of rage, and of terror at her own rage. She was punished by a threat of smacking, and abjectly begged for mercy. It was then that she adopted the " sweet little girl " as her ego-ideal, by identifying herself with her mother's hopes for her youngest and only female child. To be safe, it was necessary to become the helpless baby once more. Her phobia, therefore, broke out when she was called upon (*a*) to leave home after her marriage, and (*b*) to function sexually—which to her was a urethral and aggressive activity.

But unless we are prepared to say that her phobic symptoms are a function of her ego-ideal, we cannot regard this case as one of a simple regression. The finally adopted ego-pattern represents a self-conscious employment of an old feeling-relation which was successful when functioning naïvely and without the secondary motivation of fear. The false " sugar-icing " of the ego-ideal is *not* behaviour like that of the *really* sweet unself-conscious baby who accepts her dependence naturally and " biologically." It is compound and includes some sort of choice (at the level of its formation), such as the inhibition of prohibited affects. This patient, for example, *cannot* weep or be angry. She can only be a perfectly behaved, tidy, exquisite angel, *always* fully controlled and living in her head, sexually frigid.

We may say that on account of the repression by an intolerant super-ego, certain childish feelings were arrested, and that owing to the dread of their re-emergence the ego-ideal itself had to remain infantile and unmodified. For this state of affairs the term *fixation* is clearly correct.

On the other hand, the *phobia,* which is the return of the repressed, represents her feelings, in this case the conflict between the infantile terror of being forsaken and the need to hurt her attackers and to be omnipotent, to abandon herself to orgies of sadistic masturbation. Moreover, until recently she had also had occasional outbursts of fury when she would throw things at her mother, to be followed by abject remorse. Hence, at this level we see the play of opposites to be a conflict between the two instinctive tendencies of dependence (love) and aggressiveness (hate), the ego-ideal being the expression of the wish to be dependent or loved, once removed, over the head of an intermediate phase of aggression, with some components derived from the aggressive instinct itself, leading to a sense of swinging between opposites—consciously or unconsciously—and hence of incompleteness and disharmony. The

tension is molar, between the whole of two organized instinct masses.

There is, of course, a further meaning to the sense of incompleteness, which goes back to a different time-period—that of the separation from the mother owing to the development of independent tendencies at the end of the first year, which threaten the blissful parasitism from within. This longing to re-unite is found mostly in pre-psychotic personalities, schizophrenics and deep sex-perversions—as in the case of the man who described his feelings at the breast. Its re-experience in mystical states of consciousness is held to be the reason for the sense of Nirvanic union and exaltation, allied to katatonic states in schizophrenia which often have every appearance of intense ecstasy. To such phenomena, which are *symptomatic*, and manifestations of the id, the term *regression* is appropriate.

This brings us to another level—the earliest—of the play of opposites, the stage of oral predominance, and I believe that it is from this level that most of the cases of true behavioural sadism derive their most important component impulses. The "masochistic," dependent, passive aspect of this phase was sufficiently expressed in the above quotation, that of the exquisite, intense feeling of sensuous joy in receiving, in being held in a position of literal "hanging" ("and underneath the everlasting arms"), receiving the nipple, which is the prototype of so much later symbolism and displacement. For the sadistic phase of the same period we look to the activation of masticatory and general muscular innervations, not excluding those of the respiratory apparatus.

The evidence for the existence of this oral aggressiveness, apart from direct observation, comes from obsessional cases, anxiety cases of the pre-Oedipus type, and, of course, psychotic and sex-perversion cases. We must note particularly, however, that where sadism exists as a phantasy or a behaviour symptom, we are dealing not with *normal* aggressiveness, but with a *morbid exaggeration* of this tendency as the result of frustration, after which it has become repressed until its emergence direct as a behaviour disorder, or as a phantasy covered by some defensive reaction-formation. The symptom is usually traceable to a relationship with the breast in which the baby was furious at being deprived of the loved object, and tried to possess it violently but unsuccessfully. In addition to

biting (of which we get the most frequent phantasies), clawing, squeezing, tearing, and ripping open are all typical expressions of the aggressiveness of this stage, which can, to some extent, be verified by watching a baby in the later stages of breast-feeding. Oral sadism is the exaggeration and elaboration of this feeling by later phantasy-formation.

The same man quoted earlier in the masochistic phase also had a very horrible vampire-phantasy, following upon a deprivation which we know actually did take place through nobody's fault: he saw himself with a huge, blood-red, open maw, with thick lips, sucking a big, open wound in his mother's breast, and draining her white.

A schizophrenic girl patient had impulses to get at a certain type of large woman, tear open their blouses and be enfolded by their generous arms and to bite their breasts while snuggling into them: these feelings were accompanied by sexual excitement, and were in the patient's mind linked to breast-deprivation and intense ambivalency of love-hate towards her mother, with whom she has actually at times felt the same impulse.

The interesting case occurs of the young man, Chapter V (Case No. 25), in whom this labile, easily oscillating conflict—a true primary ambivalency—of masochistic, dependent feelings and sadistic impulses was so related. This man had *inter alia* the interesting symptom of breath-holding, and on analysis it proved to be due to a blend of phantasies of magical omnipotence and intense anxiety at the breast, due to a fear that his mother was not pleased with him and was only feeding him mechanically. The magical power in the holding of his breath suggests an origin for some of the types of Yoga practice in this somewhat humble respiratory sadism of the infant. This patient was also for ever longing for a woman to hold him in her arms and stimulate him, coupled with impulses to strangle and torture her while she was doing it.

In contradistinction to what was termed a *molar* conflict, derived from the second to fifth years of life, one could call this type of labile, easily interchangeable, ambivalent alternation rather than conflict a *molecular* one, corresponding in instability to the degree of organization of the ego, which at this stage is so feeble that any marked arrest must lead to that breaking up into fragments which all later attempts at superstructure are powerless to prevent—to schizophrenia, or at best to severe sex-perversions, if the individual

has had the good fortune to find a defensive displacement to some part object however worthless.

A remarkable case was recently in my care, which will link up again with the more Jungian view.

CASE No. 30. A young would-be genius at painting, aged 18, was referred for depression and anxiety. Known to have been intensely spoilt, delicate and fussed over, entirely fixed to and identified with his mother, his whole outwardness—his ego-ideal, his secret goal—was to be the special clever little boy, applauded for his wonderful creations, exempt from the need for effort, soft, pliable, intuitive, sensitive. On the inner side, i.e. in his phantasies, and in his symptoms, he was stubborn as a mule, intensely hostile to his parents, imagining himself living a backwoodsman's life. He also had, as his only sexual expression, orgasms when he was riding a horse. These began at 14, and were accompanied by temporary feelings of intense mastery and power, impulses to whip and hurt the horse, especially its smooth rounded hindquarters which were, incidentally, the boy's favourite subject for drawing.

Here there seems to be a reconciliation of Jung's and Freud's views: the "repressed" is the sadism of the breast stage, yet it is of course also the germ of the masculine attitude to life stifled by a soft, yielding, introverted "Chelsea-ism" of the most ineffective kind, in response to the easiest way to mother's love and approval. He remains the child, with a most intense feeling of inferiority, the sense of having been castrated, of living on the surface. He feels he has no sincerity or spontaneity, is incomplete (note here both derivations of this feeling) and cleft in two. Can we doubt that in this case, too, in spite of the obvious schizophrenic fate of this boy, the illness is an attempt at reconciliation of the severed opposites?

I hope to have shown that we can account for the many phenomena of the opposites in psychology on a dynamic theory—that these are, in fact, the expression of conflict and ambivalencies arising from the dependent and aggressive instincts respectively. The former, in its normal function of providing the dynamics of successful symbiosis with the mother is the prototype of love and social tendencies, the latter the germ of all that we mean by power, independence and individual achievement.

I would account for the much-debated appearance of clinical as well as social sadism and masochism by the observation that those two just-mentioned normal tendencies may become fused in infancy with sexual feelings. It should be emphasized once again, that only when this fusion has occurred these terms are appro-

priate. Before sadism and/or masochism can be formed as permanent symptoms, it is, moreover, necessary that the dependent and/or aggressive impulses should be first pathologically exaggerated and then forced into repression. The more general conflicts between dependence and aggression may proceed without primarily affecting the sexual instinct, but the latter will necessarily share secondarily in the partitioning of the personality into opposed energy masses, in the manner of Fairbairn's "partial egoes."

To me also, *love* and *hate* appear as the ultimate opposites. But whereas the Freudian school would identify the former with sexuality and the latter with aggression, I would tend to regard sexuality as a third instinct whose "complexion" would depend on various degrees of its fusion with either of these two others, or more commonly with a mixture of both, perhaps at different levels.

Hate, on the other hand, is not a normal, or at least not a *primary* factor in the happy healthy infant, but represents a morbid, albeit exceedingly common, exaggeration of healthy, primary aggression as the result of frustration. The exercise of simple, primary "will to power" has in it a pleasurable feeling tone, whereas hate has a painful colouring, in spite of the substitutive satisfaction which even the latter may yield.

The cooing baby who delightedly and smilingly squeezes and digs his fingers into his mother's flesh is *not* behaving identically with the one who has been, for example, choked by the overwhelming mass of a badly administered breast, and in a paroxysm of rage and terror claws and beats the air, arching himself away from the treacherous monster. Neither will this feeling, if it happened to become fixated and emerge later as a symptom, be necessarily a sexual symptom, for it may become manifest, for example, as a fear of suffocation or asthma.

From the foregoing there emerges also the necessity of explaining my view of that difficult and debatable subject in psychology—*love.* This might have been appropriately discussed in the chapter on Hysteria, when we noted the occurrence of antagonism between "the dread of loss of love" and sexual impulses in relation to one and the same object.

Clearly, a complete feeling of love is composed of tender and sexual elements, the best instance being that of the normal adult marriage relationship, in which they are so fused as to be almost inseparable. Yet the cases we have been considering, as well as those

we shall presently encounter when dealing with the sexual abnormalities, prove the possibility of a split or dissociation between them, as when the tender element excludes the operation of the sexual components, e.g., towards a marriage partner. Either of the two parts may be repressed.

It is the "sensual," or sexual element chiefly which is the conscious affective and conative expression of the libido (=the reproductive instinct), while the tender feeling is the manifestation of the instinct of security or dependence which becomes transformed and sublimated into that type of love which the psychoanalysts would term "aim-inhibited," and which is responsible for much of our capacity for friendship, protectiveness (by inversion of the parent-child situation), and charitableness in general, implying a sense of "belonging" and social relatedness.

Contrariwise, the tender element of love may become repressed under conditions which create a pathological fusion between aggression (hatred) and sexual libido. Such seems to have been the case in nearly all the clinical examples mentioned in this chapter: guilt and the formation of the "docile" ego-ideal have been directed against sadistic sexual trends, but these in their turn have been the morbid compensation against an antecedent loss of *tender* love more deeply repressed than themselves. The human relationship has been replaced by a sexual-aggressive solace discovered in the painful tension of frustration rage.

In general, the assumption of the above theory of love easily incorporates my views on the nature of anxiety, and dispenses with the necessity of the cumbersome Freudian concept of "aim-inhibition" and conflict between two components of libido. While there is no inherent impossibility of this latter being the case—for have we not the analogy of a splitting of aggression into id and super-ego components?—the views which I prefer would seem to account for the phenomena of endopsychic conflict as well as of non-sexual human relationships with greater ease.

The reconciliation of the opposites, as a problem in psychotherapy, resolves itself into the elimination of hate, by the reduction of the sense of frustration acquired in infancy. In the security of being loved, one may safely express both one's will-to-power and one's sexual tendencies, and there will be no conflict of opposites in the pathological sense.

No wonder that this serenity of unification was acclaimed as

the highest goal of human development by the philosophers of the East, and that even amongst us raw Europeans the safe establishment in our characters of those great twin pillars is the criterion of true stability.

CHAPTER VII

SOME PERVERSIONS OF SEXUAL AIM

THE purpose of this chapter is to try and arrive at some sort of unified psychopathological picture of the chief types of sex-perversions, that is to say, of those cases where the principal complaint of the patient is an overt abnormal sexual activity in act or phantasy, in contrast to those patients who merely present evidence of underlying sexual maladjustment in the course of analysis of other conditions. It will be convenient to divide our study into two main headings: (1) those cases in whom the impulse is directed towards a human love-object, and (2) those in whom an outer love-object is either not sought or in whom it takes the form of an inanimate object, i.e. fetishism.

Admittedly there are cases that partake of characteristics of both these categories, but the point of distinction is worth stressing because it has appeared to me that the former class of case can nearly always be regarded as comparable to the psychoneuroses, whereas the latter type very frequently shows unmistakable schizophrenic characteristics. The distinction thus has a real foundation in fixation level and is of prognostic and therapeutic importance. In the last chapter we cleared a certain amount of ground in considering the sources of sadism and masochism.

At the outset we must stress that instinctive needs do not function in vacuo, but that their aim is always the establishment of contact, of relationship, with objects, in a two-way process. Further, we must remind ourselves of a very important Freudian conception in the consideration of this subject, namely that of *part objects*. In the oral-erotic stage of libidinal development the nipple is the object, and later on the whole breast seems to be involved. In the second stage one might speak vaguely of the perinaeum, or, as Freud puts it, the ancient cloaca, as the zone of excitation, and the corresponding region of the people who serve as the child's love-objects as the proper part objects of that phase, in so far as the child's unconscious is said to be unable to grasp the concept of the "person as a whole." It is only with the arrival of the phallic stage that the necessary integration is reached to be able to

attach the libido to whole persons. It must be noted, however, with some emphasis that this holds good only in the sense of the *unconscious sexual* aspects of early development, as from analysis as well as from direct observation we can get evidence that in respect of other instinctive impulses some sort of appreciation of whole persons exists at much earlier stages, as, for example, in rage or in feelings of dependence or deprivation.

(1) Cases with Object Relationship

Under this heading will fall cases of homosexuality, object-sadism and masochism and sexual impulses towards children who may be of the opposite sex. I have already said that I regard these cases as equivalent to the psychoneuroses, that is to say that they present the same fundamental structure of conflict between anxiety, the result of the fear of the deprivation of love, and sexual impulses, which have become repressed as the result of that fear, with the formation of an unsuitable ego-ideal. This view, originally propounded by Hadfield, implies an important difference from the strictly Freudian one, according to which sexual perversions are regarded as arrest of development or fixation in a certain early sexual phase which then manifests itself without repression having occurred. True, that there must be such a fixation, but we need to ask what were the causes and circumstance of that arrest.

My experience also differs from that of psychoanalysts, such as Fenichel, who states that the perversions differ from other psychoneuroses in that they are "acceptable to the ego." Among a large group of patients subject to perversion who present themselves for treatment at all, whether male or female, one finds as much opposition to and struggle against the compelling abnormal sexual drive as in a compulsion neurosis, and the impulse is felt to be just as "foreign" to the ego as any other obsession.

On the other hand, there is admittedly also a group of sexual perverts whose egos accept their abnormality. One frequently gets evidence, however, that even here there is a tendency to *justify* the perversion by a sort of over-compensation, implying an enduring deeper rejection of it. This probably accounts for the cynically superior attitude which so many homosexuals affect.

It may be that we are dealing with differences in personality structure: the former group approximate more closely to the true neuroses, the latter to the character disorders.

There are, of course, various considerations which cannot be lightly passed over and which, we are bound to say, must have a profound influence on the development of sexuality towards its normal goal—notably the endocrine constitution of the individual It is in these types that we find an absence of conflict. Quantitative defect of testicular or ovarian hormone and imbalance of secretions of other glands must play a part in such cases, where the bodily configuration and facies are, moreover, of an obviously feminoid or virile character in men and women respectively. In such cases it can be argued that psychopathology has little or no contribution to make either to their elucidation or their cure, especially as they do not often seek for our help very seriously, and with such cases I do not propose to deal. Rather will I confine myself to cases where the endocrine physical factor appeared to be negligible.

Even in these latter it is, of course, possible and indeed likely, that there are different degrees of emphasis on the development of their different psychosexual phases, e.g., in a vague sort of way we may talk about people being markedly oral or anal-erotic in their constitution in a quantitative or "economic" sense. It seems to me that it is just at this point that we need to investigate the operation of the purely psychological factors which tend to suppress or exaggerate these varying tendencies. Environmental factors begin to interact with these native dispositions from the moment of birth, and I feel that on the principle of paucity of hypothesis we should endeavour to apply to the full one theory rather than "mix our drinks" by postulating inborn differences of that kind to account for obscurity or lack of therapeutic success.

I feel that this theory lies in the ascription of paramount importance to the factor of *deprivation of love* or security *at the oral level* of development. For example, before postulating a native "over-development" of the anal-erotic element in an individual with its implied admission of therapeutic impotence it would be wiser to assume some frustration of human relationship at the earlier or later stages. Instances abound both from the observation of infantile behaviour and from analytical material in which we see the child, frustrated at the breast, exaggerating its interest in excretory activity or turning to masturbation as a solace, by the action of a displacement mechanism. The same consideration holds good for the process of regression from a precarious and dangerous hold on a more advanced stage back to an earlier one, also under the stimu-

lus of frustration. Again, sexual activities may be exaggerated and subsequently repressed as the result of frustration of some non-sexual impulse, as when we see a child, unable to get its own way, in a rage giving way to masturbation after its attempts at aggressiveness have proved hopelessly inadequate, the masturbation henceforth serving as a substitute for the angry feelings. This observation would seem to form a basis for some of the Adlerian teachings concerning the significance of sex as a substitute and symbol for power in phantasy. A variant of the way in which sex is used as a defensive cover against an intolerable non-sexual tendency is that where it is employed as a reaction against paranoid anxiety. In this particular mechanism we are approaching very close to the psychoses.

The most satisfactory way to illustrate these points would be with the help of groups of clinical examples, from which the reader will be able to draw his own conclusions, which may, indeed, be different from those presented in these pages.

(a) Active Female Homosexuality

CASE No. 31. A clever and ambitious woman of 40 had suffered for the last 10 years of her life from alternating states of childish infatuation and raging self-pity according to whether her "lady-love" for the time being was constant or fickle, or had completely abandoned her. She had an ego-ideal both of wanting to be clever and achieve great things, and of being the nice little girl. The essentials of her psychological development are these: The father died when patient was a few months old. The mother had to start earning and was always busy. The child always felt in the way and unwanted, the home being turned into business premises. There was great inferiority and jealousy towards an older brother, associated with definite penis envy. The preference shown to her brother was due, in her mind, to his possessing this organ. She has always had feelings of awkwardness and inferiority in the presence of men.

She had a feeling of intense self-pity, anxiety and loneliness; and her homosexual love-affairs followed the all-or-none principle. She was completely engrossed in one person at any given time, beyond which she never had any real affective social relationships.

Any change in attitude on the part of these friends was interpreted as a slight, as a sign of desertion, and gave rise to the paroxysms to which we have referred. The homosexual relationship oscillated between masculine and feminine roles, and the activity most desired by the patient was intense squeezing of the loved person and kissing, especially with intra-oral use of the tongue. Mutual masturbation was also used, but was distasteful. There was no doubt of the predominantly oral nature of the libidinal organization. There could also be no doubt of the profound feeling of deprivation of love and loneliness and the desire to monopolize the loved person exclusively.

Turning now to the deeper analytic findings, we get image after image of being deserted, of crying and screaming with rage because all her people appear to forget about her, all seem busy and happy except herself. The most significant phase of the analysis commences with a phantasy of herself outside her mother's bedroom door, in which she has strong wishes to do to her mother all those things with which her symptoms are concerned: she wants to hug her, squeeze her tight, dominate her, and the feeling more and more merges into a wish to eat herself right into her mother with a blending of oral and phallic aggression. At one point she gets a distinct image of something like a valve tube on a tyre sticking out of her body with which she worms her way into her mother. The mother will not let her in—she feels that mother is occupied in caressing some other person—it seems to be her brother, 6 years older. This phallic thrusting feeling takes on increasingly the sense of disappointment and rage and rises to the pitch of a wish to strangle and squeeze the life out of her mother. It is after this experience that she becomes more consciously able to feel intense hatred towards a woman with whom she has until recently had homosexual relations and who has now bestowed her favours upon someone else.

There are also earlier pictures relating more definitely to a feeling of coldness on her mother's part when the patient is feeding at the breast. In both instances her rage and fury avail her nothing. In the picture outside the bedroom door she is suddenly overcome by a feeling of anxiety. All seems dark, sinister monsters threaten her, no one wants to pay any attention to her; she feels she "has done it now." It is at this point that she represses the strong ambivalent feeling towards her mother, and takes on a partly masculine ego-ideal, which she has held until the present time, of trying to emulate her brother because he is in favour, hence being clever, unemotional, amenable and self-effacing. She has since then suffered from anxiety symptoms and tempers when thwarted or not approved of.

In the later stages of her analysis the patient was able to form a positive transference. With the suggestion of a termination of treatment we discovered that this related to an intense love attachment to a much older brother, until then scarcely mentioned by her, who had died when she was about 4 years old. This brother had always been kind and understanding, and her mother had said about him, "It was a good thing he died, for he took life so seriously." This led the patient to repress her grief but at the same time to introject him, giving us a further mechanism for her masculine alignment and for the rejection of the childish element in her: she also had to take life seriously now. We saw then that there was, after all, an Oedipal phase, and from the time that this complex emerged the patient's orientation became more definitely heterosexual.

Even from this condensed account of the case it will be seen that the conflict was concerned only in one sense with the gratification of an infantile sexual wish—that of the phallic-aggressive type, which Freud has lately described as the phase preceding the female Oedipus situation; but we are as much interested in the causation

of the arrest. Here, as usual, the concomitant anxiety symptoms lead us back to the clue that the feeling which had to be repressed was not a simple representative of phallic sexuality but an exaggerated and ambivalent one. The earliest feeling, before the sense of frustration supervened, was a pleasurable and "good" one. The imperative need for conquering and retaining possession of her mother's love drove her to what was, I think, the first morbid reaction, namely rage at frustration, the inability to adjust herself to the fact that perhaps her mother was busy or really felt her youngest child to be in the way.

In other words, sadistic rage is not a normal infantile feeling, but it is a reaction to a pre-existing abnormal situation which, in this case, appears to have a real basis, recapitulating the earlier breast-deprivation experience. The feeling of anxiety and fear at having made a mistake, at getting herself still more deeply disapproved of, is just another such pathological reaction arising from this basic sense of insecurity, as the result of which she repressed the whole of the earlier reaction including the oral-phallic sex feeling which was henceforth destined to remain fixated at that level.

The case is of further interest in that this child had not got a father to whom to turn. The beginnings of a father relationship to her eldest brother are frustrated by his untimely death, after which the libido retreats from its as yet insecure hold on this Oedipal object relation to the ambivalent oral and phallic level, with an introjection of this brother as a further component of her super-ego. Had this brother lived, the development might have proceeded to a different outcome, in which the libidinal adjustment might have remained predominantly heterosexual.

An example of this latter issue is provided by the case of the girl mentioned before, Chapter II (Case No. 5), who in a similar situation actually saw herself transfer an exaggerated feeling of a similar type to her father. In her case the goal of sexuality became normal, although she suffered from a sado-masochistic reaction, perhaps analogous to the present case, when faced with men who made love to her. In the case of the woman we are now considering, the goal has remained a quest of the mother. Another interesting point in this condition is the way in which the homosexual love feelings are inextricably bound up with intense hatred for which, to some extent, they serve as a cover. It is, I believe, these feelings

which lend to her symptoms their compulsive force in the way which I have already tried to explain in the chapter on obsessions.

This woman suffered from intense loneliness—in fact, the " Well of Loneliness "—which we see to be of the essence of the condition, rather than due primarily to any social ostracism into which a certain authoress rationalizes and projects this symptom. There is some doubt whether in this case one should regard the strong representation of oral tendencies as a regression or as a vital component of the original aetiological situation. From other earlier phantasies obtained one would be inclined to regard it as the latter, as this view would, moreover, tend to bring all the sex-perversions into line, and so to some extent simplify our views, as we shall see presently.

This patient, in being homosexual, was therefore really seeking the satisfactory relationship with her mother which she was denied and which she attempted to obtain by force in the aggressive phallic phase of development; the attempt failed; the tendency, after being exaggerated owing to an abnormal need arising out of insecurity, had to be repressed lest worse things befall. The repressed complex emerged in adolescence and behaved just like a psychoneurotic symptom; the difference being that the symptom was *itself,* as it were, unaltered, albeit transferred to mother-substitute figures. The clinical condition closely resembled an obsessional state. Actual indulgence was followed by guilt and shame, and by the consciousness that *it was not what the patient really wanted*—she was really seeking a full, intimate personal relationship such as only a " good " mother could have given her. Freud, in his paper on female sexuality, has stressed precisely this element of the mother-child relationship between female homosexuals.

In the case of the so-called *active* homosexual woman, i.e., where her strivings approximate to those of the male, the feminine, or genital, sexuality is, as it were, nipped in the bud. In the patient we have just been considering, this was actually the case. In the later phases of her analysis, in addition to the eldest brother complex, there emerged quite strong curiosity about boys and men, together with typical feminine attitudes towards them, covered by reactions of guilt and inferiority. The latter were produced by the moral attitude which she had felt her mother and various aunts take up whenever she displayed those tendencies. She was therefore driven by all those factors to *regress* to earlier forms of instinct-

gratification in connection with which she had experienced her frustrations.

In many other instances of active homosexuality in women, there is evidence that this solution of the problem of mother-fixation is arrived at by complete identification with the *father,* who appears as the dangerous, castrating rival. The only indication of this being the case in the patient we have just been discussing was that she felt she was responsible for her brother's death, rationalized in childhood as due to his grief over her wickedness and disobedience.

In another type of case where a masculine attitude has resulted from a withdrawal from the positive Oedipus situation, the clinical picture is usually one of anxiety hysteria, with, true, a masculine ego-ideal, but symptoms of overt homosexuality are lacking. The sexual aspect of the personality is often merely shown by a state of guilt and genital inhibition. That does not mean to imply that in the deeper layers well-marked homo-erotic tendencies are not found. The sexually inhibited woman with a masculine alignment, a fear of and inferiority towards men, is obviously driven back to friendships with members of her own sex which frequently show distinct erotic tinges. This, however, is not clinical homosexuality, and the repressed urges of that tendency disappear very readily on dealing with the aetiological factors.

(b) Passive Female Homosexuality

Passive homosexuality as the main presenting symptom in woman I have not met with in my practice. My clinical observations on this attitude are confined to the emergence of adolescent and infantile phantasies in women whose main neurosis has followed other clinical lines. It appears most commonly in women with phobias, and is mostly of a submissive sado-masochistic-oral character, with secondary displacement to the gluteal region. That is to say, the phantasies are often occupied with being beaten by an older woman, who naturally enough turns out to be a mother figure. The satisfaction here sought is an ambivalent dependence on the mother, of which it is not always easy to be sure whether it represents a regression from the father or a really primary fixation. It seems that these women are not certain whether to solve their Oedipal anxieties by one or the other identification, and so very easily abandon their object-love for men in favour of women. These

are the same women who tend to be blessed with "majestic" mothers and insignificant fathers, so that in truth the former may be "wearing the trousers" in their family. As Fenichel says, they have failed to fuse their masochism with their tenderness. The latter alone is given to men, the former remains fixated to their overwhelming mothers at the ambivalent oral and anal level. The discussion of this problem will be pursued further in the next chapter.

(c) Active Male Homosexuality

Is there any evidence for the existence of a primary mother-fixation in the psychopathology of male homosexuality?

CASE No. 32. In this connection there comes to mind a married man of 40 who consulted me for impotence and anxiety, but was soon to disclose a conscious sexual attraction to small boys as well as a continuance of masturbation, in which alone he satisfied his homosexual phantasies. He had not had any sexual relations with boys for many years. There was present in him the same feeling of lack of love from his mother which we met in the last case. She had used the child as a puppet for her own ambitions, phantasies and anxieties, with no understanding for his needs. The boy transfers his feelings to his father, with a strange reversal of the traditional roles of the parents. The father and little boy are in league against mother, who is depreciated. The ego-ideal of the boy develops from a mixture of burning ambition derived from mother and identification with the upright tender father.

As a solace to his frustrated mother-feeling and in defiance of her, the boy masturbates. He is discovered by his father, whose reproof is characteristic of their relationship, stern but inspiring and somehow intimately tender. At this point occurs a *fusion* of the tender feeling for his father and the sexual impulses, with an identification with the father which is later manifested in the feelings for small boys, who represent the patient himself —by the mechanism of substitution and inversion.

A characteristic viciousness and sadistic quality is present in the masturbatory act, which takes place for choice in the lavatory—and there emerge phantasies of fondling the smooth rounded lavatory basin, as well as ideas of the erotic significance of faecal odours—components clearly referable both to the breast and to the excretory levels of libidinal interest. He stated: "My wife means much less to me sexually than that lavatory basin"—a vivid picture of anal-sadistic hatred and depreciation of the mother by the child cheated of its rightful mother-relationship, which was what the patient was also seeking with his wife.

The father-fixation leading to homosexuality in this case turns out to be a mother-fixation once removed. It represents a wish to be in a satisfactory sensuous, tender relationship with his mother, with

hate components reinforcing the sexual motive, itself a substitute for the *tender* love which is really desired.

While on the subject of perversions connected with children, we may digress from the main argument for a moment, to consider the case of a man whose main sexual attraction was to small girls—they must be fair, with pink and white complexion, and very fresh and clean; a fetishistic element was present in his attraction to their knickers.

CASE No. 33. A bachelor of culture, aged 40, in whom the symptom was traced to the age of 3 or 4 (in the phallic and/or late excretory-erotic phase) when the patient saw himself dominating a mother who appeared as a purely idealized Madonna picture. This mother he wished to pull about, especially her breasts, and when she resisted to maltreat her in a sadistic way, culminating in making water over her. The outraged mother now turned into an ogre, and assumed her present withered, nasty look with wrinkled, brown, pendulous breasts, disagreeable and dirty. The little girls form the contrast picture with this creature, and were a fusion of (*a*) breast phantasies; (*b*) the mother imago he possessed; (*c*) certain actual experiences at his kindergarten.

In this case also, there was a constant fear—he never knew whether his mother would be kind or angry—a feeling of insecurity and uncertainty of her. The man's entire sexuality was expressed by phantasies and occasional stealthy little caresses of young girls. The arrest occurred under circumstances which in other ways recalled a typical Oedipus-castration situation. The symptoms were thus again expressive of the wish to recapture a certain lovely, free, sensuously satisfying world in which he had not felt able to live securely and fully as a child, and could not fail to remind us of Peter Pan and his little Wendy-mother.

E. A. Bennet,[1] has described a very similar case, relating to kissing little girls. These examples must suffice for the illustration of heterosexual addiction to small children—although we shall meet with the symptom in another case where it was a partial component of a fundamentally different condition.

To return to the case of the man with the father identification, we find that the essential causation, the level whence the sexual impulse expressing itself in homosexuality emanates, is very similar to that of the woman. Both were great power-strivers, both showed not only a repression of sexual tendencies, but a general emotional arrest and inhibition of social feeling also. Both can thus be looked at from the broad "Jungian" aspect as living in an intellectual

[1] BENNET, E. A., "Psychopathology of Sexual Perversions," *Proc. Royal Soc. Med.*, vol. xxvi, pt. 1, 1932–33, p. 32 *et seq.*

persona, harsh and hard-driving, with an inner weakness and craving for intimate, emotional things: they were flying, so to speak, on one wing.

Perhaps an even clearer picture of the genesis of this type of homosexuality on the basis of the inversion of a desired father-son relation is provided by the following rather tragic case.

CASE No. 34. A powerfully built and masculine man of 38 was referred for treatment by a public authority. He had had several terms of imprisonment for homosexual offences against boys since the age of 23.

The outbreak of symptoms occurred while patient was serving in the War as an N.C.O. A very young lad was posted to the battalion in whom patient took an affectionate and protective interest, shielding him from the more dangerous duties, etc.

One day they went into action together, and patient saw the lad killed in a horrible way. He ran about like a madman and was sent to hospital for "shell-shock." From this time he became overtly homosexual, the object of his quest being boys between 10 and 13 in short knickers and bare knees. It always started as a tender feeling: cuddling and kissing and showering gifts on them. "I would not harm a hair on their head," he said, "I love them so much." "I watch their expression when I give them toys." Then he wants them naked and ultimately mutual masturbation results.

After a short sentence in gaol he obtained a good position and decided to marry for his own protection. His wife turned out to be cold and strait-laced. He was desperately longing for a son. A daughter was born first, which patient resented. A second child was born—the much desired son—only to die after four days. This started another bout of homosexual indulgences, and an increasing estrangement from his wife, who refused to have any more children. Exposure of his practices was inevitable, and further convictions and complete degradation followed. All his family washed their hands of him.

The homosexual compulsion attacks the patient always when he is desperate, lonely and down and out, and he becomes quite reckless. It is accompanied by alcoholic indulgence.

The early history of the patient was that he was the younger of two sons of a shiftless working-class man, who left his family when patient was 16, and went off with another woman. The mother was worried, hard-working to make ends meet, never had time for her boys who had to learn to fend for themselves at a very early age. His father's unfaithfulness and his brother's forced marriage "put him off the whole subject of sex," although as a growing boy he had had many girl friends with whom there had been a good deal of sexual play fully enjoyed. He professed himself devoted to his mother and furious with his bad father.

Analytical findings. Patient was co-operative and good at association. He went back to the incident in the War and soon abreacted very violent feelings over this episode, preceded by enormous resistance against "breaking down" and showing "childish feelings." This associated with his latest

exploits, and disclosed a very sentimental idealization of boys. A boy, R., "was all I wanted to be—so *manly*—I loved him better than my own daughter." He had jealous death wishes against that boy's cruel father.

Next he recalled an entirely suppressed memory of an episode at 12 with his mother's lodger, who seduced him with presents and kindness. He suddenly felt himself having his bare knees stroked by this man, who then had anal intercourse with him. Apart from mild guilt towards his mother, his attitude towards this incident was passive and narcissistic: "I was a smart kid." He now recalled various times when he admired himself in the mirror as a boy and even as a man, dressed in fancy knickers.

Then, with the help of some interpretation of the father-son feeling, he began to express feelings of deprivation of love, how he wanted someone to like him and cuddle him. He keeps straight so long as this is the case and his career is on the up-grade. He relates a conflict between memories of former girl flames and the more recent ones of boys which came and blotted them out.

Then he recalled a very painful memory, which was clearly of the greatest importance. He related how his father, especially when the worse for drink, would make a great fuss of the patient as a small boy, cuddle and kiss him, and at times masturbate him. He would take him round public-houses with him and proudly display his little son. One evening this was again happening, the boy having been sent to fetch father home (he said, "I could do anything with father"), when the mother began to remonstrate with father. The latter completely lost his temper and was about to strike his wife with a bottle, when with extreme courage the boy struck father's wrist with a stick. Then he fainted, and found himself in bed, with his mother watching anxiously and tearfully over him. He was terrified. He was sent to relatives on a farm for about six months. On his return father was a changed man: he was now religious and clean-living, but had an ineradicable hostility to the boy and lost no opportunity of showing it.

After this memory, patient was able to face his tremendous longing for the paternal love he had lost, and was able to see the mechanism by which he had (*a*) transferred this to the lodger at 13, and later (*b*) how he had inverted and displaced the situation on to other angel-faced boys.

He now began having heterosexual dreams, in a series which culminated in the mutual interest he and an ideal woman "imago" were taking in their little son.

He related how his objection to women had been fostered by the disreputable company of harlots he saw his father keep, who jeered at the smallness of patient's penis and generally were intruders into the intimate relationship between him and father. At this stage he unsuccessfully petitioned to be released from prison on ticket-of-leave and voluntary probation, so confident was he of a growing capacity for heterosexuality which he was anxious to turn into a reality.

We now began to reach Oedipal levels, ushered in by an outburst of fury against the authorities who were denying him his heterosexual life. The ideal woman "imago" was now in bed with him and he was sucking her breast. He showed marked resistance and sheepish shame over "little child"

feelings towards his mother which were welling up in him. "I feel much more brazen talking about boys," he said. He accepted the interpretation of this situation as denoting that his love for his father was a displacement from his mother who seemed cold and was also father's perquisite, and that interpretation released a flood of memories of his mother, and of comparisons between his wife and her. He was now dwelling in heterosexual phantasies (beautiful mannequins, etc.).

We next traced out the evidence of a "split libido," in regard to women, with a negative attitude towards both components: (*a*) the mother type "was a necessary evil, all right if hungry or in trouble," but otherwise always busy, unattractive, never playful or tender, father supplied the latter, until the crisis; (*b*) the "loose-woman" type: these are like the prostitutes in the "pub"—nasty-minded and unpleasant towards him. On all counts men are the superior sex.

He then came to the realization that he had been a boy up to now, but at last felt a man, which occasion he marked by taking to wearing a hat.

An attitude of self-pity was now very marked, and it was noticed that when he was feeling this, or was at all anxious, he would stroke his own nipples on the couch.

This led us directly to early childhood impressions—feelings of loneliness and "worked-up" tension. He had one very restless night after this in which he got a very vivid painful image of himself as a baby, petulant and in an irritable, lonely rage, hugging a rag doll to himself.

This experience was followed immediately by the news that his petition for release had been rejected. He was furious, almost paranoid in his reaction against the authorities, "not because they had turned me down, but for the cold and inhuman way—after I opened my heart to them." He felt murderous, and in his rage not only reverted to homosexual phantasies, *but also beat himself* with a boot-lace, stripped, for an hour.

For the first time we met now with really serious resistance, which was overcome to the extent of reviving "foster-child" phantasies. These, when interpreted, led to abreaction of typical childish deprivation feelings of the oral stage: loneliness at not being picked up and cuddled, screaming with rage, and ultimately hurting himself (linked to the self-flagellation experience). At last he sees himself completely worn out and turning away as if saying, "Well, I must fend for myself," and begins to hug himself and hurt himself so as to produce the illusion of someone hugging him tight.

He now also volunteered the information that he often tried to get his boy-victims to beat him.

At this stage the patient was freed from prison, and in spite of every assistance felt it difficult to attend regularly.

For 2½ years he remained free from homosexual feelings, but then he relapsed. The resistance to these deep ambivalent feelings proved more than he could overcome, espcially in view of the unsympathetic treatment he received at the hands of authorities who could have helped to rehabilitate him.

The case has been quoted at some length to illustrate the theory, that even in such a clear instance of a father-son basis for homosexuality there is present a still deeper fixation to the unsatisfactory mother going back via the Oedipal to the oral stage, and that the symptom—and especially the hate component which was just beginning to emerge—was based on an introjection of this bad mother. The patient is thus not only his father, but *in being father he is the substitute of mother,* who should have loved her little boy, but who now deserves punishment and degradation as well as love at the hands of her infant son. The hatred for her is reinforced by the real attitude of the father towards her, after identification with him has taken place at a later stage. It is noteworthy, however, that this identification, in spite of its serious anti-social results, is charged with much less guilt and resistance than the more inexorably repressed love for the mother, for in this case it was the mother herself who seemed to reject him, and not merely the child who by his attack on father disturbed the latter's love for him (cf. Ian Suttie's view).

The " sour-grapes " attitude towards women exemplified by this patient leads to what can justly be described as a " masculine protest."

(d) Passive Male Homosexuality

Turning now to the study of passive homosexuality, we find, in such cases as I have had the opportunity to analyse at all fully, a similar set of early unconscious events. The main difference from the " active " group would appear to be the rather crucial one of how the individual has dealt with his conflicts over his mother-fixation. The cases we have been considering seemed to have cold, rejecting mothers and tender fathers. The passive type appear to be spoilt by their mothers and despised by their fathers. The passive homosexual (endocrine factors apart—as we have purposely not considered any with features of physical feminism) is the one who solves the problem by an identification with his mother; the active homosexual transfers his mother-fixation to his father and then identifies himself with the latter, in the way we have just seen.

In both varieties of this disorder there would seem to be an intervening reaction of secondary, regressive narcissism, in which masturbation or an analogous solace is substituted for the lacking maternal tenderness. The mother is also completely rejected as a

love-object, the attitude in consciousness being contemptuous and aggressive, albeit there arise later conscious compensations in the form of filial devotion of a superficial kind.

I have not yet had occasion to analyse a case of male prostitution, nor is it to be imagined that these types commonly apply for treatment. It would appear that it is in them that a passive element derived from mother identification is linked to anal-erotic fixation.

In my experience an overt anal-erotic element in male homosexuality is not common in those whom I have treated. They have in general not shown any great interest in anal practices. The narcissistic component, as expressed in the desire for mutual masturbation, and oral, breast elements as shown by their interest in skin contact and the identification of nipple and penis, have been much more constant, lending further support to the theory of sex-perversion which I adhere to—namely that it represents essentially a disturbance of the tender relationship to the mother at the breast stage.

Let us now turn to an actual example of a case of male passive homosexuality.

CASE No. 35. An artisan aged 28, of small but stocky and masculine build. He was the youngest of a fairly large family, and his brothers were much older. He had a congenital hernia, and was guarded and fussed over by his parents to an unbelievable extent, thereby acquiring a sense of being the omnipotent baby, an exaggeration of narcissistic anxiety, and great inferiority to and fear of his burly rough brothers, whom he associated with his father. The anxiety and the wish to dominate by means of it he found to be the most useful weapons against both his parents, and his very clearly sexually coloured attachment and devotion to his mother was employed as a constant reassurance and shield against the jeers and attacks by his brothers, towards whom most of his Oedipus hostility seemed to be directed and displaced. He became completely identified with her, and all his pursuits and interests as a child were those of a girl—he was mother's help in the kitchen, and so on. He conceived of himself as the sweet, pretty, pleasing little girl, with an amazing thirst for approval. But he also formed, out of his inferiority, an over-compensatory phantasy of the athletic, healthy, muscular boy, who became more and more the object of his quest. I think we must regard this case as one in whom we may speak of a projection of his male self—we may almost say animus, so feminine was his persona—on to the outside. Accidental mutual masturbation at 14 sealed his fate.

Consciously masochistic, feminine and precious, this patient in his phantasies is " more masculine than a male " in a way similar to the last case. He wishes to cut those silly, jabbering, soft creatures

of women out of his life, he worships the form, the clean-limbedness and virility of the young lad towards whom he feels as a bride towards her husband. At the same time his mother still sits enthroned as the ruler of his life, and an unbreakable taboo extends to all things pertaining to normal sexuality. Evidently, we may in this case speak of a narcissistic regression from a threatening Oedipus situation, with projection of one's own masculinity into the homosexual object, while seeking safety in identification with the mother, by which one hopes to disarm the father.

(e) "Narcissistic" Homosexuality

By the use of the words "narcissistic" homosexuality—an apparent contradiction in terms—it is intended to imply merely the clinical object choice of this type of patient. The active homosexual loves a boy, someone weaker, younger and more feminine than himself; the passive behaves as nearly as possible as a woman with regard to the type of lover desired. The "narcissistic" type chooses someone of his own age, often an idealized version of himself.

Thus, while in all cases of homosexuality, male and female, there is an exaggeration of, and fixation at, or regression to, a narcissistic level, as we have seen in the case material so far presented, there is in this third variety of the disease an absence of modelling of one's object choice on either the paternal or the maternal pattern, the patient himself being the object. Thus:

CASE No. 36. A young homosexual man of striking handsomeness had a dream in which he saw himself running with his own double, very like the representations of the two "dioscuroi," or the astrological sign "Gemini." His love of himself did not even need any idealization of the partner.

It is not surprising that this type of homosexual is much less desirous of cure, and at best seeks treatment for what he considers secondary symptoms, such as a sense of loneliness or anxiety, or from social expediency.

CASE No. 37. Another typical case is that of a professional man of 26 who was caught, so to speak, in the act of becoming overtly homosexual at the time of his treatment, his love-objects being aristocratic "'varsity men." His actual sexuality consisted of masturbation following admiration of himself in a mirror dressed in evening clothes. This proved to be (briefly put) an identification with his mother who had social aspirations for him and had repressed in the boy all the more self-assertive tendencies, which had also suffered as the result of prolonged ill-health. The boy at first wished to be

a worthy swain for his mother, with whom he sided in conflict against a "silly, rough, uncultured father" who was of no account. He then identified himself with his mother's admiration for him, and finally, really in quest of an object relationship other than the mother, who is barred by castration fear, he projects his narcissism on to other elegant young men.

The mechanism is: "I must not love mother, but she can love me. I shall love men as nearly as possible like myself and so maintain my mother's love: 'I shall love *them* as she loves *me*." The narcissism here is of a secondary, one may almost say acquired, character, really a form of dependence on the mother together with an identification with her, but not with her passivity.

Such cases as the last three do not appear to have suffered any deprivation but rather an excess of maternal love, nevertheless they would appear to conform to our fundamental formula of the sex-perversions, that the symptoms are the result of substitution of a sexual activity for the feeling of loss of the mother. The difference as between them and the earlier mentioned cases lies in the fact of a morbidly *exaggerated narcissism*, the result both of coddling and admiration, and of the sense of weakness and concern about their health taken over from their mother. In this type of case the self-assertive—or as we have called them in the last chapter—masculine tendencies simply do not get a chance. They are frightening and like father and must be repressed. At the resolution of the Oedipus phase such a child refuses to surrender his mother, but being driven thereto will obviously identify himself with the mother with the results which we have seen in the last chapter and in the previous case. Nevertheless at this time under the pressure of the incest barrier he also has to sacrifice the special libidinal relationship to her, which then becomes withdrawn back into narcissism. The particular sense of inferiority which was mentioned in previous chapters as arising from the repression, or dwarfing, or frustration of the aggressive tendencies is compensated for by the type of narcissistic phantasy these men have.

It may be said in one sense that the passing of the interest from purely auto-erotic activity to a quest of others constitutes an advance, a progression in the direction of growth towards object-love. On closer investigation we tend to find that this is not real interest in another person but partakes of the nature of imago-feeling, of projection of phantasy, of seeing in the homosexual partner or phantasy partner those qualities that they would like

themselves to possess, while at the same time they are obeying the maternal wish in worshipping the image their mothers have made of them. This explains the ever-unsatisfied, bickering, fault-finding nature of such homosexual relationships. In this identification lies their defence against the feeling of inferiority and anxiety which such men have in relation to normal " tough " males.

So far this aspect of the narcissistic homosexual has been dealt with from rather a general and superficial point of view. A case will now be quoted which will serve to stress the depth to which the component impulses leading to a sexual perversion reach, to illustrate the fact that our classification is artificial, and to show the over-determination which makes the presentation of these cases in detail so complicated. It will also serve as a convenient bridge between the two main categories of sex-perversions we have distinguished—namely that in which object relationship is sought and the one where object relationship is not sought, or where it is confined to part objects.

CASE No. 38.[1] A graduate aged 29 complained of compulsions to gazing and mutual masturbation, confined to frequenters of public lavatories of a low type to which he often repaired for the purpose. The desire to see was almost limited to uncircumcised penes, and included those of small boys. It was recognized by the patient from the beginning as being associated with the wish to reassure himself that his own penis (on which circumcision was performed at the age of 7) was after all not so different from others. A corollary of this was the desire to prove that fine athletic men were either circumcised or also indulged in his sort of sexuality.

Other symptoms were the obsessional fear of being or becoming a homosexual person, also of syphilis—leading to vigilance over all spots on the skin, enlarged glands, etc. The tendencies to which he was compelled to succumb were hated and feared most intensely by the patient both on ethical and on practical grounds. The practice of what he called " lavatory expeditions " had been going on for four of five years, while the desire to see penes had been present from early childhood, but especially since circumcision. He had a marked sense of inferiority to normal men, for which he had until recently quite deliberately tried to compensate by adopting the attitude of a high-brow and aesthete in dress and manner, with intellectual glorification of homosexuality as an advanced and superior cult, but he later abandoned this pose. Socially he was intensely shy and isolated, with no interest in women or in people in general, but intellectually and artistically active. His social awkwardness and feeling of depravity became lessened since reading psychological books.

Patient was the only child of very elderly and strait-laced parents. The

[1] This case was published incomplete in the *Brit. Jl. of Med. Psych.*, vol. xi, 1931, p. 239.

mother, well into her sixties, was still alive, and there was a strong antagonism against her for her religiousness and Victorianism, but with it the knowledge that he was hopelessly tied to her. He knew that his parents wanted a girl, also that he was entirely bottle-fed. From the age of two or so he was conscious of sexual feelings and interests, and masturbated with a sense of guilt after about four, when there was an episode in which he proudly displayed his penis to his mother, only to be told that he must never " touch himself there " on pain of Divine wrath and diseases. At this point he felt a sense of loss as though his penis had been cut off, especially as earlier he had experienced gratification when held out to pass urine by his mother, who on such occasions used to handle his member. In this scene he experienced great stubbornness, and would not give in until threatened by the dire results mentioned, but then he felt he must obey and conform to his mother's standard. Later he associated this prohibition with growing up, and hence disliked anyone or anything that would make a man of him: school, games, uncles, teachers, all hearty people.

He now masturbated through his pyjamas, and also expressed his sense of virility by micturating all over the place and wetting his bed as punishment for his mother. At five or six he practised mutual handling with a small neighbour and thence dated his scoptophilia, as it was a forbidden practice. When he went to school—a mixed kindergarten—he was charged by his mother to tell her everything, to be a good boy, and when he evinced interest in his little girl friends was told to think of better things. By the time he got to public school he was a real mother's darling who could neither fight nor play, was shocked by sex, and hopelessly ragged.

The effect of circumcision was to make him give up masturbation as he felt that the wrath of God was truly upon him now. He related this experience with terrible fear largely bound up with castration, as it were a much intensified recapitulation of the earlier fear with his mother. He recalled having been much nursed and pampered by his mother after the operation and feeling very happy and holy and rid of sex. When after a few days her attention slackened, he began to experience doubts and fears of being led into temptation again, and a need to see that his penis was still there. These feelings the patient recognized as being those of his main symptoms. So to the original scoptophilia was added the need for reassurance against the effects of what seemed to have been castration.

Masturbation was resumed again at fifteen. A chance meeting with a man who exposed himself to him in a lavatory led to the development of the present symptoms. An important feature about them, which emerged at a later stage, was that the compulsion nearly always came upon him when he had been thwarted in some way, such as missing an appointment or a friend, or when he felt lonely and bored. Then an intense depression, or fear, or both would descend on him, and this would gradually become changed into the desire to go on a lavatory expedition. This feeling was distinct from the fear of contagion, or of exposure, and disgust which would supervene after it was over.

So much for a summary of the patient's conscious story. It is necessary, for a fuller understanding of the meaning of his symptoms, to outline the

main points in his phantasy and dream material. From these it emerged that preceding masturbation the patient had had intense sexual longings towards his mother. Three dreams indicate this—all recited in the first few interviews: (1) I dreamt I was sleeping with mother as her husband and felt very ashamed of it, (2) I dreamt somehow my mother had got mixed up with homosexual men in lavatories, (3) I saw an archaic ugly statue of a woman with erect penes for breasts. Elaborate aggressively toned sexual phantasies of trying to grasp the mother's nipple and her withdrawing it, as well as of definite genital advances, were related; of how he was pushed away and put into a separate cot and experienced intense separateness and isolation, as well as mad fury and hatred against her for depriving him of the normal enjoyment which all other babies were entitled to.

The following brief excerpts from verbatim case-notes will establish the sequence of the development: "If only I could put my penis between her legs I would outdo father and possess her entirely." "But I have been completely frustrated—so I masturbate. I want to sort of swallow her up—but I am thrust aside by a lot of silly grown-up people like my father." "All women were in the position of my mother—sexually unapproachable, and they despised me, saying I must be brave—so I had to take to homosexuality to get over this. In it I appropriate men, and I want to choose a manly man with a foreskin." Later he expressed the breast phantasies, charged with feelings of thwarted desire, loss, and fury and revenge. "I try to grasp the nipple but it eludes me. There is no milk. So I try to get desperate pleasure from some sexual act. Then suddenly I am taken away. Why can't I have the breast like other babies? I can imagine moving the nipple up and down like a man's penis and sucking. It is like an erect penis, with milk squirting out like water from a boy's penis. I feel furious with the whole race, not having had what they have had." "I feel stranded and alone in bed—away from father and mother." "But I can console myself with my penis—I hadn't noticed before how attractive it was. But when I turn to masturbate I want to reach out to somebody—a breast." This, he said, was the normal, and he felt through it as he did towards little girls at school and understood lovers.

Another aspect emerged when he related how he saw the penis of a young man and felt deprived. "I felt hurt and pained, quite different from other people, and excluded. I am going to remain aloof. I saw a baby feeding, he was holding the breast like a penis, moving the nipple up and down, till moisture came. I got an erection when I saw this. I can't take part in any such act. I'd like to tell the world I am impotent and castrated—that would make me more furious. I want to pile up my grievance and make them realize how badly they have treated me. I can imagine other children suckling, while I lie in my cot separate . . . taking their pleasures as a matter of course—same as everybody's penis seems better than mine."

After these sort of phantasies, the analyst became his mother—he felt he was having his secret dragged out, and discharged violent and destructive hate impulses and obstinate abuse, for having had his pleasure treated as sin, and mixing them up with attempts at being forcibly cured—as in circumcision.

At this stage sexual desire for lavatory expeditions practically ceased, and all the fear of them vanished. Even when the compulsion was felt, it lacked sexual emotion, and was easily resisted, with considerable addition to the patient's sense of confidence and self-respect. Scoptophilia—actually now a desire to reassure himself about his penis—and some anxiety about relapsing—remained. There was an awakening of heterosexual interest. He felt he was back in the time before his mother forbade him masturbation.

The meaning of his symptoms can be summarized in the patient's own words, "I see it is fear that supplies the motive force"; and he sees the loneliness without mother fuse in his mind with that preceding lavatory expeditions. "I wanted to be frightened, to get back to mother. I feel better now I have got to this conclusion. Apart from that penes have no meaning for me. The first time I was tempted was when a man exposed himself and I saw his glans—I had only seen my own—and here was a chance of fellowship with an equal (i.e. one presumably also foreskin-less). Also it was a protest against mother. Also—a revenge—to drag others down to my level. Also—heterosexuality was associated with mother and something religious and moral and no pleasure to be got from it. The fear is the same as before circumcision. Mother is a safeguard. I want to be entirely dependent and kept from going wrong. I think it all began by her being annoyed when I looked at her breasts. I felt deprived. It was immoral for me. Other children —yes, I want to drag them down just like people with foreskins. My anxiety is to get someone like myself—or to drag them down to my level. It is all one now."

The phase of analysis that followed was almost entirely concerned with the uncovering and smashing of his mother identification—i.e. a false ego-ideal of priggish, prudish purity. It was after this had emerged fully that he was able, with the help of some actual prohibition, largely to dispense with the mental habit, and make some ventures into the heterosexual realm, in spite of many social and financial handicaps.

This case was, to my mind, one of fetishism—only the fetish happened to be an anatomical one—a penis. The significance of this statement will become clearer when we deal with fetishism.

In this case we see something of the terrible power of the part object to distort the entire life of an individual. From the theoretical point of view it had many interesting features. The first one was that the patient knew definitely that he had never been breast-fed. How then, we must ask, can he be fixated to the part object of the nipple he has never experienced? This raises the whole problem of the nature of these early, deep phantasies on which we base most of our psychopathology.

I believe it to be possible for very early events to be imprinted

on whatever is the physical basis of memory. We must also suppose that the urge towards the exercise and experience of certain appropriate innervations belonging to the mother-child-breast-sucking relationship exists "preformed," and is endowed with powerful energy charge since it is the essential impulse of this phase from the point of view of survival. The imperfect, perfunctory satisfaction of this instinctive pattern must leave a great amount of unexpended tension, and it is, perhaps, a painful accumulation of this kind which is precipitated into phantasy via the sensorium, and later elaborated. The phantasies may picture as actual what in reality were only dispositions to action, with their appropriate affect, as well as drawing into their orbit the emotional results of dissatisfaction, frustration, etc. It is really the same problem as that of the undischarged tension of the sex instinct in adult life which persists as "anxiety," where the latter may become linked regressively or secondarily with early conflicts. Such dispositions may remain entirely unconscious.

The other points of interest are largely concerned with the question of object-love and the relation, in the structure and psychopathology of the condition, of sexual to non-sexual motives and tendencies. There was no doubt that a large slice of this man's sex instinct was arrested, one might almost say sealed off, at the beginning of his latency period—about six or seven—when he was circumcised. It did not take long to unearth the most frank Oedipus wishes, clustering around masturbatory and urethral phantasies charged with feelings of omnipotence. But the dream of the archaic statue with penes for breasts hinted at what was to be, as tested therapeutically, the most important theme of the illness, viz., those very early phantasies to which allusion has already been made. It was at the breast level of development that most of the conflict between sexual aggression and fear of loss of the mother was fought out, and the circumcision was but a recapitulation of the earlier catastrophe. Freud himself has stated that he finds it difficult to distinguish between regression to early infantile fixation points and later, secondary formations, which many believe to be the long and the short of early phantasies.

I believe, at least in this patient, that early fixation was the most important. Firstly, there was the memory of an erection when he saw an infant at the breast, he being then fifteen. He remembers envying the child the intimate sensuous relationship which he felt

was like that of lovers. Secondly, the real capacity to love was practically nil in this patient. Every sexual interest, every human interest was in terms of penis, apart from purely intellectual relationships with colleagues, proving the lack of any but the earliest object interest.

A third point was the almost delusional nature of his belief that he had been robbed of his sexuality by circumcision, and with it the phantasy that this act of sacrifice had restored him to a pure, holy relation with his mother—a schizophrenic symptom, fortunately still amenable to interpretation. This he linked with an antecedent feeling of having been incomplete, of having thrown away something of great value—which turned out to be precisely the nipple. We frequently observe that at this early level the child interprets deprivations in terms of its own guilt, e.g., "Mother does not love me because I am bad." He also tends to introject the lost object, turning the ambivalent feeling against itself, and this is followed by anxiety and depression. In this case we discovered that feeling—and the reaction to it, which was a regression to narcissism and masturbation. At this point occurred real withdrawal of libido from the mother-breast on to the penis, to the accompaniment of powerful hatred and revenge feelings. His grievance and self-degradation also become his means of power—he glories in his shut-in-ness and peculiarity—to the extent of forming one of the chief resistances in his analysis.

At the phallic level we notice the abnormal preoccupation with his own penis—the wish to display it to his mother, etc. It is already then an obsessive substitute. From it he regresses easily to bed-wetting and excretory phantasies and activities after masturbation has been forbidden. It was actually on account of these regressions that circumcision occurred—hence the lavatory part of the symptoms. The lavatory became for him the only place both of self-assertion and of displaced mother-safety and we can imagine his feelings of reassurance, when he there finds others like himself. Again we find the early substitution of sexual solace for fear of loss of the early, sensuously loved mother—actually in opposition to a later loss of love of the non-sexual, terrible mother who becomes his super-ego, and creates an ego-ideal of purity and complete identification with her point of view, so far as sex is concerned. The meeting-point of the sensuous, the aggressive and the dependent impulses in the symptoms is very clear. For Adler this case

would illûstrate the lengths to which an individual can be driven in his search for self-assertion and significance, especially when we consider his wish to make himself the equal of "real men."

(2) Cases Without External Love-objects

We are now in a position to deal with cases in whom the sexuality does not even seek an external object of human shape. In the last patient at least there was the urge to seek the experience of intimacy aroused by mutuality, albeit it partly represented again a projection of his own narcissistic wishes, and of his desire towards restitution of his loss of the real love-object—the nipple, beyond which his libido had not advanced.

(a) Fetishism

Let us turn to a study of those manoeuvres by which the patient manages to dispense altogether with the hated and feared external object by enacting the entire drama on himself, or on some real or phantasied fetish object. It will be possible to quote a case of great value for the illustration of the complicated play of opposites and the various mechanisms and conditions underlying a *fetishism.*

Case No. 39. A man of 30 complained of erotic phantasies concerned with servants' linen caps and aprons, to a lesser extent with white linen knickers, and also with the image of his penis being put in a linen bag. These were the only objects capable of arousing sex-feeling, either by their simple contemplation or else through the idea of being dressed in these garments. We were thus dealing with a case of partial transvestitism, mostly in phantasy but with one or two actual yieldings to the impulse. Sometimes the phantasies would take elaborate form, always associated with masochism, e.g., that while dressed in servants' clothes he would be dragged along by a chariot, or hurt or humiliated in some particularly cruel or beastly way. The sex of the torturer was practically immaterial. Masturbation would result from these phantasies.

The patient became a "rolling stone" after he had matriculated from public school, where he was intensely unhappy and isolated, and for the last ten years had been living as a sort of companion to a woman much older than himself who had rescued him from the gutter, in the hope that he would prove a lover to her, but this he had found impossible because of impotence. His father had been a sadist who had eventually committed suicide when the boy was quite young. The mother was a very forcible public woman of some note, sufficiently described as the "steam-roller" by her friends, an ardent feminist who had no use for men, and had persistently depreciated the male sex in front of her children. The patient was the middle child, having an older sister and a younger brother.

The childhood had been a continuous series of illnesses, beginning with an intussusception in the first year of life, pneumonia, tonsillectomy and circumcision, all before the age of 4. Apart from the phantasies, the patient was a compulsive thinker with a gift for short-story writing, with which he could never get on owing either to an intolerable sense of strain and fatigue, or else because he was overwhelmed by the phantasies. He was, he said, incapable of any emotion except sulkiness with an underlying streak of cruel feeling. For a long time he had a compulsion to dance, the significance of which we shall presently see.

The fetishistic phantasies were related to two incidents in early childhood. That of the linen knickers dated from an experience of mutual handling with his sister, whose soft, warm flesh he felt through such a garment. He then felt how much more life and happiness his sister had, and how much more worth while it was to be like her in mother's eyes. The sensuous experience he had then was entirely in terms of his sister's feelings, i.e., we early on discovered the fact of his having identified himelf with a female role. The servant's cap and apron phantasy and the linen bag phantasy originated in a somewhat earlier experience, which fused with the later one emotionally. Apparently the latter referred both to a surgical dressing applied to his circumcision and to a half-joking punishment by his nurse for bed-wetting. He says, " It gives me a strong sex-feeling to have a bag put on by someone; I go back to a scene where my nurse is kneeling before me putting it on, she does it so daintily—I had wetted my bed, I had been washed and dried, and I am standing naked—I feel intense surrender. My eyes are full of her—I see her uniform, not face, it is the idea of being played with by her fingers and me not resisting. She is big and protective—I am obeying a loved person's command—that in itself is an exciting thing to to. I want to hug her really—a real emotional feeling. I am sorry for her that she is a servant—I love her and I am sorry—that takes on a whole lot of things I have experienced." (Here one must interpolate that this emotion emerged rather towards the end of the treatment when the early mechanisms had to a large extent been resolved, so that the identification with the servant and her submissive role was not so clear here as at an earlier stage of the analysis.)

The wish to put the penis in a bag or into drawers apart from the significance of loving intimacy had quite another motive—that of regressive castration. He says, " Putting my penis into drawers gets rid of it. It is an excrescence. I want sensation *over the whole surface,* not localized." (We note in passing the *regression* to auto-erotic skin sensuousness.) " The more I imitate a girl the more my sensuousness becomes spread. I dislike the penis there, I really want to be a girl—all the little tricks of a girl I am forced to imitate, she hasn't got a penis, a sensitive spot that sticks out. A cap and apron are highly feminine things—just like drawers. I want to play the passive role to a girl. I seem to be mixed up between what it is like and what it looks like to be a girl. A girl's figure is an object of desire—the only way to satisfy it is to be like it myself. I see girls and envy them—it gives me pleasure to imagine what they have on underneath, and wish I had it myself."

So much for his inversion into the passive feminine masochistic rôle, by identification—or, see later, by introjection of the object.

With a patient of this degree of introspection it was not difficult to revive phantasies of early relations with the mother, to which some allusion has been already made in this chapter and in a previous one. The greatest part of the analysis was occupied in the tracing out of the meaning and motivation of the inversion. We passed to this through some intermediate pictures of great fear of a majestic mother conflicting with his wish to maltreat her breast. This was an echo of phantasies relating to the situation when he had had his intussusception and was feeling completely weak and helpless. He experienced the disappointment, and even the taste in his mouth, of being fed on meat juice. The essentials of the picture were that he could obtain no milk, and later on the feeling that when the milk returned he was by this time so depressed and furious and weak that he could not take it; it was forced on him and then had a bitter taste, leading to what follows in the patient's words:

"I feel I want to squash and squeeze the breast with my fists and injure it. Yet I feel the breast is really inside me as I have been forced to take this filthy bitter milk, so I want to hurt myself. It is my own feelings towards the breast which I am somehow violating in a perfectly rabid desire to suppress them at any cost. I have the same feeling as in castration; I have got a feeling I am suppressing with a vicious hand myself, and getting a vicious satisfaction out of it. I am really enjoying myself and fulfilling myself in the arrestment of everything. I want to attack my own feeling of love of flesh, the response to the breast in me. It is an illusion to think it was ever outside me, it only appears to be the breast I am fighting. When it comes to any really strong sensation it reveals itself inside me. As there comes this sadic feeling it gets inside me—epecially the love of flesh and the flesh itself. I cannot distinguish whether it is inside or out, it is where we become continuous."[1]

In the next session he was feeling an increasing sadism towards himself, chiefly in the form of castration. This associated with his hatred for the breast; he says: "One must do something to get rid of this tension" (relating to the inability to get milk). "The tension goes on and on until I either burst or have the milk. I break. I lose the battle, my intention and feeling gets castrated, I am always in my phantasies inviting this loss of battle, so that I could have the sensuous love, so as to avoid a repetition of the awful pain-sex tension which I could not stand."

We thus see a very complicated mechanism of feeling of deprivation of the breast, arousing violent sadistic hatred which is

[1] This passage appears to provide striking evidence for Fairbairn's hypothesis of repression, being concerned not with impulse as such but with impulse in relation to a bad internal object.

introjected; and in the identification of the patient with the mother's breast we obtain the clue to the meaning of the later castration wishes which are seen to have a much deeper stratum of motivation than that of wishing to have approbation and significance in his feminist mother's eyes. The castration wish is masochism. The masochism itself is a fusion of himself as the victim—i.e. the introjected breast, with his need, owing to his fury or disappointment, to squash his wish for the breast in himself. This is causing a sort of restlessness and lack of comfort. Sadism, he says, is an exaggeration of this state of mind. "The increased wish for the breast increases the self-cruelty and need to squash this feeling."

As an example of very early endogenous repression we may also quote the following passages: "I have been swamped and knocked over by these feelings—now for a moment I have my head upright and so I am hanging on like grim death to this little patch of security—don't have any more of this panic or breast-love."

This is a striking example of the fear of obliteration of the feeble ego by overwhelming feelings of anxiety and oral aggressiveness by a withdrawal into a de-emotionalized "castrated" state of consciousness: the germ of the compulsive intellectualism of his later days which, in addition to being an attempt at pleasing his literary mother, is a castration equivalent. The idea of using omnipotence against omnipotent feelings, which we have already seen in a previous connection, occurs also here. "I rear up and smash down on myself—I get angry with the feelings that are trying to get in—I, the triumphant me, rise up in my might and smite them." We are reminded of the mechanism of the obsessional boy (Case No. 13), in the splitting of the aggressive instinct.

After this stage, the fundamental anxiety and complete weakness and feeling of lovelessness emerge. He says: "I know now that my sex phantasies are a compensation for anxiety. I have worked through that stage—now I am just uncomfortable and bed-stale. I am suspended away—isolated from everybody. I am holding myself in—for fear of being hurt. I daren't move or touch anything—I must be completely relaxed. The only relief are sensuous dreams. I want to break down and weep, but I can't. I want to be weak and somebody to comfort me—I am crying on a nurse's bib—soft breast yielding under my face. If I could break down I should be emotionally at ease—sex phantasies don't give me that—they only make up for it. I have sobbing feelings—I daren't let go—if I did I would get sharp stabbing pains over the heart—I believe I have pneumonia—I seem to be main-

taining a state of unrelaxed breathing for years for fear of those pains—it might happen any moment—like mother's slap when I didn't write properly."

Here we get another layer of meaning of the later fetish—an oscillation between self-pity and a wish for the external mother, and a fulfilment of the wish in the *tender* identification with the comfort and happiness of his sister and his nurse. The fusion of nipple and penis was discovered in yet another phase of the linen bag phantasy which was the mouth and the nipple. The process of dissociation from his feelings fitted in with the way in which he later dealt with the Oedipal mother situation—by identification with her and the wish to emulate and be approved by her.

This also has its counterpart in the early phantasies: he sees himself wanting to smash the breast—but if he did it would (he says in error significantly) " swallow " him (corrects it to " smother ")—" I should lose my identity—be blotted out." He says, " If I am not nice to it it will swallow me. I am getting worse and worse—worried stiff—I have to go back to it. I now get an awful feeling of weakness, wanting to cry—desperate inability to do this thing—no notice is taken—if I could abandon myself to weeping—it would give me enormous relief—I would be one person."

At other times also the very infantile projection-introjection mechanism in regard to his own hostile impulses was brought out in his variously feeling he wanted to slash the breast and the breast going to slash him—this being at the root of many of his phantasies of being slashed and tortured. He says, " I want to experience again this most acute sensual feeling possible—more so than any emission. I have the nipple in my mouth and that is most exciting to me as adult—this most excruciatingly lovely feeling."

The dancing compulsion, incidentally, proved to be his one activity as a " whole person "—a going forward towards mother.

The test of the real meaning of this psychopathology is in the therapeutic relief, and this has been surprisingly considerable, in spite of the schizophrenic mechanisms which this, as most cases of fetishism, showed.

A point which did not emerge from the quotations was the significance of the linen as *covering* the flesh—the resistance—the pure and sexless veil for that which was repressed—the flesh and love of the flesh. Such a description of the main outline of this case of fetishism will go far to obliterate from our minds the possible impression that in dealing with fetishism it is sufficient to trace out the specific trauma determining the actual fetish-object. The underlying motive, without question, is the fusion of opposites over the breast as an object of love and hatred, the repression of this con-

flict, and with it of all capacity for the advance in sexual object-investment and love; with the phantasies as the only relief to the tension of these repressed vital impulses. It is worthy of note that the patient experienced them as "bad objects" and threatening forces in concrete form: all manner of "Pan" and "Caliban" figures appeared to his vision with almost hallucinatory vividness during his long analysis.

Glover formulates the following general outline for the genesis of fetishism, with which we are bound to agree: "(1) In the transition between paranoidal systems [in this case represented by the introjection-projection reaction between ego and breast, H.V.D.] and a normal reaction to reality ... fetishism represents not only the continuations of the anxiety system within a contracted range, but the beginnings of an expanding reassurance system. The reassurance is due to contributions from later libidinal stages in infancy which contain a decreasing amount of sadism. (2) That clothing in general is, after food, the next line of defence in overcoming paranoidal reactions to reality. It appears reasonable to suppose that the first paranoid systems of the child attach themselves to food, that these anxieties are modified not only by the appearance of less sadistic impulses, but also by a determined effort at displacement of anxiety. In this displacement clothes take their part. When subsequently displacement leads to reactions to the clothes of external objects the foundation of the classical fetish is made."

Other cases occur to one's mind in which the therapeutic problem was easier owing to a better fundamental relationship between the patient and his mother.

CASE No. 40. A young graduate of marked athletic prowess was analysed for a fetish relating to mackintoshes. His aim was to be wrapped up in this tissue as tightly as possible and then experience an orgasm. There were practices of tying himself up with cord. The orgasm came with the feeling of complete helplessness.

The story, briefly, was that he was the youngest of the family and had a very strong feeling of inferiority, especially as the "family culture" inculcated heroism and manliness. This emanated from a very dominating mother, who made her husband look ridiculous before her children. The patient was actually referred for repeated failure to pass certain higher examinations, with much the same early history as that of the previous case. His masochistic phantasies were superficially a compensation and a rebellion against the pressure of his ego-ideal of perfection and "manliness."

The deeper findings consisted of the liberation of powerful aggression at the phallic stage, when he was so obstinate and restless that he was tied

down in his cot, lying on a mackintosh sheet. Here he saw himself struggling in a rage, fruitlessly, until exhausted he " gave in " with the feeling · " Let it all be—it is their responsibility—I can do nothing," and experienced delightful relief which he associated with orgasm. At that level also the reaction functioned as a way of escape from external compulsion. The essential mechanism was therefore again a narcissistic—or auto-erotic—regression to the level of dependence, so characteristic of the oral phase. This cloaked his fury and rebellion against compulsion, and was in turn cloaked by an ego-ideal of perfection. There was a consequent loss of libidinal relation to love-objects. The only real love-objects were small school-children if dressed in smart uniforms—a fetishistic identification of himself with children not so ragged and ugly as he felt himself to be.

Another patient showed a fetishistic reaction of a still more limited extent, functioning as an outlet for repressed omnipotence wishes.

CASE No. 41. A young professional man came for treatment of a compulsion to imagine himself as a poor servant girl, with subsequent masturbation. As in the other case of this fetish, he had to phantasize various humiliating situations. Sometimes he would give way to impulse and dress in cap and apron.

The symptom in this case had come on actually some months before being seen, after discovering that he was impotent with the girl he was engaged to marry. She was a highbrow, very intellectual, and had interests he could not follow. She was strong-willed and in general always got her own way. The culmination of this unsatisfactory relationship came when she openly went away with another man.

In his childhood, and up to then, he had been the apple of his rather dominating mother's eye, had always had *his* own way, and admitted to being a very spoilt child given to tempers when thwarted.

After about the third interview he was given the interpretation that as he was unable to assert his manhood with his girl, he had first reduced her to a poor skivvy and then proceeded to enjoy her humiliation in his own person. The result was as dramatic as it was unexpected. He accepted the mechanism, parted very quickly from his fiancée, acquired a new—and more congenial—girl friend and became entirely free of symptoms, so much so that he had no further interest in the analysis and stopped attendance after twelve interviews. He was warned that further treatment was necessary—and returned four years later with a recurrence. Owing to the war this could not be taken much further.

The case is not quoted as a therapeutic success, but as an illustration of the importance of introjection of the hostile agency, or at least of masochistic identification with it, as a means of expressing power and aggression. It is another variant of the " power through weakness " theme. It illustrates also that such

mechanisms may be slumbering in apparently well-adjusted heterosexual folk, awaiting only a frustration or a challenge to emerge fully fledged. In this last case there had been only very slight evidence of any overt sexual deviation in adolescence, in an interest in the vestments of choir-boys, and a pre-occupation with blue and black: nurses' and maids' colours. Through the first case of fetishism (No. 39) we can, however, guess at the fundamental transformations which the instinct life must have undergone in relation to the dominating mother.

Surprising as it is, there is scant record of cases of fetishism in women. I have seen one patient who admitted to a ritual of dressing in warm undergarments, snuggling into blankets in front of a hot fire and then masturbating. This she referred to a wish to make up for lack of maternal affection, which had been given to a younger sister especially during an illness. Yet one frequently observes little girls in infancy with the same sort of reassurance rituals as little boys: one will have to twirl her hair, another has acquired the need to have a fur to stroke while going to sleep, and so on.

Is there then something in the more marked aggressiveness of male babies which needs this form of compensatory masochism, or is it because women's masochism finds natural expression in later life more easily? Even so, the typical displacement to tissues or articles of attire remains an obscure problem. The assertion of psychoanalysis, that the fetish object is always a symbol of the imagined maternal penis (Fenichel) as a guarantee that castration shall not occur and one may then indulge in sexuality, seems to throw very little light on the above-cited cases, the first two of whom, moreover, recovered under the process of analysis, in which such an interpretation was not even hinted at by the material which they produced. If anything, the wish to castrate or even destroy the hostile mother would seem to be the determining motive, which, moreover, clearly derives from oral levels. In my view the fetish object therefore is ultimately the breast.[1] The predilection for soft textures and envelopment seems to lend further support to this view. The third case, still in process of analysis, however, seems to hint at the maternal penis theme. The most marked feature of the case, however, is the degree of direct and sublimated oral aggressiveness in his personality.

[1] It may be that Fenichel alludes after all to the same phenomenon. In phantasy breast and penis are often equated.

Other Types

One's views on the psychopathology of various conditions are to some extent determined—and *should* be determined—by the case material that passes through one's hands.

It has never been my lot to analyse a case of *exhibitionism*. From single examinations of such patients I am only prepared to admit a sense of inferiority, such as we found in Case No. 38 (the man with the compulsion to see penes in lavatories), and to assume that this feeling leads to the need to convince others that one possesses a penis. This is some evidence for the correctness of the psychoanalytic conception of this disorder, pending personal study of cases which might either confirm or modify my views. The same position I also hold in regard to *transvestitism*—where partial study of one case, however, leads me to believe that the motive of unconscious escape from a too masculine conscious father-identification (i.e. on the lines of compensating opposites—see previous chapter) both by being a girl and by hiding behind mother contributes factors additional to the Freudian view of this condition.

We must now turn to another form of sex-perversion, namely, that which expresses itself in *persistent auto-erotism*; and in order to "kill two birds with one stone" a case will be quoted in which this activity in addition to straightforward masturbation also took the form of *(a)* tongue sucking and biting, and *(b)* self-flagellation.

CASE No. 42. An undergraduate with a typical schizoid personality, an only boy with a younger sister. The symptoms had been going on for years, the flagellation at first in phantasy and later on in actuality. Two years before being seen he stopped all these activities, including masturbation, and then developed a very severe anxiety state. He became obsessed with the ideas he was trying to suppress.

The history takes him back to a constant feeling of misunderstanding, suspicion and mistrust of his mother. It may be summarized in his own words, "One always had to keep up one's dignity with mother. Either it was the relation of being someone special or no one at all. She provoked it. Besides one never knew when one's confidences might be turned against one." Many incidents of this superiority reaction against being treated as a small boy, really a wish to stand well in mother's esteem, came out early in the analysis, and these were accompanied by grandiose phantasies, e.g., of being the ruler of an imaginary state, which always gave him great reassurance.

Again two layers in the formation of this sex-perversion were discernible. The top layer was formed at the Oedipus stage and was analysed as a beating scene in his father's study, in which he attempted to be airily indifferent to

the punishment, but as the beating proceeded he suffered increasing fear and nervous contraction of the perinaeum which fused with sexual excitement. The pain now turned into a feeling of pride and manliness, and became a refuge and point of defiance; as he said, "a manly secret no women ever know." "You may think you are punishing me, but inside I have this warm glow as of achievement, and it's easier than doing anything, i.e. retaliating." At this stage, therefore, we uncovered a reaction of obvious utility: the sexual excitement enabled him to reassure himself against anxiety, he identified himself with his omnipotent father, and at the same time experienced masochistic homosexual gratification by this manoeuvre.

Following this point, he experienced furious hatred against "them," i.e. his parents and the whole world—a feeling which he had repressed by the sexual symptom-formation. The feeling of impotence, following the realization of how useless was his fury against his parents, was succeeded by marked depression which dominated a long period of his treatment. We then arrived at the stage of the birth of his sister, when he was three, whom he hated for displacing him from his position of omnipotence and monopoly and whom he used to hit and worry on every conceivable occasion. It was here that his wish to be someone special arose, and that constant friction with his mother began. The depression eventually was traced back via a dream to feelings of deprivation at the breast. This dream was interesting enough, and it was of little twin girls who had breasts. The girls collapsed like balloons and had to be pumped up, but somehow this failed and he felt very depressed and sorry. The symbolism was a fusion of the hostile little sister and the hostile breast, which he attacked and wanted to beat. His own buttocks were also those breasts, as indeed they were a symbol of his little sister, with both of which "bad objects" he had dealt by introjection and displacement.

The reaction to this early failure at the breast appears to have been very similar to the compulsive intellectualism and withdrawal into the self which we saw in detail in the fetish case quoted at length (No. 39). Again we see the exploitation of pathologically produced sexual excitement as a reassurance system against feelings of deprivation and anxiety at oral and later levels and against their intolerable sequel—aggressiveness, which nevertheless manages to gain expression through the beating symptom by the mechanism of introjection first of the breast itself, next perhaps of the sister, and later of the angry father whom one thereby renders innocuous.

The symptom also enabled him to maintain his phantasy of superiority, i.e., of equality with his father, as well as that of the omnipotent baby. "The intense pleasure of being beaten is only possible by suppressing all idea of outside—burying oneself in bedclothes and shutting everything out. It was my defence against loss of dignity, from realising one is a small boy." It is the triumph

of the helpless through introjection and masochistic enjoyment of one's own agression, while maintaining an ego-ideal of aloof grandeur.

Intermediate between such a case as this and one with object-investment is the one of the boy whose sexual object were the hindquarters of a horse, which was mentioned in another connection (Case No. 30, Chapter VI), where again the breast significance of the anal substitute was clear to the patient, as well as his wish to remain a castrated small boy, with an over-compensation into intellectuality and high-browism.

Conclusion

In the few cases we have reviewed in which the psychopathology has practically emerged from the patients' own mouths, which must always be the most satisfactory way of learning it, we can trace very clearly the over-determined nature of the sex-perversions; but at their root lie always the feelings and phantasies of deprivation of love fused with the hatred and fury thereby evoked. The early levels at which the libidinal and aggressive tendencies energizing the symptoms are arrested, explain the occurrence of schizophrenic mechanisms in this type of perversion. The wish for castration, for ridding oneself of the troublesome member, is an example of such a motive. But whatever the details, whatever the variants, certain fundamentals stand out—the whole thing turns round the factors of *reassurance against anxiety*, and the search for the lost position of being loved, sensuously gratified and secure, for the sake of which one will even attempt to surrender one's penis, granted the occurrence of certain early mechanisms—what Glover has called the classical fetish structure.

Our purpose is to try to account for the structure of the sex-perversion of this second category, if possible on the same theory as that which we found to cover the psychopathology of the more "mature" perversions. I think the answer lies in the observation that in sex-perversions we are invariably dealing with a *traumatic exaggeration* of the early sexual tendencies. On these the infant seizes as a way of relief of tension, of anxiety, be it from actual deprivation, or from misinterpreting a situation as such, with rejection of, and hostility towards, the original love-object. I cannot agree with Hadfield's view that the symptoms emerge in the form in which they were originally repressed, or that they represent

simple substitutes for the breast. This is true only of their emotional content. As regards their manifest form, we find that they may undergo enormous elaboration and displacement, as well as be the focus-point of secondary determinations that become attached to them, especially from anal levels.

But the essence of the matter, as I see it, lies in the *way of escape* which the sexual feelings can give to the infant under stress of anxiety, or rage, or both. The acute sensuous experience in some measure replaces the normal pleasure attendant on successful symbiosis with the mother, though it never satisfies completely. Its further fate will be inevitably either a simple persistence or repression, in the absence of special educational or therapeutic intervention. If it persists, the sexual instinct as a whole will still be capable of some development, and a comparatively normal adult sexuality may result, in which the original exaggerated tendency persists as an integral part or as an activity either disturbing to normal sex life or preferred to it. To this type of abnormality the name of *sexual aberration* can with advantage be applied. This will be taken up further in the next chapter.

If, on the other hand, repression occurs—as for example in the case of the fetishist where the pleasure of regaining the breast after deprivation was upset by fear and pain and "bitter taste"—then the usual sequence of a latent period of varying duration is followed by a return of the repressed, in the form of the symptom, in which, however, only the emotional core and the fetish object in its final crystallized state remain unaltered.

In the rejection of the breast as a love-object the feelings at that stage are left homeless and, being repressed, can henceforth only function at the same part-object level. It is in these cases that we get the full-blown perversion, which owing to its aggressive components frequently takes compulsive form.

There is another consideration, as to why arrest at the breast level, with subsequent repression, may lead to sex-perversion. It lies in the non-specificity of the instincts in the first year of life—a sort of "to be secure is to feel sensuous pleasure in attacking the breast" experience. Therefore any deprivation in the actual sucking function is liable to sequels of this kind. We saw earlier that other reactions *are* possible—such as some of the anxiety states with early components, depressions, and possibly a schizophrenic disintegration. If, with Freud, we regard sex-perversions as the inversion

of psychoneurosis, that is to say, that there has been total failure to deal with the impulses by reaction-formation, allowing them unaltered sway in the unconscious, we would ascribe this to the weakness of the ego at this stage of development. But I think I have been able to show that the persistence of these exaggerated sexual impulses is *not* a simple one, but is in *itself* a reaction-formation precisely *by means* of those impulses against deeper feelings of deprivation and loss of the mother, or the breast, to recapture which they are an attempt. Only by tracing out each detail in the symptoms can we hope to resolve all the determinants and components which have led to their formation. Because they are of the nature of reassurance the patient will cling to them until all the underlying anxiety and depression has been lifted.

The therapeutic outlook in the perversions, consequently, is not so unpromising as some would have us believe, but, in all but a few cases, it is a task of years to free the libido from its early fixations and to make it resume its interrupted path to genital heterosexuality, and to permit the love-life to move beyond the search for an all-satisfying unattainable mother, hated and loved in one's own person.

CHAPTER VIII

ABNORMALITIES IN SEXUAL FUNCTION

(a) "Aberrations"

In the previous chapter we considered the chief types of disorder arising from more or less total arrest of the sexual instinct at a pre-genital level. But the exaggeration of some component impulse—depending on the level at which the traumatic experiences occurred—replacing the normal flow of feeling between the child and its world, is not the same as its repression. We may get a *simple persistence* of such an impulse. If this happens, the major part of the libido will remain capable of further development, so that a comparatively normal adult sexuality may result in which the original exaggerated tendency persists either as an integral part or as an activity either disturbing to normal sex-life or else preferred to it. To this type of partial abnormality we give the name of *sexual aberration,* as already stated, in contradistinction to the *perversion,* a term reserved for the major forms of arrest.

As examples we may quote cases of people who prefer mutual handling, or sundry other variants, to the normal act, in an otherwise well-adjusted marriage, or where other items of fore-pleasure (which is of course the normal adult exploitation of infantile sexual trends) may largely replace straightforward coitus, which pales into relative insignificance as a means of satisfaction.

Into this heterogeneous group, I believe, also fit the cases of latent bi-sexuality or homosexuality where the mechanisms we have considered have annexed only some part of the available supply of the libido, while in other respects the aetiology may be similar to that of the true, full-blown perversions. Apart from its responsibility for manifest variants in sexual practice and potency along "normal" lines, such annexed libido may be entirely unconscious, expressing itself through choice of mate, or in still more obscure forms as various characterological traits, enriching or complicating the personality; or there may occur localized and circumscribed reaction-formations affecting the marital relationship through inhibitions and paradoxic behaviour, caused by displacement, projection, identification, and so on, in never-ending variety.

The amount of guilt present, the capacity for love and social relationship, and the degree of impoverishment of personality suffered, will be the indices as to what extent such aberrations in sexual life are to be considered as "neurotic," as reactive character traits, or as integrated and "normal" functions of the particular individual. The full investigation of a patient's sex-life *in relation to his or her partner's* is thus of the greatest possible value if we are to nail down seemingly non-sexual neurotic symptoms—vague fears, moods, or stresses of the domestic life. Such marriages will be successful to the degree to which the aberrant tendencies of the two partners are complementary and compensatory to one another.

We must now pass to consider the two most important types of abnormality that we meet with in practice: (1) *Hyper-sexuality* and (2) *Hypo-sexuality*. By the former we mean the real or alleged excessive wish for the exercise of the sexual function, while the latter covers impotence and ejaculatio praecox in men, and frigidity and vaginismus in women, as well as loss of desire in either sex. These purely descriptive terms should not be read as implying any biological standards of gonadal activity.

(b) Hyper-sexuality

In both men and women we may meet with the statement that they are too "highly sexed" as a matter of guilt or pride or most likely both. We may at once dismiss those in whom in fact we discover a fairly normal degree of sexual functioning which for reasons of cultural and educational influences is regarded as excessive, or when the patient wishes to shine by way of his splendid capacity for self-criticism and control. Here we are dealing with an abnormal ego-ideal.

The other type of person—the exaggerated rake of either sex—does indeed over-indulge, to the detriment not so much of his physical health (which is often feared) as of the other functions of the human being and the relation to other people.

In the case of *adult masturbators,* we are dealing with a sex-perversion, on the lines indicated in the previous chapter. Where "normal" coitus is concerned, in the case of *men,* we are dealing most frequently with over-compensations for feelings of inferiority in the Adlerian sense, or more deeply, for a repressed sense of lack of love and general social adjustment. In these people we find, more-

over, that the sexual act, even if normally carried out (which frequently is not the case, as many of them suffer from ejaculatio praecox), does not result in complete peace and satisfaction. A painful sense of incompleteness remains, that has to be relieved by more sex, the true nature of the displacement downwards being unconscious for the patient, who usually boasts of his callousness in the matter of tender feeling.

The general psychology of these cases confirms the fact that their sexuality is in reality a substitute for earlier deprivations: they often treat the woman without affection or respect, therefore frequently choosing inferior types of women; it is as if the sex act itself was ambivalent and used as an excretory act, with subsequent disgust and hate. They have to keep proving to themselves that they are strong and bold, in order to conceal from themselves their anxiety and childish dependence on the mother who rejected them and upon whom they make their forcible and vindictive onslaughts through the medium of her debased imago—direct or inverted and dissociated from the tender element—also to reassure themselves that their prowess is really as big as their father's.

In the analysis of such cases we may discover that in early life there were experiences in which, seeking their mother's love, and being rejected, they turned disconsolately to masturbation, which by and by helped the repression of their anxiety, and was gradually enriched by the phantasizing of beautiful girls. In practice, these girls never prove satisfactory, and the patient often experiences a strange lack of enthusiasm when it comes to the sexual union as compared with his preliminary phantasies—so, as mentioned, he tries to conjure it up by the magic of more and more orgasms. These, therefore, are people who in reality suffer from a repression of love in the non-sexual sense of that term, while their sexuality has a sadistic tinge derived from anal or phallic levels.

By way of illustration of this type of pathology there might be mentioned the case of a man aged 35 whose main reason for analysis was that he was always becoming involved in passionate relationships with girls whom he had no intention of marrying.

CASE No. 43. This patient was the youngest child of a family of five, of the professional class, with a strong puritanical background. The father was a serious, ascetic, probably neurotic man who was an elder of his church. The mother was a good but overwhelming whirlwind type of woman who made an absurd fuss of the patient, who was her "little ray of sunshine."

From early childhood he was a rebel, but had to repress his self-will completely when he developed rheumatic carditis at the age of 11, spending a year in bed, fearing Divine retribution.

The whole family, several of whom were examined by me, suffered from an intense sense of sexual guilt and had more or less serious psycho-sexual arrest.

The patient, in brief, proved to have a typical Oedipus anxiety with which he had not dealt successfully: the earliest phantasies were at the anal and urethral level, thwarted by the mother herself, and causing displacement of the now much more aggressively toned wishes to various schoolmistresses and girls at his kindergarten. These phantasies were of an omnipotent character: he was the little angel-boy who could by his attractiveness and power compel them to surrender, to undress and urinate before him.

The father situation entered at a later age, perhaps 5 or 6, when the patient, with his bigger brothers and sister, took part in various exhibitionist games, with a strong excretory flavour. In this he was discovered by his father and admonished with religious earnestness. He now felt rage and rebellion but also guilt, which led to fear of Divine punishment, culminating finally in the rheumatic fever which completed the adoption of an ego-ideal of holiness. During this long illness there was constant struggle with masturbation, and a series of phantasies of women as described.

His unconscious guilt led him to choosing a career of great discomfort and mortification of the flesh, with a constant identification with the underdog, an inability to co-operate with senior men, in fact every evidence of the operation of a castration complex.

His dealings with women in adult life followed the classical Don Juan pattern. His appeal to them was through a mixture of pathos and sexual boldness. His sexual advances were never complete, the preferred activity being to give them orgasms while he himself had none: this turned out to be not only a satisfaction for his phantasies of omnipotence but also of his wish for self-effacement, i.e. a compromise: he was not contravening his father's injunction. Coitus, however, was possible and normally performed. He could never resist a woman—nor apparently they him!—so that he would often have three or four girls, in all of whom he was trying to find the ideal woman. Further analysis showed the admixture of hatred and revenge both against mother and father: he was reducing the former to a state of sexual slavery to him, while he was taking from the latter what is not allowed. Marriage was impossible—it was dull and holy (cf. Case No. 38), nor could he give himself fully to any one girl, it was dangerous because of the (now repressed) *dependence* or admission of love to his mother it involved. It was also too incestuous: the other practices were of the order of substitutes and displacements, and so possible, like the phantasies about the schoolmistresses.

This case shows the typical structure of a psychoneurosis. There is a fundamental mother-fixation, with a rejection of the sexual component of his love. This latter now finds outlet in a phantasy system which also incorporates his aggression. The phantasy system

itself renders him liable to the danger of castration (loss of love) at his father's hands. His general life is that of the unconscious rebel against authority, before which he capitulates with mock humility. In his sex-life he never surrendered the substitute gratifications of his Oedipal wishes, which operated as a sort of underworld or *demi-monde,* in which he became involved. In general, his girl friends were of a culturally humbler type to himself, although the split in his love was not complete. The " hyper-sexuality " turns out to be more apparent than real and undoubtedly functions as a reassurance against the threat of sexual deprivation. For that reason he can never miss the chance of another intimate conquest. His delinquency is always forgiven because of his palpable pathetic charm, his irresponsibility and childlikeness, proving the persistence of his essential dependence on these women as mother-substitutes, who are kinder and more forgiving, but also " naughtier " that the real mother.

This case, incidentally, also provides an illustration of a sexual aberration, in that while the patient was normally potent, he certainly preferred the practice of handling women, in which his passive component impulses were receiving gratification by identification with the girl.

Turning now to *nymphomania*—the poetic name applied to female hyper-sexuality—we find much the same phenomena, and similar mechanisms as in the case of men. Again, on probing such cases we find that they do not really get pleasure from the act of coitus, and especially that vaginal sensation is absent or defective, but that they are compelled to seek the intimacy and promise of fulfilment which it gives because they consciously are unable to love, or disdain to be so "sloppy." They are really protesting against the feminine rôle, and are in fact trying to play the part of the male rake who can boast numerous conquests. In addition, a certain greed derived from oral sources, is present in the cases of which I have had personal experience, and the sex feeling, such as it is, is pre-genital, with a bi-sexual flavour; fluctuating between activity and aggressiveness on the one hand, and passive yielding related to the relaxation of sphincters on the other.

In this connection we may refer back to two female patients whose psychopathology was outlined in Chapter III.

Case No. 8, the woman with fear of heights and the bull episode in childhood, was such a " rake," consciously bi-sexual, using

homosexuality as the "masculine" partner in the same way as heterosexuality as an expression of her phallic masturbatory power phantasies, themselves compensations and cover for the sense of unwantedness and contemptibleness as a girl. Here the power of the environment to modify a sexual attitude is very clearly illustrated.

Case No. 10, a claustrophobic girl, did not *practise* her nymphomania, but had compulsive ideas of becoming such a person, and was phantasying sexual orgies all day long. Her unconscious sex-life was described in adequate detail to show what sort of impulses were responsible for these "nymphomanic" desires. In truth they had very little to do with the nymphae in the strict anatomical sense of that term, as her libidinal organization had scarcely advanced to the genital level. Some components relate back to a mother-fixation in which she wishes to behave towards mother as father did. Most of the energy, however, is invested in father, but the wish is *to do as he does.* The identification with him leads to a phantasy of experiencing sexual feelings from a phallic, male point of view, the female "opposite" being represented by her phobia of "letting go"—ultimately her sphincter control. Here again the strong fixation to an unsatisfactory father, the fear of falling in love, and the compensation by sex-power phantasies tinged with castration-wishes against men, are very obvious.

In another case, where the pathology is not fully worked out, the dependent love is directly served by the symptom: "It is so lovely to have someone want you—it is the intimacy I want—sex means practically nothing to me—after a time or two I get bored and the affair is finished." Yet this same girl, attractive and of good family, has laughed to scorn dozens of most eligible men who have asked her to marry them. She cannot fall in love. Clearly, the analysis must be directed to those symptoms which might provide a lead to the repressed dependent love feelings—towards father and even more often to the earlier mother-relationship—and those feelings liberated.

These people, therefore, provide examples of a "split libido," in which the ego-ideal aligns itself with the revengeful and aggressive pre-genital components, scorning love in its tender and responsible genital aspects. This is probably part of the psychopathology of prostitution, although I cannot claim to have any clinical experience of the analysis of prostitutes. In this connection

it is relevant to recall the self-punishment motive inherent in the need for degrading oneself into a harlot (Case No. 11, Chapter IV). The female cases of compulsive masturbation, which come under the heading of hyper-sexuality, betray a still more infantile organization, and frequently have a definite self-punishing, self-degrading element, related to the introjection of frustrated rage, in which respect they closely resemble those of male patients.

(c) Hypo-sexuality

Only psychogenic cases in whom organic and toxic factors have been ruled out will be considered under this head.

It is well known that debilitating organic diseases, such as syphilis (especially of the nervous system), tuberculosis, etc., may lead to loss of sexual desire and of potency. In rarer instances, particularly in pulmonary tuberculosis, there is a hyper-sexuality. It is very likely that this is of a compensatory psychogenic character. It reminds one of the intense short-lived sexual activity of may-flies and butterflies who are so soon to die. In the psychological impotences—in which female frigidity and dyspareunia without anatomical cause must be included—the picture is just the reverse —almost a fear that if the act were permitted death would come!

Speaking of both sexes, the simplest pathology is that due to ignorance and/or purely educational shyness. Much precious psychotherapeutic time has been wasted owing to the oversight of this factor by doctors who assumed in their patients a degree of straightforward knowledge of sexual biology which was in fact absent in even quite cultured people. The deeper psychopathology, individual and social, of this state of ignorance will always repay investigation, but for the relief of symptoms straightforward tuition may be the only treatment required.

Such cases apart, the psychopathology of impotence and frigidity really follows the main great subdivisions of the psychoneuroses, of which indeed it may be said to be a special symptom, deserving a special chapter on account of its clinical and social importance rather than on the strength of owning a specific deeper aetiology of its own. Accordingly, we will treat the subject under the headings of (1) Latent Homosexuality or Bisexuality; (2) Narcissism; (3) Obsessional States, and (4) Anxiety States and Hysteria.

Outside the realm of psychosis, I feel sure few cases of male or female impotence exist in which the psychopathology of one or another of these conditions is not found to account for the genesis of the symptom.

When we examine cases of *male impotence,* we naturally subdivide them into two classes: (1) failure of erection, and (2) failure in orgastic function, either as ejaculatio praecox, or as anaesthesia leading to complete inhibition of orgasm. A third class—that which combines both elements—constitutes a rarer and even more complete type of impotence.

The converse of what was said about hyper-sexuality is true of a great deal of impotence: the apparent lack of sexual potency conceals a draining of libidinal energy into non-genital activity, whereas in the so-called "over-sexed" people non-sexual tensions such as "the will to power," or dependence are being compensatorily discharged through the genital channel.

1. *Latent Bisexuality*

In the previous chapter, we reviewed already one type of impotence—namely that due to latent *homosexuality,* and studied the psychopathology associated with this condition. I use the word latent rather than unconscious, as the homo-erotic trend is often very near the surface. We are reminded of the case of the man (No. 33) who used to fondle the lavatory basin, in whom most of his sexuality was discharging along the phantasy levels of the one- to two-year-old child, and in whom an inverted father-son relationship played such an important part.

One could easily multiply examples of men who marry (usually mother-surrogates) and have children, then become disillusioned and find themselves resenting their bondage, which does not emotionally satisfy.

It is a moot point whether we should follow Freud or Jung in our interpretation of such cases. For example:

CASE No. 44. A business man of 34, of a lepto-somatic, sensitive type, and a very obvious spoilt child who was proud of being successful and clever at his job, came for treatment on account of mild anxiety symptoms and of declining erotic interest in his wife.

His life-history was that he was a posthumous only child and was brought up among a lot of doting female relatives of his mother's. The early environment was dominated by a fear of T.B., from which his father had died: and this led to a great exaggeration of narcissism and anxiety. The only counter-

weight was provided by a gruff old grandfather, whom the patient feared and avoided. There was also an atmosphere of religious puritanism in his home which led to severe guilt reactions over pubertal masturbation. The patient said he "idealized his mother as something fine and wonderful." He married early (at the wish of his family), the wife being a girl from the same congregation, and settled down to a dull suburban life, a job which was too easy for him, and the care of a single little son, of whom he was intensely jealous.

During the analytical conversations it emerged that his wife was an obvious mother-surrogate, was sexually frigid, and unresponsive even in the sphere of tenderness. The patient's phantasy life, always active, now becomes filled with longings for a fuller richer life, for congenial male companionship; he had really always felt himself hemmed in, a little insignificant fellow, and had worshipped real men—like Greek gods. He expressed very definite passive homosexual longings towards them, and discovered in himself many "artistic" and feminine characteristics which did not in the least fit in with the *milieu* in which he was compelled to work and live, a sturdy, beer-drinking business community and a "potter-about in the garden and mend the wireless" sort of leisure, which nevertheless he had neither the means nor the equipment nor the courage to leave or modify.

It also came to light that in his childhood he had been very constructive and imaginative. The latter tendency was simply and sternly repressed as "lies" for which one had to ask God for forgiveness, while mechanical and artistic activity was condemned as not in the school curriculum. This led on to guilt associated with his early interest in faeces, as well as with masturbation, which during puberty had been mutual. When his wife failed to live up to his ideal of the warm, tender and understanding mother his interest regressed to this level. He said, "You fall back on those things when life doesn't interest you." He chose it as an alternative to adultery, which had at one time tempted him.

This patient had thus a very difficult reality situation to face, both as a child and in his present life. His choice of mate was neurotically determined, and the mother-fixation prevented him from dealing with it effectively. The Freudian view would interpret such a case as a partial fixation in an Oedipal conflict resolved by identification with the mother, and regression to anal levels, while the grandfather—the dead father's representative—was abhorrent and rough to the narcissistic child. We are reminded also of the mechanism of "narcissistic projection" such as was discussed in the previous chapter.

The Jungian interpretation presumably would be that of an evasion of the task in this man's life—how to fuse his feminine anima with his persona—the artistic creative side with the slick business man, and the failure to solve this resulted in a regression

to sexual expression of the anima, through passive homosexual phantasy and the abandonment of masculinity, resulting in the loss of potency.

2. *Narcissism*

The next type of impotence, with ejaculatio praecox at first, then complete failure of erection, is illustrated by the following case:

CASE No. 45. An educated man of 38, three years married, with one child, came for treatment of increasingly complete impotence. A condensed version of his first interview in his own words will go far to illustrate the psychopathological picture:

"My father was difficult and always away on service. Mother absolutely doted on me and my sister, four years younger; we have always been terrific friends, and I could do nothing wrong in their eyes.

"My potency went off soon after our infant was born. I was worried at not having enough money and no job at the time. I was always 'light off the trigger' and could easily have an emission before entry; not like some of the people who can go on for quarter of an hour: that's how one ought to be. That has been the case with all women. In other respects it is an ideal marriage—only this impotence causes my wife so much worry.

"It went off gradually—now it is like getting into bed with a blood relation—like one's own sister—anything like intercourse repels one, and sends cold shivers down the back.

"Previously in any affair one simply parted company at this stage: the physical would die off and one would lapse into terrific friendship, far greater than at the beginning. Right through life I have looked on 'having a woman' as a safety valve. I am no artist at it—it doesn't much matter to me whether I have her properly or whether she just masturbates me. I always went in fear of them getting babies, but I am impatient and hated precautions.

"The baby was an accident—of course, he is a dear little chap—but I would far rather have a Bentley than a baby! And certainly no more for me!

"I have terrific desires for other girls—they must be of a slightly vulgar type—I am sure I could do it with them. I have tried desperately for my wife's sake—but it got worse and worse—now it has got me down. It started on one occasion when I worried because my erection died off."

On further occasions we discovered that behind the façade of perfect marital bliss the patient harboured deep resentment at his wife's intellectual superiority and "bossiness," which made him feel inferior in relation to a woman—a new experience to him—and this "interfered with his affection." It also became quite clear to us that his impotence was a way of punishing her for this unseemly lack of respect.

He very quickly realized that at heart he did not desire a cure and broke off treatment.

Here we are dealing with a very typical mother-fixated *narcissistic* personality with a markedly "split libido": it is a case of either a brother-sister relationship or a sexual one, but not both together. His object choice followed a narcissistic type. His mother transference is displaced to his sister, with a consequent operation of an incest taboo, clearly expressed in his own words. His narcissistic phantasy of himself as the little prince among women makes him resent his wife's demands and criticisms, and his resentment against her provides another component of his over-determined symptom. His love of comfort and fear of responsibility and sacrifice cause him to use impotence as the best means of birth control. His lack of concern for the alleged love-object makes him really prefer the phallic and auto-erotic practice to the normal one. Of all the factors, narcissistic anxiety and persistent auto-erotism as a defence against incest are the most conspicuous. He wishes to remain the spoilt baby and to demand impatiently immediate and safe gratification, in order to escape the situation of having to take his father's place, into which position his mother's unsatisfied love needs were threatening to push him. Such a case, incidentally, also illustrates the spurious hyper-sexuality mentioned above, for here was a man who was in his way quite a "lady-killer," though unconsciously perhaps in the more literal sense of that expression. No doubt deeper analysis would have discovered many of the early motives and mechanisms of the Don Juan psychology we saw in Case No. 43.

It would, I think, be fair to say that the Adlerian point of view would have stressed the "pampered child" aspect of this patient and emphasized the insult to his vanity which resulted from his inability to subdue his wife, and perhaps also from the necessity of financial retrenchment as the result of the little rival to his claims to her sole attentions. This interpretation would not do justice to the full implications of the situations in terms of libidinal and love development.

Nevertheless there is an aspect of the *Adlerian power-psychology* which is found to apply to this narcissistic type of impotence case. Thus we often meet the individual with a phantasy of omnipotence who experiences, maybe, accidental failure or relative failure at coitus such as may happen to anybody. This so wounds his flimsy but inflated self-regard that he now adopts the method of conscious preparation and worry at each subsequent act, thereby

inhibiting his natural and spontaneous somatic response to the love situation. He must "exert control"—it is intolerable that such a one as he had failed in so essential a task of masculinity and power. Thus he establishes a vicious circle, in which his vegetative and unconscious processes seem to mock at his conscious vanity and conceit. It is not altogether surprising that members of the military profession are quite often prone to this type of impotence. Few of us would accept this picture as valid in the last analysis, but for practical purposes it sometimes suffices, though caution is necessary before deciding that such a diagnosis exhausts the aetiology of the impotence symptom. Here again, in a different sense we may speak of a narcissistic basis for the failure of potency. These are, however, not the commonest cases.

3. *Anxiety and Obsessional States*

The majority of patients with complete impotence, or with ejaculatio praecox, are suffering from anxiety states and/or obsessional conditions, and from hysterical inhibitions.

While we may speak, in the narcissistic group, of a purposive evasion of the normal sex act on account of the libidinal fixation elsewhere, i.e. a real lack of heterosexual interest, in this group we are dealing with more mature individuals, who may have achieved potency and some degree of "genitality" and whose disability is due to *inhibition* through *guilt* and *anxiety*, though compensatory power phantasies play a part here also.

In applying the customary clinical labels to individual cases, we must never forget the point which was made earlier (Chapter III, page 45) in connection with the phobias—that there is much overlapping and over-determination. As an illustration of such a complex problem a case will be presented which would no doubt be classed as an anxiety state, but clearly displayed components derived from other systems: an obsessional element, manifested as a compulsion as well as by a severe super-ego, and a classical "Adlerian" omnipotence phantasy, in this case incorporated in the ego-ideal derived from the whole family setting of the patient.

CASE No. 46. A self-made, successful business man of 40 came for treatment of a recently developed severe ejaculatio praecox. He was the youngest but one of a large poor Jewish family with the typical background of strict orthodoxy, a harsh, tyrannical father and a devoted anxious mother. At 7 he practised mutual masturbation with a brother, and suffered terrible punish-

ment and threats from his father for it. He was at that time an '" attractive and a cocksure little devil." At puberty masturbation was resumed, but resulted in severe guilt and anxiety with depression, leading to an attempt to cure himself by coitus which failed. He now became suicidal, and carried out an attempt at self-castration by burning his penis with caustic (aged 17½). He renounced sex and almost immediately devoted himself to the pursuit of success and power. Fear of harming himself and of the effects of masturbation were always with him, and he cut himself off from society, overworking relentlessly. Somewhat later he achieved successful coitus.

At 28 he made a " good match," which helped him to a position of financial security and some importance. His married life was dull, there being no bond save sex and two unrelished children—one of them a Mongol, to his great distress. Throughout he felt that his sex guilt was visible to others in his dull eye—an almost paranoid symptom.

His search for happiness was limited to extra-marital sexual exploits, in which he was always hoping to meet a cultured girl who would share his dimly felt artistic and cultural needs.

He also felt a compulsion to conquer women and had phantasies of a veritable Eastern potentate with a harem of wives and concubines. Coitus with someone or other had to occur daily for years.

His impotence first occurred with an obese woman older than himself whom he described as " motherly," a year or two earlier.

It next occurred with his wife after she had taken him to task for his interest in a pretty maid. He said he was " tired at the time "—but when it occurred a second time he was anxious. " It lit up all my old fears," he said. He immediately reacted with the thought that he would lose his best chattel—his wife—yet was also thrilled by the idea that she might become immoral.

He had various wish-fulfilment dreams at this stage, but also dreams of burglaries in his house.

His ego attitude was expressed by the words: " I have always fought—never gave up." He was earnest, grim and tense in his bearing and expressions.

Recently he had met a girl who most nearly fulfilled his wish for a " cultural companion," with whom he had also been impotent. Analysis, in addition to revealing the above connections, was directed towards the guilt (*a*) of deceiving his wife; (*b*) of the adolescent period; and (*c*) of the seven-year-old period, when it was discovered that in addition to homosexual practices he had also played " mothers and fathers " with his sisters. There emerged a guilt- and revolt-laden nuclear incident in which the father was finally introjected as his severe super-ego, to give rise to an ego-ideal based on the " cocksure little devil "—the person whom no one could resist, and always " on top," as a compensation against his dread.

Another helpful feature in the treatment was the employment of the Jungian conception of the " anima," which this man was, it seemed, so clearly seeking in the " cultural companion," to complement his fallow emotional and personal life.

As I read this case, we are dealing here with a man who, owing to Oedipus guilt, has deeply repressed his love cravings for his mother, for his first adult impotence occurs when he has an attempt at coitus with an older, "motherly" woman. We learn also that he has split his love into its two elements: the sensual and the tender, for in coitus with a woman who appears to be a satisfactory love-object in the general sense, he also cannot behave sexually. At 6 or 7 he evidently had to repress his love for his mother under the very real threat of his father, who caught him, from the point of view of incestuous phantasies, "red-handed." In this case more clearly than in any other I have seen, the displacement of incest guilt to masturbation guilt was demonstrated.

His compensation at this stage of the latency period was the narcissistic ego-ideal of the irrepressible, clever boy, which remained unmodified in adult life. To such an ego-ideal the thought of failure is unthinkable, hence the inferiority feeling after his first adolescent experience of impotence, and the formation of a further, more relentless compensatory drive for power and significance in the non-sexual field. We see here, incidentally, the deeper roots of such a compensatory attitude, which makes the Adlerian approach seem comparatively superficial, though its utility in practice must be admitted.

The sexual instinct was now also constellated into a means of achieving power, and remained split from love and tenderness. I take it that this is typical of the "phallic" phase of libidinal organization. His marriage and his subsequent infidelity are illustrative of this immaturity. As Hadfield rightly points out (in *Psychology and Morals*), the polygamous phase is adolescent, and as such not only a racial recapitulation but probably also a recapitulation of the infantile phallic phase. This patient, owing to his mother-fixation, in Hadfield's words "has failed to keep pace with nature—he has been arrested in his development." The whole emotional side of his nature has remained undeveloped. In the Jungian sense we may well speak of the impotence as a signal from the unconscious that a reconsideration of values was essential to this man as he himself indeed realized and proceeded to put into practice.

A further mechanism is clearly seen in the sudden invasion of his hitherto normal sex-life with his wife by his symptom after she becomes an accuser. Henceforth *all* sexual intercourse becomes

charged with guilt and doubt—possibly by the simple operation of a conditioned reflex, by the admixture of anxiety and guilt which inhibits erection, and leads to the compromise of ejaculatio praecox which has always seemed to me to be a way of " having one's cake and eating it." Revenge motives were only dimly perceived in this case—by contrast with the previous one.

The case is discussed at some length because it appears to illustrate very fully the many typical findings in impotence patients, so much so that a fair interpretation might be given according to several of the schools of psychopathology. For a relatively rapid therapeutic approach all of them are useful, and in no way contradictory to each other. I must admit, however, that I am more ready to see similarities than differences in these approaches.

There seems to be something rather significant in the frequency with which one meets with impotence in men of forty or so who have risen from humble beginnings by enormous efforts, due both to innate talents and to the compensatory power drive above mentioned. They are too young to be classed as involutional cases, although some of the clinical features (anxiety and depression) suggest this diagnosis. As a rule, hypo-sexuality is only one of the many symptoms of which they complain, but it looms large with them, because so often, when they " have conquered the world " in the sense that they can no longer rise in their careers or progress farther along this path, and when they turn belatedly to erotic channels, they find these blocked or atrophied. In their youth they may have had a few insignificant sexual experiences with prostitutes or " inferior " women, in which their deeper love feelings have never been aroused; there may or may not have been an almost perfunctory marriage very much relegated to the background of their lives.

In one sense (e.g., following Culpin) we can class such patients as obsessionals, although the classical features of compulsive rituals, etc., are absent. It might be more accurate to speak of them as anxiety states in obsessional character types.

The last case quoted showed some of the features of this type. Considerable sociological interest attaches to this problem which is apt to beset some of the ablest members of the community (e.g., professional men, high executives in commerce and industry) in their prime when they should be giving of their best instead of still trying to solve their adolescent love: power conflicts.

It is of interest, therefore, to consider a second and perhaps more striking example of this form of impotence neurosis, in the hope of furthering our understanding of the condition.

CASE No. 47. This patient was another self-made man, aged 48, unmarried. He was referred for treatment on account of depression, anxiety and the classical symptoms of the "neurasthenic" syndrome. In quality and gifts he was the thinker and scholar rather than the man of action.

He was the eldest of a large working-class family, and had to start work at 10, as his father, a drunkard, deserted the home. From his earliest years patient felt both a heavy sense of responsibility and a strong urge to prove worthy of his devoted, hard-working and wise mother to whom he was deeply attached, and with whom he spent nearly every week-end even at his present age. His hard work and great talents enabled him to transform himself completely into a man of deep culture, entirely self-acquired, in a prominent position and one of the leaders of his profession.

In his youth he had had a short-lived love-affair with a girl of higher social standing, the failure of which determined him never to marry and to devote himself entirely to work and to the care of his younger siblings. In his young days he also passed through a brief phase of sexual promiscuity and managed to acquire a luetic infection which was efficiently treated at the primary stage. This gave him an enormous sense of guilt which manifested itself as a syphilophobia when he broke down.

His breakdown was precipitated by a psychotic episode in his younger brother which coincided with a time of crisis in his work, and also with an illness of his aged mother. When first seen, he was in a very restless and anxious state. It soon transpired that his real anxiety was over the fact that he had now met a woman of very suitable type whom he loved deeply and whom he wished to marry. On the surface the thought of the old infection made him shrink from this. "Everything has gone wrong with my private life—one has been frustrated by disease and the way in which I cut myself off as the result of it."

As a preliminary, a full neurological examination, including lumbar puncture, was performed and revealed no abnormality. This reassurance did not help, for the patient, on the day after the favourable verdict of the examination was reported to him, suddenly developed a psoriatic eruption over his hands: he maintained that this was obviously luetic. It disappeared as dramatically at a slightly later stage of his analysis when we unearthed the *wish* to be syphilitic for reasons which appear below.

From the age of 22 until a year before he came for treatment, the patient had lived an entirely celibate life, had forsworn alcohol and tobacco, from fear that his paternal heredity might overtake him. He soon confessed that he had made attempts at sexual intercourse with his woman friend but had failed through ejaculatio praecox. He was in the grip of a fear of impotence which had fused with his syphilophobia to make him feel that he could never be happy. He also feared damage to his nervous system by seminal loss. His general character type was that of an obsessional thinker: superstitious, meticulous and scrupulous in speech and thought, extremely self-

critical and introspective, and with a very severe super-ego. He was tortured with compulsive thoughts about various sexual topics he had read about in the works of Havelock Ellis. We proceeded to the analysis of his symptoms, and soon came upon unequivocal Oedipal material: of fear and hostility towards his father whom he nevertheless admired for his dash and "devil-may-care" attitude.

He recalled how in his youth father had admonished him gravely "not to overdraw on the account of life" by which the patient had understood excessive sexuality—at that stage masturbation. Castration phantasies and dreams emerged; an incident at 8 when after an episode of mutual exhibitionism he developed a paraphimosis, causing fear of irreparable damage; a memory of a thriller he saw as a boy when an officer of the Inquisition ran his sword through a cupboard and killed a boy hidden there. He concentrated his hypochondriacal thoughts on a "genital jump" (i.e. a cremasteric reflex) which he said happened when he remembered these things. At this stage it was possible to bring the threads of his self-punishment mechanisms together, to his great relief.

We now entered another phase, dealing with his mother-fixation, which underlay the castration fear. He began to have relevant dreams, at first of being imprisoned in a narrow cell, in swaddling clothes, of being torn between his mother and his woman-friend, etc. It was at this stage that he realized that his wish to give himself the "stigmata" (his word) of syphilis was so as to have to avoid surrendering the intimate relationship to his mother. From this time his compulsive sexual phantasies disappeared and he was able to look forward to marriage. He also lost his ejaculatio praecox and his anxieties about the welfare of his family.

A follow-up letter a year later showed that he had married and was keeping well.

The technique employed, in addition to reductive analysis, included re-education on Jungian lines, by talking of the evasion of the task of fusing a medieval (i.e. pubertal) outlook on life with a free humanism (i.e. sexual maturity). This cultural interpretation made a strong appeal to his type of mind.

The case was interesting as throwing light not only on the ascetic type of bachelor—a source of bewilderment to many continental observers of English life—but on the whole problem of the factors behind the "power-psychology" of gifted men. The analogy with the previous case is interesting, as showing the effects of castration fear in producing this compensatory reaction. In the one case, perhaps significantly the Semite, this included the development of a spurious, phallic hyper-sexuality, while the Anglo-Saxon, having passed through the influence of Christian thought to an unusually sincere degree, reacted ascetically, with his pre-genital sexuality confined to compulsive phantasies. His impotence was chiefly a self-punishment symptom, although it was at the same time also expres-

sive of his wish, and the price he had to pay for remaining his mother's loyal son. His ego-ideal was derived both from a positive identification with his mother and from a negative identification with his father ("I will *not* be like father").

Freudian analysts have drawn attention to a mechanism in the production of ejaculatio praecox which emerged in this case, viz., the displacement of the touching prohibition from one's own hands to that of touching the vagina with the penis: a hurried phantasy comes to the rescue so as to enable one to comply with, and yet evade the loss of orgasm involved in, the taboo (= having one's cake and eating it).

Another symptom of great frequency in cases of sexual difficulty is the fear of injury through seminal loss. Coupled with guilt, this may, as in our last patient, give rise to a feeling of weakness, malaise, etc., after orgasm has occurred. Fenichel, quoting various Freudian writers, points out that the fear of seminal loss may be connected also with its identification in the unconscious with the auto-erotic pleasures of playing with urine, and hence represents a fear of making water into the woman. In the chapter on obsessional neurosis occasion arose to comment on the relationship in phantasy between power and urination, at the level from which the typical obsessional neurosis seems to be derived.

In some instances the sexual "negativism" of the obsessional type of impotence goes to great lengths and invades the whole psychic life—unless perhaps the reverse is the case and we say with Adler that the sexual attitude comes into line with the patient's general pattern of "cutting off his nose to spite his face." Such a case was partially analysed when the recent war intervened:

CASE No. 48. A professional man of 35, of a strongly schizothyme, introverted and thinking type, is bullied into consulting a medical psychologist by a young woman whom he admires. He suffers from the conviction that he has, by his past excessive masturbation, exhausted his sperm, and when a genito-urinary surgeon demonstrates the contrary, he transfers this conviction into the instinctual sphere. In these circumstances he proves impotent in action, while he has lurid sexual phantasies. He tortures himself constantly with his failure in all spheres of life and feels fate is against him. He is incapable of free association, and is strongly contra-suggestible or negativistic.

His adolescent masturbation phantasies consist of the sadistic pleasure in seeing women pushed into the water. He can just remember phantasies of having something wet and warm clinging tight round his loins. He can also recall impotent hostility against his father who expected him to "play

the man " and be a credit to him in the " public school " sense. He says he fully agrees with his father's deprecating judgment of him. He remembers the quietly martyred, acquiescing insignificance of his mother. He also remembers his stubborn defaecatory negativism in childhood, and states that as an infant he suffered from severe diarrhoea. His mother had hoped for a daughter and had " treated him like one." His make-up is fetishistic (e.g., he is stirred much more by clothes than by what they conceal) and " excretory-sadistic," with many obsessional symptoms and profound ambivalency.

We can infer, although we cannot prove by the patient's acceptance and production of real infantile material, that we are dealing with a mother-fixation at an excretory-exploratory level, with an unconscious sado-masochistic identification with her, on top of which he has accepted his father as an ego-ideal including a contempt for his mother. His impotence (loss of erection) would then be the dread he believes his mother to have experienced at such attacks as he in phantasy wanted to make; his self-punishment for having made such attacks (i.e. a kind of self-castration which pervades most of his activities); a half-unconscious wish not to part with his semen which, I have some evidence in his phantasy, he equates with faeces; a wish to defy his ego-ideal and *not* be a man; a masochistic and self-pitying desire to degrade himself before his introjected father, who is thereby also punished and defied (the evidence is from transference manifestations); and finally the patient really does not wish to give himself to anybody—this latter perhaps the same as the reluctance to part with his semen (faeces) at anybody's behest. Magical omnipotence phantasies—of the type " I ought to be able to control my erections by thought "—are also present.

An undercurrent of suicide-motif runs through his inner life.

Here was another type of bachelor—since married and a father (1945)—still struggling with the adolescent recrudescence of his pre-genital conflicts which he had solved by the sacrifice of his manhood: the paradox of playing the castrated before his introjected father in order to escape castration at the earlier levels, or perhaps more correctly, in order to be allowed to retain his repressed sadistic phantasies intact, by their complete insulation. His anger at any real analytic discovery was most interesting, and he would not shrink from denying or controverting the findings of the previous treatment session. Six years later he admitted that his analysis had a deep effect on his recovery.

There are other cases recorded where a very similar state of affairs has been traced back unequivocally to Oedipal wishes towards the mother, both of the urethral-faecal type (wish to soil) and of the phallic type, and where the subsequent reaction formation has approximated to the obsessional pattern—notably with regard to the self-punishment motif. Here I recall Graham Howe's paper on " Compulsive Thinking as a Castration Equivalent."[1]

[1] *loc. cit.*

The majority of all cases, fortunately from the point of view of prognosis, fall, however, into the group of anxiety hysterias, and thus represent, according to the formula mentioned in the second chapter, a direct inhibition, through anxiety, of the genital function, at the behest of a super-ego prohibition.

4. *Hysterical Inhibition*

In one sense, the " final common path " of all functional cases of loss of erection must be in the nature of a blocking of the sacral-autonomic system by efferent nerve impulses from the higher centres, or an antagonistic action (e.g. through anxiety) by the sympathetic system to the impulses in the sacral centres which control the nervi erigentes. The former would correspond on the physiological level to the type of impotence which is due to conscious anxiety and " preparation " of which we spoke earlier in this chapter as interfering with the smooth performance of an unconscious reflex. This mechanism would come into play in the majority of cases, and a similar nexus would also apply to the ejaculatory functions. On the other hand, the local overruling of the parasympathetic sacral system by the sympathetic might account for failure if, e.g., a man were preoccupied with some actual worry while attempting coitus. In a person predisposed unconsciously to link such an event with earlier guilt and anxiety systems, such a " physiological " occurrence would serve as a precipitating factor for bringing into operation the first-mentioned mechanism.

Impotence, regarded as an isolated functional disturbance, is therefore to be regarded in the same light as a hysterical paralysis, no matter how various may be the conflicts and mental mechanisms which at a higher level determine the interference with the normal synaptic connections between the sacral sex centres and their cerebral representations.

There are cases of very simple and naïve aetiology, in which we may properly speak of auto-suggestion as the cause. They occur as a rule in elementary personality types, who respond well to explanation and/or suggestion. One such example will serve to illustrate the structure of this type of impotence which I label " hysterical inhibition."

CASE No. 49. A retired seaman aged 54, unmarried, of very religious family, was referred for loss of erection and creepy paraesthesiae in his testes, which had been present for seven years. He was a healthy, well-preserved

man, conceited and vain, and could not bear the thought of his loss of manly pride, especially as he had lately met a widow who was a most promising matrimonial proposition. Eight years previously he had contracted gonorrhoea and was treated thoroughly at Singapore. He was left for a time with a gleet. At this stage he met a woman who proposed coitus. He experienced pain with his erection, and this aroused a sense of guilt at being diseased and fear of permanent damage. His erection failed at this point, and a sense of weakness and genital shrinking (=the creepy feelings) took its place. He determined then, as he now was able to remember, "to give women the go-by." He had unconsciously lived up to this resolve and had not troubled about the matter until he met the widow. To his dismay, he found that whilst he had a desire to have coitus with her, instead of an erection he only experienced pain and the shrinking, creepy sensation of weakness.

Full uro-genital investigation, including urethroscopy, revealed no abnormality or infection, and the general physical and neurological condition was normal.

This type of impotence may justifiably be regarded as a conditioned reflex. The erection is painful and becomes associated with a straightforward and easily intelligible sense of guilt and fear in a man of considerable self-respect and quite high standards, whose religious background has perhaps particularly emphasized the "unclean" association with venereal diseases. When the original stimulus is repeated, the conditioned fear overpowers the erection mechanism. The memory of the occasion when the inhibition first occurred was suppressed. We shall see presently that the same mechanism may operate also in the frigidity of women.

Surprisingly enough, in some instances in such men the real fear is one of aggression rather than of sexuality. Thus, one patient says, "It is the fear of injuring the girl that stops the desire when I get down to it." We surmise the presence of pre-genital, aggressively toned phantasies towards objects from such statements.

Frigidity and Vaginismus

Very often these reactions of guilt in men are activated by the behaviour of the woman during the first attempt at coitus: then it may be *she* who has the real neurosis, and succeeds, by her fearful or prudish bearing, in reanimating the man's latent guilt. It is of course noteworthy how frequently the woman's—and the man's—choice of mate will play into the hands of such complexes: the man, afraid of his own aggression, fails to understand the masochistic components which, in common with the Freudians, I believe to form

an essential part of normal feminine sexuality. His guilt causes him to try and "live up to" his ego-ideal of kindness and gentleness, to the profound unconscious disappointment of his partner, and to the possible wrecking of his relationship with her.

This, it seems, is the essential situation in many marriages and it develops into a vicious circle of anxieties, regressions and revenges. The woman, cheated of her satisfaction, is soon apt to develop anxiety. This may be at first the direct result of deprivation (Freud's "actual neurosis"), but very soon re-attaches itself to her pre-genital trends with their typical reaction-formations and veiled hostilities, resulting frequently in a neurosis of the phobic type.

A remarkable example of such a vicious circle is that of a young and very attractive married couple, in whom the blame for precipitating a double neurosis must fall on the man, fertile though the soil of his wife's unconscious disposition was.

CASE No. 50. Under this heading it is proposed to indicate the psychopathology of both wife and husband, who were seen by me, the former for analysis, while the latter was analysed by a colleague.

The young woman was referred for a severe claustro-agoraphobia and revealed at her first interview that the marriage had not yet been consummated after a year, owing to a "pact," based on fear of children and dislike of contraceptives. The patient had an artificial, "nice little girl" personality devoid of decision or purpose, anxious to please and be approved of. She felt hopelessly at sea in marriage in which she had looked for complete childish security, only to discover that the husband had had the same unconscious aim. They were both "parent and baby" to each other and, though probably genuinely in love, were really children playing at mutual masturbation, continuing a situation laden with enormous guilt and little sexual satisfaction for the wife.

The husband had a very pronounced obsessional personality with guilt over aggression, and his sexual development was anal and phallic-sadistic, with not a few fetishistic elements. His wife was his lovely doll, who had to behave sexually in complete conformity with his own masturbation phantasies, but apart from that was not allowed (unconsciously) any opinion of her own. He behaved towards her like an omnipotent baby towards a completely devoted and submissive mother: e.g., the girl had to pay off taxis and go into shops which he was too shy to enter.

I hoped that at this stage advice to start full sex-life might have beneficial effects, before condemning both of them to the rigours of a long analysis with unequal rates of progress. It was followed quite eagerly by the husband who now displayed his ineptness as an adult lover. The sequence of complete vaginismus and loss of erection respectively ensued.

In brief, the psychopathology of her vaginismus (which was accompanied by severe pains and vaginal frigidity) was over-determined, as was to be ex-

pected in a phobic case, and could not be separated from the latter. First we met a complete hysterical dissociation from "the lower part of her." Then there was superficial guilt over pre-nuptial sex play with fear of discovery. "One of us had to keep our heads—and it was me." This anxiety linked on to classical Oedipus level phantasies of coitus as a sadistic act: the penis as a weapon to rip her body open (ambivalently feared and desired), and hence to be refused and even torn off—the revenge motive associated both with an infantile wish to steal and appropriate the paternal organ, and to punish her husband for bullying her. We then unearthed sado-masochistic beating phantasies, based on childhood play with other little girls, and linked to a strong ambivalent mother-fixation (also transferred to the patient's husband) at the anal and oral level. With the emergence of this theme there also came the classical phantasy of the denial of a vagina, conceived of as a bleeding wound caused by a castration, and the idea of harbouring an internal penis (=her completely repressed masculine and aggressive trends). The inferiority was historically well-founded, inasmuch as she remembered how as a baby her mother doted on her and made a little princess of her: then at the difficult aggressive anal and urethral stage, her mother turned against her in favour of an older brother whose side she always took no matter how he bullied the patient. Most of the hatred and penis envy was directed against this brother (also transferred partly to her husband).

A very traumatic incident was analysed, in which she raged and kicked at him impotently, and then lay on the floor while her mother coldly admonished her. She now repressed all her aggression, formed the ego-ideal of complete submission to her narcissistic mother (who, moreover, despised her husband and was undoubtedly frigid herself) and became identified with the insipid "little angel" persona which she still maintained to the present. She retreated almost completely into a phantasy of an anal-sadistic and urethral-phallic type, began to masturbate and withdrew all conscious love from her mother, and also took quite consciously to being the miserable, *ill* little creature in order to obtain love.

(This is the case also described as No. 29 in Chapter VI.)

Only the most condensed account of a complex and interesting case has been given, and that mostly from the point of view of the sexual defect. The precipitating factor of this woman's neurosis was the unconscious disappointment that her husband had taken her at her word and not given her a passionate and full sexual experience when they were first married. The realization that he was not a "safe" and protective husband then reawakened her old and guilty ties and ambivalencies to her also unsafe father, and especially to her mother, so that we were dealing partly with a hysterical inhibition and partly with a regression to earlier levels. Through the patient's analytic and transference work, their relationship improved and the vaginismus disappeared, especially after the beginning of the negative transference to the analyst. The awakening of the

patient's sexuality was still accompanied by a great deal of aggression against the husband whose progress has unfortunately not kept pace with that of his wife, so that she had to face a difficult adjustment in a reality situation with much ambivalency.

In Chapter III we have already seen one or two other instances of this type of case (Nos. 9 and 10), which was also alluded to partly in the paragraph on passive female homosexuality in the previous chapter, of which the present case is a further example.

It is necessary to emphasize again the importance of the man's attitude to the woman in considering such cases as the one just quoted. This is a much wider and subtler affair than the sexual practice in the strict sense, although the general bearing and the specifically sexual orientation will often closely tally. Two more such marriages come to mind, in which the husband has made a narcissistic object choice and then proceeded to try and hammer his wife into the requisite mould of his phantasy.

CASE No. 51. The first is a couple of about 37 with two children, in which the wife also had a narcissistic character, and was sexually cold from the beginning. She had a fear of the penis and regarded semen as dirty. The husband had an obsessional power psychology with ejaculatio praecox, with a severe taboo on tenderness, with which he infected his wife, so that their relationship became increasingly sarcastic and superficial with an undercurrent of half-bantering hostility, in which the husband owing to his sharper wits always won the day. Eventually the wife began repaying him with hysterical conversion symptoms, such as abdominal pain, nausea and fatigue, as well as developing dyspareunia, until he was reduced to complete impotence.

She now began desiring him ardently, and he had repeatedly to admit his incapacity, as well as being put to endless inconvenience and irritation by her mysterious ill-health. Her background was that of a youngest spoilt child who had suffered a good deal from her older siblings and had adopted the attitude of the innocent hurt little prig, obstinate and contrary. Analysis also revealed a good deal of excretory guilt, especially of the urethal type, by way of an urgency of micturition which assailed her in the analytic hour. This, as usual, had chiefly the significance of self-assertion and represented her masculine, pre-genital aggressive wishes, hitherto unconscious.

There was evidence that both these people really preferred mutual masturbation, and the wife's excitability was wholly clitoric and external.

Again, this couple was really immature; he wanted a compliant puppet, and she, at bottom, wanted to be managed, but could not accept a feminine, passive role owing to the unsolved conflicts over the wish for omnipotence of her pre-genital period and the resentment of being treated as something inferior.

CASE No. 52. A woman of 26, with one baby, complaining of dyspareunia and revulsion against marriage. A very similar type of husband to Case 51, but older and more worldly than his wife, and with a more conscious ambivalency towards her. The house had to be run perfectly, yet his wife must never be seen working or dishevelled. His affection was only manifested when she was naked and in bed, and then took a violent and not altogether genital form, which frightened and revolted the patient. It was sensual and lacked tenderness. She herself had the Cinderella psychology, not without good reason, for she had an inhibited uninterested father and a mother like the one of Case 50. She resented most that (1) her husband did not have coitus when she had been worked up to it during courtship and had left her "strung up," and (2) that he never made any allowances for her need for protective, tender love, and (3) that he was jealous of her baby. It was noteworthy that the dyspareunia only appeared after the baby's birth (without structural cause).

The main theme was the humiliation of her sexual position, her sense of self-pity at having tried to mould herself to her husband's ideas—even performing fellatio for him, and now she hated it all, and received no "love" in return.

It is therefore my experience that frigidity in women is frequently the expression of a conflict between assertive and submissive tendencies, which in turn depends upon the persistence of pre-genital (masculine) personality trends and sexual wishes, to which these women regress when their maturer love needs are thwarted by their husbands. The latter may become recipients of the mother transference. I have not met in women much direct evidence of the fear of castration by the father, upon which so much stress has been laid by Freudian writers. In Case No. 50 it did appear as a subsidiary phantasy.

But as in the case of men, so in that of women narcissism and obsessional mechanisms come into the picture, with fears of loss of personality if they allow themselves to be taken, and complete identification of sex with excretion.

CASE No. 53. This patient was described in detail in volume xi, 1931, of the *British Journal of Medical Psychology*.

There I tried to show that the patient's revulsion against, and frigidity towards, her husband was based on his becoming identified with a brother who had himself taken the place of her father, who died when she was two. Her obsessional neurosis consisted of defensive rituals against injuring her husband and family by broken glass.

This in its turn was a later inversion of the fear that she herself would swallow small objects, a compulsion of which she had in fact once or twice given way as a means to suicide. The significant psychology from the point of view of the sexual inhibition was the phantasy—indeed one may say the

unconscious delusion—that she had caused her father's death, followed by an introjection of him, with the result that she had such an intolerable self-hatred that she had to re-project some of it on to all those around her who were in any sense love-objects. In her father's sick-room she pictured herself as having broken his medicine bottle and being punished for it by having to die in the same way. She hated him for being taken away from her. The sequence of the neurosis was: marriage to the brother-substitute aroused guilt and required sexual (genital) inhibition. This caused regression to the level above indicated, with the re-emergence of early, highly ambivalent phantasies of impregnation, and of the introjected father.

These points were not discussed in the original paper describing the case.

In such desperately severe cases of obsessional neurosis, the patient's view of the nature of sexual intercourse is coloured wholly by hatred and aggression, introjected and projected, and by such complex ambivalencies that I seldom come to anything like a complete clarification of the whole picture.

Fortunately, however, the great majority of cases of feminine frigidity are due to fairly simple anxiety inhibitions on the basis of upbringing, and do not go very deep, unless accompanied by other symptoms.

Trauma

Trauma, in the sense of early sexual assaults, seems to play a certain part in these sexual disturbances of women.

A very good example of frigidity with a purely traumatic aetiology may be quoted.

CASE No. 54. An attractive, "feminine" woman of 35 came for treatment on account of frigidity. She had been married for 13 years to a "safe" idealistic man, and had blamed her lack of sexual response on to him, for he was not demonstrative. In recent years she had, however, fallen deeply in love with someone in a much more mature way, but to her surprise was frigid with him also, except for some feeling in the clitoris. Now she felt worried.

Under free association there very soon emerged a completely forgotten and most affect-laden incident at 4 or 5 of being secretly masturbated by her own grandfather. This showed her as enormously excited, and then, in dread of her feelings and on account of the old man's furtive behaviour, repressing all her sexual emotion.

The abreaction of this scene was quickly followed by relief from the frigidity and associated insomnia, and enabled the patient also to see why she had always been afraid of "real men," had married a cold and "pure-minded" man; and also that what sex feeling she had was of the type she had experienced as a child.

Maberly and others, who have been studying the late effects of

sexual assault in childhood, come to the conclusion that the important factor is not the assault itself, but the bearing of (*a*) the person who commits the assault and (*b*) the adults who deal with the child afterwards (if any). The child may merely "quite enjoy" the experience if the man is kind and playful about it, and no sense of guilt is imparted. They also state that the assault is likely to play no great part in the aetiology of a subsequent neurosis if it has always remained conscious. In the case just cited the trauma was certainly repressed and the assaulter's bearing induced guilt, especially as he would have functioned as a father-substitute.

The "Actual" Neuroses

In a survey of sexual disturbances commonly met with in practice one should perhaps make some mention of two conditions which were amongst the earliest to be described by Freud. He called them *actual-neuroses*, implying that they had no psychopathology, but were in the nature of quasi-chemical upsets due respectively to lack of sexual satisfaction, and to over-indulgence. I refer firstly to the *anxiety neurosis* of women who are sexually stimulated but who, usually through ejaculatio praecox on the part of the husband, or through continual practice of coitus interruptus, do not complete the act; and secondly to *neurasthenia* attributed to excessive masturbation persisting into adult life.

The anxiety-neurosis is, in its pure state, very rare, as the unconscious quite evidently seizes on pre-existing conflicts and anxiety situations of childhood, and we are presented with a case of anxiety hysteria. Perhaps cases Nos. 50 and 52 originally passed through such a phase of being just "strung up" and unsatisfied, not unlike anxiety conditions seen in widows.

There is little doubt that with a satisfactory sex-life, for example, in the young phobic woman (Case No. 50), this neurosis would not have developed.[1] It is a matter of common observation that women resent lack of erection more than premature ejaculation, provided there is some penetration—probably because of the gratification to the normal receptive trend in their sexuality.

The latest psychoanalytic explanation is that the damming up of libido acts analogously to the birth-trauma in increasing tension; the anxiety of this neurosis would thus be very primitive. I can

[1] On account of unsatisfactory object-choice, due to deeper causes, this desideration is frequently impossible of fulfilment.

neither confirm nor deny this statement from my own observation. It is obvious that treatment must be directed towards sexual hygiene at the earliest moment, before the woman has, by regression and repression, lost her capacity for genital satisfaction.

"*True Neurasthenia*" so called, a typically male complaint, is also very rare if indeed it exists. Most often it is an anxiety state in which exhaustion predominates, which may have a basis in the adrenal mechanism (see Chapters II and III). New Freudian teaching has now also concluded, as some of us have long felt, that there *is* a psychological aetiology for this condition, for it may be asked: Why do adults continue to masturbate? It is obvious that they are in vain trying to satisfy a need by inadequate means, that they are calling upon phantasy and higher mental functions to supply what should normally be provided by the stimulus of a loved partner, and so probably drain much mental energy into this channel. It is hard to understand why these people lose interest in the outside world, unless one accepts the idea that they have been severely thwarted in their earlier object-relations and have retired into narcissism, that the tension of their need for love is directed on to their bodily functions and organs, and relief from the restlessness is sought in masturbation. The majority of chronic masturbators that I have seen have not shown this symptom, whereas one of the severest cases of subjective exhaustion I ever met was an obsessional narcissist, hale and strong, with a crushing handshake and a voice like thunder, whose one dread was of seminal loss, which he consequently avoided. His psychic energy was almost entirely taken up with keeping down terrific aggression in an attempt to fulfil the rôle of a medieval saint, which he had adopted as his ideal.

Conclusion

In this incomplete review of some points of interest with regard to the sexual dysfunctions, we have adhered to the broad position that these disorders are not neuroses *sui generis*, but expressions in the somatic sphere of various personality troubles which can in the main be grouped under the psychopathology of the anxiety states, hysteria, obsessional conditions and sexual perversions. The "final common path" at the somatic end of the functional disability (loss of erection, vaginal spasm, etc.) is probably the same for these different neuroses.

In our case material we were impressed by the way in which repressed non-sexual love needs were tending to receive symptomatic relief through exaggeratedly sexual channels, whereas guilt and disappointment in fundamentally normally-sexed individuals could inhibit the genital function and cause reactivations of, or regressions to, pre-genital trends with their attendant conflicts and ambivalencies. Several interesting observations could be made in our cases with regard to the relation between the tender and the libidinal element of the love organization.[1]

On the one hand—mostly in the male patients—we noticed the cleavages of these two important factors (to which phenomenon we applied, for convenience, the term "split libido"), leading to abnormality or loss of genital function in relation to their marriage partners who were chosen according to a parent-substitute pattern. Here, clearly, an incest-prohibition is at work, and the psychoanalytic theories find full application.

On the other hand, and predominantly in our female patients, we became aware of just the opposite: that they found in their partners a *lack of total response*, or were unable to have their *tender* love needs satisfied, and *therefore* retaliated by withdrawal of libido: as if their demand was for a unified love, to give as well as to receive, failing which they had to look for other real or imaginary love-objects, who would be able to provide the tender protective aspect of the relationship in which alone they could feel free to give themselves both in the general and in the specifically sexual sense.

From the deep analysis of women I have drawn the conclusion that this "all-or-none" response is probably normal in women and seems to correspond to a direct link between the dependent oral stage of a completely satisfying symbiosis with the mother and genital (vaginal) love organization. Such wives are not really pleased with husbands who fail to realize that theirs should also be a protective parental rôle, in the security of which women will open their bodily and spiritual treasures.

This situation seems to me to strengthen the argument in favour of postulating the "third instinct" of security, ultimately based upon the mother-relationship in either sex, which tends to influence the libidinal organization of later development. It need not be

[1] Much attention has been paid in the past to the sexual symbolism concealed in apparently non-sexual behaviour. The reverse process should prove equally fruitful.

emphasized that a person who receives nothing but tender companionship and love, but no adequate sexual gratification, will also tend to be disturbed in mental health.

The impression gained from a study of sexual maladjustments of this sort is, however, that it is more often the tender love element and human valuation which are lacking expression or reciprocation, and that the genital function breaks down as a symptom of this need which for some reason seems to be more difficult or ignominous to acknowledge than impotence itself—perhaps because the latter is still, like other conversion symptoms, interpreted as a physical disorder by patient and doctor.

Into quite another category fall the cases of omnipotence where the personality development has not reached hetero-sexuality, and coitus is not desired. A third, one may say benign, category is formed by the cases of traumatic inhibition (such as Nos. 49 and 54).

The interplay of the "opposites" in the love relationship between men and women—of the masculine components of the female unconscious and the feminine aspects of the male—hence of homosexual tendencies, of parent-imago and -feeling, of narcissistic trends and phantasies, and lastly of real object-love—if such a thing exists after all the foregoing have been subtracted from the relation! —the satisfactory elucidation of this tangled web is at present beyond our power, but presents perhaps the greatest contribution to social anthropology that our science can hope to make. This relationship will always remain the central core of the lives of most of mankind, and its quality and deepening permanence will inevitably affect the children resulting from it. Truly if the parents have eaten sour grapes their childrens' teeth will be set on edge.

CHAPTER IX

DRUG ADDICTIONS

THE problem of addiction to drugs is one of the least explored in psychopathology. This is perhaps due to the fact that few drug addicts fall into the hands of analytical therapists, and that even when they do they do not often persevere long enough for the purpose with which we are concerned, namely, the establishment of the pathology and deeper aetiology of addiction.

There are really two distinct questions which our studies should try to answer: (1) the psychopathology of addicted persons, and (2) the psychology of drug addiction itself, as a psychological, social and anthropological phenomenon.

On the first problem some illustrative examples will establish the fact that will already have been guessed—namely that drug addiction represents fundamentally a fixation at and regression to the oral level of development, but that apart from this, it may become the last resort of a number of different reaction types when other purely endopsychic possibilities of defence, reassurance or compensation have proved insufficient against the threats of abnormal anxiety due to conflict, or when chance has placed this method of escape into their hands.

The present study will be confined to alcohol and morphia as the two potentially lethal addictions of common occurrence in this country, and because of my lack of experience with other forms of addiction. It seems unlikely, however, that analysis would disclose any great psychopathological differences between takers of morphia, cocaine and other " hypodermic " addictions; on the other hand there *might be* some difference as between the symbolic significances of drugs taken by mouth, or sniffed, and those injected, but I do not pretend to be able to speak with authority about such differences.

With regard to the second problem, namely, the deeper anthropological origin of drug-taking, we are really only able to theorize or draw on the records of our cases by inference, while the literature on this aspect of addiction is not yet helpful. It is, to begin with, necessary to remind ourselves that addictions may exist to things

other than narcotic drugs, and that every medicine, article of food and drink, and even toilet requisites may fill this role. There are numberless people who have to smoke or chew something when they are thinking or performing difficult tasks, or immediately after unpleasant or critical events. In these instances the pathology may go no deeper than the reward by a sweet which mother used to give; but on the other hand, these trivial compulsions may be the representatives of deeper fixations to the oral phantasy life—the golden age of omnipotent dependence, and thus a reassurance against impulses of hatred or revolt against the real world which robbed us of paradise. We are plunged into the same levels of development which we found in fetishism and the other "self-contained" sex-perversions; to these the addictions seem most nearly allied.

The phylogenetic origin of the magical value of drug substances is lost in obscurity, but certain comparisons and analogies in analytical material and in the behaviour and symbolism prevailing in savage tribes and to some extent in highly civilized religious communities are possible, such as the doctrine of the magical immanence of the deity in the drug or potion—and the imparting of some of its qualities to the addict or partaker during its influence, which is interpreted by the primitive as "possession" by good or evil spirits. The Freudians, at first, explained the significance of the drug to modern addicts as symbolizing semen, and the partaking of this substance was a means of equalling oneself with one's father, and so acquiring omnipotence at the phallic phase of development. Food and drink substances are, in addition, the most obvious objects for the displacement of the still earlier anxieties of the oral stage, a fact pointed out by later psychoanalytic studies. We have seen how the primitive introjection-projection mechanism operating in fetishism (Case No. 39, Chapter VII) evolves such phantasies as the milk becoming bitter or like pus or poison, and how the fetishist deals with the "bad object" partly by introjection, partly by displacement of libido on to clothes or some other fetish object functioning as a reassurance and a solace. This may happen with, or as an alternative to, compulsive masturbation. The sado-masochism connected with the fetish activity represents the infant's (and perhaps infant humanity's) ambivalency towards the love-feared breast, his *only* love-object, resulting in an almost psychotic detachment from all more mature objects.

Suppose now that this displacement to a fetish, or to masturbation, has not occurred, and that the individual has nevertheless remained largely fixated at the oral level, with its ambivalency of frustrated wish for the happy relation to the breast and of bitter hatred for its hostile behaviour appreciated in the infantile sensory terms of "bad" or "poisonous" substance. Suppose further, that such an individual with his primitive unconscious tensions and problems arising out of the unsatisfactory relation to the world of objects and his neurotic reactions to it, meets with a drug such as alcohol. Alcohol is already phylogenetically surrounded with the halo and mana of that ambivalency, and it does, after all, possess the requisite pharmacological properties of abolishing higher control and inducing "elation." It is the great healer—"it does good." Yet it is also "that filthy stuff" which every alcoholic hates. It is in fact regarded as the primitive regards it, as good or evil "spirit." By the operation of regression to an abbreviated, condensed, localized paranoid system in the mastery of anxiety the drug comes to function as the representative both of hostile and of friendly, desired substance. Its ingestion provides expression for aggressive trends, and also at the same time acts as a breast-substitute. In its hostile aspect it is dealt with by the primitive, one might say cannibalistic, manoeuvre of swallowing the enemy, making him harmless by incorporation, unlike the case of the fetishist, where the same hostile impulses can be dealt with sado-masochistically (i.e. by self-degradation). Yet this same sado-masochism is probably largely responsible for the self-destructive, orgiastic indifference to consequences, the sense of vicious abandon of the addict when on a bout, resembling the compulsive masturbation of schizophrenics. The periods of abstinence are apt to be marked, though not universally, by paranoid fear and resentment, or by the feelings of deprivation, guilt and especially by depression, according to the original reaction of the infant, corresponding to phases before the accomplishment of the ambivalent introjection manoeuvre, and these lead to further need for the drug as an alleviator and solace. This cycle is also found in the sex-perversions, as already indicated.

Addiction frequently arises to meet intolerable external situations such as organic pain, bereavement, etc., but is, of course, used to dull the *inner* stimuli to which such situations give rise. The normal person will abandon his use of the drug when the situation calling for it has passed away. It is only the person with a predisposition

towards the sensual solace against intolerable frustration feelings who will become addicted, for he will find in the "pharmacotoxic" orgasm or orgy (Rádò's term) something he had not bargained for—*pleasure* more intense than perhaps other methods can provide, so that it will be easy for him to displace the magical solace, and recapture of infantile satisfaction and "security in satiety" on to the drug.

Certain more superficial, but nevertheless important, symbolic valuations of drugs will emerge from our examination of some typical clinical material to which we will presently turn for such confirmation as we can get of these difficult matters.

Before proceeding, we must, however, mention other aetiological aspects of alcoholism especially, and to a much lesser degree of addiction to other narcotic drugs, such as the problem of heredity. It is difficult to accept heredity as a cause for alcoholism *as such*. It would seem more reasonable to regard the transmission of alcoholic tendencies from parent to child as environmental and psychological, perhaps not even psychopathological, in that it can be ascribed to the normal mechanisms of imitation and identification with one or other parent. It is a matter of interest, on the other hand, that a large number of children of alcoholics suffer not from alcoholism but from psychoneurosis. Here one would be prepared to concede the possibility of a hereditary element, in spite of the obvious environmental traumatic factors which a drunken parent implies. This frequent correlation forms an argument in favour of the modern medico-psychological view, which holds that drug addictions are an expression of neurosis, and thus an attempt at escape from intolerable inner tensions, often entirely unconscious, when endopsychic defences are not strong enough.

It remains at present a moot point to what extent we are to regard the mental changes in addicts as primary, i.e. as the manifestations of those relevant early fixations which determined the recourse to the drug, or as secondary to organic or toxic damage to neural tissue. By secondary I would mean a change which had come about by the destructive action of the drug itself, in accordance with the pharmacological law of "dissolution" which postulates a gradual disintegration of neural levels from above downwards, exposing more primitive responses. It is probable that both factors combine to induce regression. Without some primary psychological determinant we would have to look for another "cause," as

obviously mere habit formation is not a sufficient explanation. Thus, do not some " non-addicts " in fact drink more than some addicts?

We may now turn to a case for material of further discussion.

CASE No. 55. A lady aged 50, a gipsy by descent, came for analysis, complaining of uncontrollable drinking bouts, and also of lack of self-confidence and volition. These bouts had started about two years after the World War I, but had evidently not struck her as anything to worry about until she did some psychological reading. (It might have been as well if she had not contacted our new gospel!)

She was the youngest child, having three brothers. The father was a showman and, from what one could gather, trained his clever and histrionic little girl for stage-work from earliest times, using the whip freely for this purpose. The reaction of the patient to this treatment was superficially one of fury and rebellion, but underneath, as emerged during analysis, one of masochistic enjoyment.

In this Bohemian and shabby household there was a great deal of sexual play between herself and at least two of her brothers, which undoubtedly produced a marked degree of fixation to infantile sexual stages which in this case can only be described as " polymorphous perverse," for the patient produced an extremely rich variety of memories of oral, excretory and masturbatory practices and experiences. A crucial experience for her occurred somewhere about the age of 5, when she was discovered masturbating by her parents. As is so common, the child's reaction was first one of obstinate rebellion and determination not to give in, followed by one of guilt and fear of losing her unique position as the parents' pet little girl. This caused some degree of repression, while the repressing force, i.e. the fear of losing love, now led her to adopt the ego-ideal of the nice, clever, helpful little girl.

The further history may be said to commence at the age of 16 when in the course of her wanderings as a little show-girl she came across some man with whom she lived and with whom she reproduced some of her infantile sexual experiences, especially fellatio, accompanied by much conscious conflict between orgiastic enjoyment and guilt and loathing. Throughout this period, as during her subsequent marriage to a respectable man whom she saw to be a father-substitute, she was never able to give herself fully in normal intercourse. The War offered opportunities for various affairs, always with men considerably younger than herself, who invariably played a subordinate rôle to her, and who appeared in her dreams as pet dogs or little monkeys, the interpretation of which symbolism caused her a good deal of distress. After the War she was divorced and started a career of living on her wits, with fluctuating fortunes.

She was remarkably vivacious and a young woman for her age, with a phantasy of artistic exquisiteness and perpetual youthfulness, convinced of her undying power to charm rich young men. Her whole psychology was that of the narcissist to whom sex means power and self-aggrandisement. In addition to alcoholism, she indulged in endless cigarette-smoking, and she was both a gourmand and a gourmet. All these habits were a matter of

guilt and remorse to her, as it transpired, for two distinct reasons: firstly on account of her ego-ideal derived from the parental prohibition, inasmuch as all these oral pleasures associated back to their sexual roots in early childhood, and secondly because of the insult to the picture of herself as the exquisite person who was always longing for spiritual fulfilment and purity—a modification of the narcissistic phantasy.

Actually the amount of alcohol taken was quite moderate, e.g., one or two glasses of sherry were sufficient to produce the nice orgiastic depraved feeling which was her main symptom and source of guilt. Sometimes in the course of treatment she would turn up in this curious half-drunk condition, hoping that I would act like her father and punish her.

It will be sufficient to condense the complex motivation of this addiction which like other psychoneurotic states showed the phenomenon of over-determination. The taking of alcohol was the direct representative and symbol of the early sexual tendencies, it was a way of self-punishment due to the masochistic component, and it was, at the same time, the vehicle of repression of her essentially crude sexual phantasies. Lastly it helped to perpetuate the sense of youthful, sparkling euphoria which, at her time of life, she found it difficult to maintain unaided, and which was yet essential to the preservation of her phantasy of the ever-attractive siren. Analysis succeeded largely in removing the sense of guilt, but it hardly touched the narcissistic perpetual youth phantasy which the reality of her age, spreading figure and fading charms was challenging. She ceased treatment with me as she had done with a previous psychotherapist when he endeavoured to deal with this aspect of the case. Recent news shows that her general psychological condition has improved but that the alcoholic indulgence has continued unmodified.

The case is quoted not as an example of therapeutic success, but as illustrating an important aspect of the psychopathology underlying alcoholism. It accords with the theory of fixation at the earliest levels of development. The addiction apart, this case presented the clinical aspect of hysteria in the " narcissistic " personality type (see Chapter V), by reason of various accompanying conversion symptoms, and on account of the marked Oedipus situation which formed the kernel of the condition.

Thus the patient reproduced a scene in which she saw herself being whipped by her father, experiencing masochistic and exhibitionistic feelings towards him, then lying on the floor in a state of self-pity, wanting to remain the centre of father's attention. She cannot accept, as she says, that she

has been thrown out, and clings to the feeling that she is a special person. She says that she fears she will be left without anything if that goes. To this she has clung, this has been her " pedestal." In addition to these feelings there was present the other component essential to the constitution of the female Oedipus situation, namely a feeling of hatred and resentment against her mother, to whom in her phantasies she ascribed all the deprivation of sexual pleasures in childhood. Innumerable memories of punishment, of phantasies of mother's shadow following her, and of guilt associated with her mother were produced. From her mother was derived that part of her ego-ideal which was connected with guilt and with the wish for moral perfection, whereas from the father she derived the wish to be attractive and a stage star. This was one aspect of how she resolved the Oedipus conflict by the unsatisfactory method of a double identification.

The sexual wishes of that stage then seemed to undergo a process of secondary regression to auto-erotic and oral levels, e.g., after one of the " scenes " with her mother she sees herself sitting on a window-sill feeling revengeful, saying to herself, " I have finished with her, she doesn't love me so I won't love her, and I will continue to enjoy the feelings "; with this she masturbates. There follows a guilt abreaction, after which she recalled oral phantasies centring round an hallucinatory vision of a nasty worm. This was ultimately analysed into feelings of (1) deprivation at the breast and (2) at having her mouth cleaned with a swab as a baby associated with mixed ambivalent feelings of extreme greed, disappointment, and resentment.

It is to this level that ultimately we traced the origin of her addiction. It is not always that we can get such clear evidence as in this case. The patient said " somehow self-pity seems to lead in me to a wish to break out " and it is then that she feels the greed which leads her to take alcohol, the least amount of which produces a euphoric, truculent, depraved feeling which is soon followed by loathing and remorse. The self-pity, a sort of reactive depression, was related to the level of oral deprivation. We also learn that alcoholic euphoria is necessary to some people for the preservation of narcissistic phantasies.

Thus, although superficially, we were dealing with quite marked Oedipus conflicts, at the genital level, an important part in the dynamics of the condition is played by the early breast ambivalence, with the usual blurring into later pictures and phantasies, so that we get the series: nipple—nasty worm—ambivalent brother's penis. By far the greatest amount of *feeling* was connected with the frustrated oral wishes, telescoped with later incestuous sexual experiences and only repressed at the beginning of the latency period. It was therefore, *libidinal* rather than *aggressive* in character, although the patient brought out much hatred and disgust for the

"worm," and later against her mother, whose purity-identification in herself she was trying to poison by taking alcohol; at the same time she was compensating by drink for the loss of the nipple-penis, i.e. the lost feeling of love and security.

It is certain that in this case the pharmacological effect was unimportant by comparison with the symbolic value of the alcohol In that way the addiction functioned as a quasi-obsessional ritual, part of which was to experience profound nausea shortly afterwards which (apart from guilt) we might speculatively assign to a wish to eject-project the hostile, poisonous mother—milk-breast; but no associations clearly to this effect were obtained.

An extreme example of the release-reaction of alcohol is the condition known as *mania a potu* in which the ingestion of the least amount of the drug leads to an outburst of maniacal destructive violence which we can only attribute to some symbolic and *magical* adjuvant effect of the alcohol on a very imperfectly repressed primitive aggressive trend. Here we are almost certainly dealing with the same forces of the id which also manifest in the manic psychosis, and which are perhaps akin phylogenetically to the frenzies which are ceremonially induced by a somewhat analogous process of drug-taking, incense and ritual dancing in certain primitive communities, where they would seem to subserve the need for periodic release from severe taboos, with social sanction.

I can only indicate these fascinating anthropological correlations which those better qualified are still exploring.

Relation of Alcoholism to Homosexuality

There has been in psychopathological literature a marked association between alcoholism and homosexuality both overt and repressed, and quite apart from the study of cases coming for treatment, many of our social drinking customs are strongly suggestive of this motive.

Firstly there are the many ceremonial observances in connection with banquets, loving-cups and so forth, reminding us of the magical quality assigned unconsciously to the "blood" of the grape, which in this instance appears to function as a bond of friendship—in other words as a defence against aggression: a motive we already found in homosexuality as such.

Next we notice the behaviour, in all classes and many nations, of men—especially of the regular "crony" type—when drinking

together. Childish ambivalencies appear: there are embraces and terms of endearment (often of an affectionately obscene sort) and there are fights. The behaviour towards anyone who does not keep up is one of challenge and hostility: he is hardly a man, he is a traitor and somehow a coward. The atmosphere is like that of small boys masturbating together and trying to overcome their guilt and anxiety. Superstitious observance of ceremonial is traditional: e.g., sending the port round clockwise; or the angry derision which greets anybody so "unmanly" as to hold a bottle "underhand"; or the many rhymes and even religious quotations which accompany ritual drinking in German student corps and in Eastern Europe.

The whole is strongly suggestive of an oral substitute for homosexuality of the type which defies the Oedipus threat of castration, and so perhaps linked with such phantasies as that of making oneself equal with father—or perhaps even symbolically destroying him by cannibalism. Such speculations lead us to the primitive totem feast, blood-brothers and the like: practices which seem strangely akin to some of the Nazi doctrines.

From observing the effects of alcohol it is also clear that it can function both as a lifter of repression and as a reinforcement for repression (i.e. as a defensive reassurance or substitute against aggressive, paranoid feelings and against infantile sexual wishes).

The association of alcoholism with paranoia itself is another link in the evidence, as the latter condition is frequently a psychotic defence by means of the projection mechanism against unconscious homosexual trends. I may mention at this stage two examples of alcoholism associated with homosexual tendencies, which illustrate some of the above points:

CASE No. 56. A most excellent and conscientious butler, aged 38, was seen after his discharge from gaol. He had been convicted for mutual masturbation in a public lavatory. He had got into the company of homosexuals with whom he had been drinking for some years, and from time to time, *under the influence of alcohol* (again taken in minimal amounts) had homosexual relations. In his mind the sexual offence and the alcoholism formed a single entity. The genesis of the homosexuality was very interesting. He had always had a profound sense of inferiority and guilt leading to over-conscientiousness and the fear that he would be blamed for anything that went wrong. At school-leaving age he had coitus with an elderly woman. After that he "walked out" with what he called a "nice girl" for some years, but always felt shy and nervous with her, and could not make any sexual advances to her or to any other girl since. He was conscious of not being a "proper man" and for that reason could not trust himself to marry,

both because he could not associate " nice girls " with sex and because he felt he could not satisfy a wife sexually. He thus had a mother-fixation with a splitting of the mother image into two. This inference was supported by his further statement that he could always spend a night with a prostitute. On this soil fell an accidentally overheard talk among soldiers about a man with a huge penis whom they had masturbated. He gets the thought, " I would like one like that," and begins to have phantasies of mutual handling with men. His sense of guilt is overcome by giving himself Dutch courage with alcohol, under which conditions alone the instinctive tendency can gain expression against the resistance of a severe super-ego.

This is a very simple example of the function of alcohol in deadening the conscience and securing for the homosexual complex a temporary release. It was in this way that alcohol was used in the orgies of antiquity, and it still has this purpose in solving conflict either by overcoming the super-ego inhibition which we may visualize neurologically as situated in the higher layers of the cortex, thus allowing expression to the emotional centres normally under its control; or by precisely the reverse of acting as a substitute for the inhibited tendency of which we already saw an example in the case of the woman quoted above (Case No. 55).

In this patient the deeper oral components were not analysed, but it may be permissible to compare his psychopathology of " big penis envy " with that of Case No. 38 (Chapter VII), that of the man who went on lavatory expeditions, when a very suggestive similarity emerges.

In this alcoholic the drink functioned almost exclusively as a *lifter of repression* and as a libido reinforcement as between himself and his bad companions.

In the case that follows we shall see alcohol playing the part of a *substitute* for unconscious homosexual trends, and at the same time as a protection against anxiety, i.e. in the main serving the purposes of the ego-ideal.

Case No. 57 was that of a married man of 29, suffering from a fairly acute anxiety state and alcoholic tendencies. The latter he had had ever since his entry into his profession, and, as is usual, he regarded them at first as a proof and buttress of his masculinity. The anxiety state first came on at the age of 19, when after a " thick night " he was afraid that his chief would find him out, for his hands were trembling and his knees were tending to shake on important occasions. Since then he had almost a phobia about meeting his superiors, various physical anxiety symptoms and a fear that his alcoholic indulgences were showing in his face. In order to make himself feel better he resorted to more alcohol, which restored his feeling of well-being.

The story of his neurosis was clear enough. He was an only boy, very much spoilt and coddled by his mother, while his father was always expecting him to " be the man " and devote himself to the serious side of life. The boy's easy-going temperament and dependent attitude persistently ran athwart the father's ambitions about him, which resulted in the patient having to resort to lying and subterfuge to have his own way at all, and engendered a sense of smouldering rebellion. A crisis came at the age of 14, when he was discovered masturbating at school, and this was reported to his father. There was a dreadful scene in which the outraged father hurled curses and abuse at the boy, called him " worse than a beast," and said that he had ruined his health and future, and that he was completely spineless and a failure. This resulted in a great increase in the patient's inferiority and sense of guilt, and he sought refuge behind his mother. His guilt was all the greater because the chief thing had not emerged—namely, that there had actually been homosexual practices among the boys. The boy now formed the wish to be good and efficient, but as this ideal was largely motivated by fear, it was insufficient to keep the sexual tendencies in check, and from time to time the patient abandoned himself to the same practices—now definitely with a sense of rebellion and defiance. At the same time the paternal attitude and threats were never absent from his mind. At about 16 or 18 he was always looking at himself in a glass, worried about the fact that he had, as he thought, a " nancy-boy's " face, that his beard would not grow, and that his penis was much smaller than other people's—all attributable to his guilty practices, to which nevertheless he still felt himself attracted.

The same conflict continued, but presently he was in a position to pay for his drinks, and to have intercourse with women, all of which was done in an exaggerated way to prove himself a man. It was noteworthy that he would never bathe impromptu in the presence of other men for fear lest they should criticize the smallness of his penis. He was even now frankly frightened of his father, to whom he tried to give the impression of being a teetotaller, and several of his superiors at work also had that effect on him. This situation accounted for the onset of his symptoms on a morning " after a debauch," as the chief was to him the father who would discover his delinquency.

The deeper analytical findings were interesting. His real anxiety was due to the persistence of passive homosexual phantasies towards his father of an anal-erotic type, which had formed at the Oedipal stage. They consisted of ambivalently charged beating phantasies with a distinct masochistic flavour. He recalled early masturbation incidents (at 6 to 7) in which he was also discovered and beaten, with a fusion of helpless rebellion and fury and sexual enjoyment. From this there resulted a phantasy of possessing a concealed " inverted " aggressive penis inside his anus which he hoped would one day emerge and make him the equal of his father. His attitude to the father became one of submission and even hero-worship, as expressed in his ego-ideal, punctuated by tantrums of rebelliousness during which his incompletely repressed aggression found outlet, but which also masked his passivity. These discoveries lent further content to his feelings for his chief.

The Oedipal attachment to his mother was not fully analysed as the patient's duties took him abroad.

Once again we see the substitution of masturbatory and homosexual tendencies by alcohol. Once again there is the dual function of the drug—to prove himself the man, and to repress his sexual immaturities; and thirdly to cloak his father-fears which may be taken as a classical example of castration anxiety. The paranoid projection mechanisms, representing the fear of his homosexual trends, are also illustrated in this patient.

These two cases show clearly the sort of role that alcohol fills in the life of the neurotic with homosexual tendencies. Whether we approach this from the Adlerian standpoint of inferiority, in which case the sexual aspect becomes symbolic of the general feeling of lack of manliness, or whether we look at it from the Freudian angle which, as always, seems to me to be the more profound, alcohol deadens anxiety due to conflict between the paternal prohibition and the forbidden sexual impulses, and compensates for the deficient sense of manliness due to an awareness of the actually persisting passive traits. In the case of the last patient there arose a new anxiety, namely that his trembling hands would give him away as one who could not carry his liquor, and therefore again as something less than a man. So divorced was this unconscious anxiety from reality that this man was not in the least reassured by his entirely masculine, powerful build and his brilliant achievements in athletics and on horseback, nor, indeed, by his being himself a father.

Anxiety

A somewhat different aspect is presented by the case of a man whose condition demanded rapid measures as he was acutely ill with a dilated heart and cirrhosis of the liver due to twenty years of hard drinking, during most of which time he had been consuming two bottles of whisky per day. This patient's story was one of organic inferiority in which the deeper aetiology was not fully investigated, but which, so far as it went, provided some confirmation of one of Adler's main tenets.

Case No. 58. The patient, aged 50, was the youngest of three sons in a patriarchal family, and at the age of 8 had the misfortune to have one arm completely withered and the other disabled down to the elbow by infantile paralysis. Since that time, in spite of the fact that he might have pursued a scholastic or professional career quite adequately, he was never allowed to

do anything for himself, and was always talked about as "poor so and so." He gallantly tried to compensate for his tremendous sense of inferiority in various ways. For example, he displayed great ingenuity in the tricks which he used to dress himself, to drive a car which he did with conspicuous success, and so on. His emotional attitude, however, remained childish and dependent, to the increasing scorn of his very successful older brothers. There was no difficulty in getting the patient to tell me why he drank: he felt abnormally sensitive and inferior about his disability. This patient perforce had to be very dependent and latterly had been unable to be without some female attendant—mostly his elder sister—not for any bodily needs but from a strong sense of anxiety which recently had amounted to phobias of fainting, of crossing streets, and even of driving his car, and this anxiety had always been abolished by the taking of alcohol.

The psychoanalytically inclined reader may well wonder as to possible symbolic importance of this as well as of the disability to our patient, but no clinical evidence was obtained of deeper meanings, whose significance would in this case have been secondary to his considerable physical handicap.

Depressive States

On theoretical grounds we would expect the manic-depressive type of personality to be subject to periodic bouts of addiction, especially if we accept the psychoanalytic views put forward by Glover[1] and see the essential instinctual basis of drug addiction in the level of development at which the infant is trying to find ways of dealing with its own intolerable aggressive urges by attaching them to external objects which then function partly as a reassurance (a "good" healing substance) and partly as the enemy. In the absence of any alternative psychological theory of equal depth or consistency, we are glad to find in the Freudian psychopathology a concept which links the paranoid, manic-depressive and drug addiction syndromes, and, moreover, relates the latter to the truly psychotherapeutic field of sexual perversions, which seem to be alternative "reassurance systems" to addiction.

If the protective value of an addiction, as of a sex-perversion, is granted, then we must at times regard them as attempts at development, or self-cure. This is the view which was forced on me by consideration of the following case seen only once in consultation.

[1] Glover, E., "Common Problems in Psa. and Anthropology: Drug Ritual and Addiction," *Brit. J. Med. Psych.*, vol. xii, p. 109, 1932: and "On the Aetiology of Drug Addiction," *Int. J. of Psycho-Analysis*, vol. xiii, 298, 1932.

CASE No. 59. The patient was a foreman aged 58, and Irish, who was married and the father of eight children. He was described as a first-class worker and leader, cheerful, reliable and loyal, normally aggressive, stably faithful to his wife with whom he still practised regular coitus. His complaint was of periodic attacks of depression since the age of 40, occurring at 6 to 7 months' intervals, and ushered in by insomnia and *loss of appetite*. There was no obvious cause for any of the attacks. "In depressed times I think and think and want to commit suicide." "I take beer for dope—four to six pints a day knocks me over; I do this for a week and make a proper beast of myself. Then I get nervy and remorseful—then I recover." In contrast to his usual social behaviour he goes out drinking alone. He has no appetite, but feels a sort of restless urgent *greed* to get at the beer. Again, in contrast to his usual easy-going friendly attitude to his men, during his depressive (alcoholic) phases this becomes one of *suspicion*: "I get feelings people are going to steal my job." He said he had an ideal employer, who had forgiven him his periodic "blinds" for many years. During his bouts he could not face this man, and just after them he *felt terribly contrite* and remorseful. Severe, paternal words had a liberating, steadying effect on these occasions.

The episodes were usually over in from ten to fourteen days, after which a period of happy easy-going sobriety prevailed.

I gave his doctor and his firm the opinion that this was a case of manic-depressive psychosis of a mild order, and stated that I regarded the drinking bouts as an attempt at self-cure. Psychopathologically I believe this to be true. Although speaking by inference, one cannot help interpreting the addiction as a substitute for self-destruction—"a dope for suicide."

If the melancholic phase of the manic-depressive psychosis is expressive of oral-aggressive impulses which have turned inwards against the ego through the introjection of the loved-hated breast, then the alcohol has come to serve this patient's unconscious as both the love-object and the destructive agency by which that object (now in the patient) is attacked. A libidinal element might be inferred from the terrific *greed* which the man used to feel just before his bouts.

The case, as far as it goes, seems to confirm both the "oral-sadistic introjection" theory of melancholia and the psychoanalytic views of Glover on the nature of the impulses and mechanisms responsible for addiction. We note the coincident appearance of a well-marked paranoid mental state during the attacks, and conclude that the addiction has also served to lift a normally adequate veil over a hostile projection system which is probably related also to feelings and phantasies of oral deprivation —"people are trying to steal his livelihood."

A Digression: Some Notes on Treatment

From the above outline of some of the typical psychological states which form the background of alcoholic addiction one must draw the conclusion that the *treatment* of the condition is as individual a matter as the psychological problems for which it is the anodyne. Departing from the line observed in the other chapters, let us devote a few words to this important problem. The treatment obviously resolves itself into two parts, that of the underlying psychopathological state and that of the addiction habit itself. The former part is of commanding importance in such cases as that of the woman and of the butler, where the amount of alcohol was pharmacologically negligible. Here the treatment would need to be as far as possible on analytical lines, and in the first case this was followed with limited success. The method of treatment was sufficiently outlined in the case report.

In the cases of the other two men the dehabituation problem was a more real one, as there can be no doubt that alcohol, like other drugs, is habit-forming in the toxic sense, requires larger and larger doses to produce the desired effect, and gives rise to serious symptoms if suddenly cut off—presumably owing to the withdrawal of the usual chemical stimuli to the circulatory system, and possibly by the over-production of antibodies. The deprivation symptoms usually take the form of shivering and feeling cold, sinking sensations, thirst, and restlessness, in addition to great aggravation of the anxiety and other psychological symptoms which lie at the root of the alcoholic craving and which it served to cover up.

In the choice of treatment which is to achieve both a psychological cure and dehabituation from alcohol, one has to be guided by the urgency of the situation, by the capacity of the patient to undergo analysis, and by the risks attendant upon the withdrawal, if a suitable resolution of the psychological tensions or a less harmful substitute cannot be provided. Thus, in the case of the man with infantile paralysis (Case No. 58) it was imperative quickly to stop him from drinking himself to death. He was not a suitable subject for analysis, and in any case his difficulties were mostly on the surface.

It is in such cases that *hypnotic suggestion* is the method of choice and gives good results. The patient should be confined to bed, with skilled nursing attention. He is told that he will get as much alcohol as he requires, but that it will be given him in regular,

measured doses. In the actual case the contents of two bottles of whisky were divided into twenty-four equal parts and presented to the patient hourly on the first day. It was found that several of these doses were not taken, but still the routine continued, the amounts being very imperceptibly reduced by a drachm or so each time, until at the end of three weeks the patient was taking none. This has a very important result in that the refusal appears to be coming entirely from the patient, with the doctor almost urging the patient to go on drinking.

Actually the refusal on the patient's part is strengthened on alternate days by giving hypnotic suggestion, which is usually not difficult to achieve provided the patient himself wishes to be cured. A sufficient degree of hypnosis is reached when the patient is breathing regularly and does not respond to a gentle pinprick of the hand. Then suggestions are made, which increase in forcefulness from time to time, of the patient's disgust for alcohol, of his having the power and the wish to refuse it, of his increased sense of well-being as the result of abstinence, coupled with reassurances against the feeling of anxiety and positive inculcation of feelings of self-reliance, worth and will-power. From time to time it is interesting and useful to test the efficacy of the method by suggesting a definite combination of words which the patient will use on waking up:

Thus, at the sixth hypnotic session the patient was told that a nurse would come in on his waking, offering him a drink. He was commanded to say, "Take the beastly stuff away, I don't want it." The nurse was unaware of what was going to happen, but was asked to make a note of the patient's words when she brought the usual dose in. The procedure worked word-perfectly.

In the case of this patient all craving for drink had gone after the second hypnotic session. After the sixth suggestion over fourteen days the patient looked an entirely different being. His appetite had returned—he was even able to enjoy the smell of bacon for the first time in ten or fifteen years. He was feeling strong, was going for daily walks and his heart had returned to normal size. At the end of three weeks, he was completely strong and normal, and had no desire to drink even when in the company of other men who were drinking whisky, the smell of which he had been commanded to detest. He was also given the alternative of toffee and barley-sugar as a substitute. The patient has remained free from all desire to drink even under the temptations of club life, his sense of superiority having been enlisted by suggestion on the side of his abstemiousness. He is also engaged in mild social work, in addition to pursuing his usual interests in amateur engineering.

This case illustrates incidentally the merits and defects of treatment by hypnotic suggestion. As regards the drug addiction, this has been excellent. As regards the underlying anxiety state, the result had to be reinforced by further visits owing to a return of the fears of crossing streets, etc., i.e. the fundamental situation has not been permanently affected in spite of the temporary " boost " which suggestion was able to achieve. With it, however, there is no desire for drink, but merely the wish for female protection.

This problem the patient tackled satisfactorily by a very suitable marriage!

In Case No. 57 (the man aged 29) we were dealing with very different material—an eminently analysable patient in whom the addiction seemed a secondary problem and had not persisted for long. In his case analysis was given, and in a few months resulted in a marked diminution of his need for alcohol going hand in hand with release from anxiety by reassociation and interpretation of the father situation and the connections between alcohol and the repressed passive homosexuality. The weapon of suggestion can be kept in reserve if time factors or other circumstances render it necessary. But it is obviously more satisfactory to deal straight away with the fundamental problem. It is also clear how fruitless would have been such methods as are commonly used by those without knowledge of psychopathology, namely those of admonition, appeal to will-power, and moral considerations. Firstly, this is precisely what the patient had had *ad nauseam* as a youth, and they would merely have aroused unconscious resentment against the paternal note of such appeals. Secondly they will increase guilt and anxiety and so tend to make the need for alcohol more acute from this point of view.

Certain medicinal measures are of undoubted utility during the period of dehabituation to combat the vaso-motor collapse. These are almost traditional and certainly seem to be of some use. There is the oral administration of a mixture containing strychnine and atropine sulphate, compound tinct. of cinchona and compound infusion of gentian, given three or four-hourly. There is also the hypodermic administration of the first two ingredients in increasing doses as the alcohol decreases, and gradually discontinued as the deprivation is seen to be well tolerated. This mixture can also be given after the main treatment is over. The prescription is found in most textbooks.

Glancing back for a moment one would say that in institutions and in other situations where time and expense are important factors hypnotic suggestion would be the method of choice, as it certainly cures the symptoms and the patient can, of course, always return for what we might call a " refill " as the effects begin to wear off and he wavers in his resolution.

MORPHINISM

We must now turn to the consideration of morphia addiction, and we will adopt the same method of introducing the subject by a case from which we must endeavour to draw such conclusions as we are able as to the differences between this addiction and alcoholism. It will be suggested that these differences lie (1) in the much greater degree of repressed aggression and sense of deprivation, (2) in more marked loss of object relationship and of narcissistic defence in this condition.

CASE No. 60. A highly cultured man of about 40, a member of a colonial service, came voluntarily for treatment for morphia addiction. His story was that he had been out trekking through uncharted territory accompanied only by his native porters. During this trip he contracted dysentery and had to dose himself heavily with opium which he carried in his first-aid equipment in order to keep himself going, which he was obliged to do in order to reach his water-supply from day to day. He got into such a state, surrounded by hostile tribesmen and wild animals, that he found himself taking all his supply. On his return to civilization he was given morphia both for the pain of the abdominal condition and for sleeplessness, and this apparently started him on the habit. Returning on leave he made an attempt at cure, but funked the deprivation symptoms as they began to appear, and also refused to accept the rigid conditions which a doctor wanted to impose upon him for the treatment of the condition. He returned to service, and a year or two later was asked to resign as his addiction had become known to the authorities. He had since found a civilian occupation in London, and it was then that he was referred to me.

At the time of his first visit the patient was in splendid health both physically and mentally, and no one could possibly have suspected him of being a morphine addict. He was then taking about four grains daily. It was imperative that he should remain at work, and we decided to tackle the question of causes first and undertake dehabituation when he was in a position to absent himself (a mistake I have since learnt to avoid). I undertook the prescribing on the condition that the patient would not obtain further supplies from other sources. On the psychological side it was soon apparent that this superficially stolid and stoic individual, cheerful and optimistic, with whom " nothing could go wrong," was suffering from a

profound anxiety state with a number of obsessional features. As in the case of the alcoholic lady (Case No. 55), though on a higher cultural plane, there was a very large oral-erotic element in his make-up. It will be a matter of some difficulty to condense the complicated analytical material which this patient presented.

He was brought up in a very respectable and well-to-do home and practically never saw his parents. From earliest times he remembered rows and tantrums with his rather hard nurse, who made him feel that he was a disgusting little pig and the most horrid boy that ever lived. From such contact as he had with his parents he imbibed the doctrine of never showing his feelings, and he remembered such scenes as sitting in the corner and nearly bursting with pain over a hurt thumb rather than cry and ask somebody to come and comfort him. Things were complicated at the age of four by the birth of a second brother, and the burden of being the eldest was now imposed upon him. He was always so big and strong that no one suspected him of ever wanting anything but to kick and fight and be rebellious. At the age of 5 or 6 he was living in a particularly interesting adventurous phantasy with which he burst in on his mother, full of enthusiasm. She looked him up and down and told him not to be so silly and tell fibs. He was very deeply hurt and resolved entirely to keep his own counsel, never trust anybody and lead his own life. He put on the " don't care " attitude, and further buried his wish for sympathy. At school he was clever but clumsy, and wore eye-glasses, and both his attitude of superiority and his appearance made him the butt of the other boys, which led him to scorn his fellow-men and become entirely introverted and intellectual in his interests. He remembers watching some school match, standing by himself, and thinking, " Look at all those poor fools cheering and being so childish in their enthusiasm—I wish the damned school would lose " (meaning his own school). He said, " I got so that I didn't care whether people were there or not. If someone let me down I didn't care." Constantly he had to hold in his temper, as it was always a hopeless fight against overwhelming numbers, and besides it was childish to show temper.

Another statement he made was how proud he was when as a small boy his father used to take him out and talk to him like a grown-up man on their walks: " . . . and then we would come home, he would go to his study and I would go back to the nursery, and all the illusion would be shattered." Out of these circumstances of deprivation of love, misunderstanding of his sensitive side on the part of his elders and the expectation that he should be big and sensible there grew an enormous ego-phantasy of Buddha-like calm and detachment on the basis of an identification with his " omnipotent " father. The emotional life, apart from phantasies, remained completely atrophied.

During the War he married a woman older than himself towards whom he felt little or no sexual desire, and with whom he could never share any intellectual interest. All his phantasies were concerned with himself and his own interests, and he soon came to consider his wife as nothing but a tie to his roving spirit. As he put it, however, he could not even bother to quarrel with her as it was beneath him—he just let her have her way in all

the details and, as in all other matters, he dismissed his defeats with the thought that these trifles did not matter. He would sometimes stand at a busy street corner, and survey his fellow-beings with an air of complete detachment and aloofness, comparing them to a lot of puppets, moving on wires, having nothing in common with him. It was the greatest possible humiliation to a man with such phantasy to have to come and ask to be treated for such a condition as drug addiction, which proved that there was at least one subject in which his control and detachment were not absolute. Owing to his Olympian indifference to the lesser things of life his money matters were always in a muddle, a circumstance which helped ultimately to break through his phantasy of detachment from sordid trifles, revealing the anxiety underneath.

No notable progress in the uncovering of the anxiety was made, however, until the patient was able to enter a nursing-home for dehabituation. The procedure was quite simple. With the patient's permission very thorough search of his belongings was carried out and he was placed on regular injections of morphia three times a day, starting at three grains, which was the dose to which he had himself managed to reduce his intake whilst being treated outside. Quarter-grain reductions per day were given until after ten days or so the patient was receiving injections of distilled water which were discontinued after a few days, and the patient was then informed that he was now off the drug. His deprivation symptoms were moderately severe at that time, and consisted of running from all the mucous surfaces, restlessness, especially an inability to keep his limbs still, aching round the large joints and, in this case, asthma. These were all treated symptomatically, with belladonna as the basis, with very good results.

Most important of all, from our point of view, was the change in the patient's mental condition. He now felt like a caged-in beast, he said, and expressed feelings of furious resentment against the Government for not letting a man take drugs if he wanted to, saying it was enough to cause anybody to take more drugs to be treated like a child. Here we had the paranoid projection emerging when the drug was cut off. With it came two other new symptoms—a sense of emptiness and lack of any sort of enjoyment in life, and a sense of detachment from himself as if *he* was now the puppet, doing things automatically while one part of him looked on. These various feelings were traced back to the appropriate childhood background (down to the age of 3 or 4) and the patient seemed to be able to put them together and accept the psychopathology of his condition.

After a while he became irregular in his attendance, and eventually it transpired that he had relapsed under stress of his financial complications. He kept this secret out of sheer pride, which is probably the usual reason why morphine addicts so frequently and needlessly go behind their doctors' backs. Another reason for this lies in the rebellious character traits which the patient exhibited, and which explained why morphinists tend to go against the law. A distinguished colleague of mine once said he felt sure that if

dangerous drugs were legalized the number of addicts would fall considerably for the reason given!

The most striking fact about this patient's psychological make-up was his ego-ideal of stoical detachment and aloofness, which was explained in the analysis by the repudiation of dependence on others, i.e. of object attachment, whether in the strict psycho-analytic meaning of that term or in the sense of a separate instinct which has been suggested in previous chapters. His attitude towards his family, his school mates, and later towards his wife were, to say the least of it, cold; under the stimulus of a feeling of un-wanted-ness he had at first become extremely hostile, later covering this by the façade of indifference. There was evidence that his unconscious hostility was especially severe against his mother and her substitute the harsh nurse, and that his attempt to smother his unsatisfied love demands in that direction led to a transference to the father, with whom identification took place, with a resulting contempt for everything feminine and "sloppy."

The drug, which was started as much for the terror of isolation in the wilderness as for abdominal pain, seems to have acted firstly as a reinforcement to the omnipotence phantasy of his ego-ideal, and might thus be regarded as a symbol of the father's power. It seems, further, to have represented the love element so much lacking in other respects, producing a feeling of satisfied "on top of the world" superiority.

The psychological state during abstinence from morphia was perhaps the most instructive part of our study. Here beyond question we were dealing with an infant deprived of his fundamental rights, viz., the breast, reacting with a mixture of depression (introjection) and paranoid (projection) hostility against "authority." The amount of aggression liberated was much in excess of anything I have seen in alcoholics, and only equalled by some of the fetishistic sex-perversion cases. It is possible, though not proven, that his aloofness and superiority also represented an earlier mother introjection (cf. her attitude to him at five), and that it was this enemy he was trying to attack as well as to render harmless by the incorporation mechanism alluded to earlier.

A striking feature of the case was one also noted in psycho-analytic writing (Rádò)—the exquisite pleasure he derived from the prick of the syringe. It was as necessary to him as the pharmacotoxic effect of the morphine. I did not get any reply to my

attempts to make him associate on this point, so that such interpretation as I have rests on the analogy of psychoanalytic findings (perhaps also inferred!). The sadistic pleasure was beyond doubt: it probably represented both an attack (phallic) and a masochistic gratification of being given a pointed object—the nipple. As already mentioned, the patient was characterologically of an oral type, and his manner of noisy, avid smoking was very suggestive.

Rádó's notion of the drug producing the equivalent of an "alimentary" orgasm—which he reads into the greedy sucking of the infant followed by blissful satiety—is perhaps exaggerated. The addiction at least in this case did not replace sexual (genital) satisfaction entirely, as suggested by that writer. Casual sexual intercourse did in fact occur fairly regularly. It was the *tender* element—perhaps related to the "third" instinct—which was so conspicuously repressed.

I have no doubt, however, that in more advanced cases, and in people with a less stable reality sense, i.e. with more psychotic fixations, the pharmacotoxic satisfaction may well replace all other relationships and reduce the patient to complete psychic amorphousness. The man under discussion was certainly still working successfully some six years after first coming under my notice. His later fate could not be ascertained.

A very similar story was presented by another morphia addict of some years standing:

CASE No. 61. A former flying-officer of World War I, aged 40 when first seen, of athletic habits, contracted the addiction for relief of pain after a bad crash which had left him lame. This man descended to incredible depths of degradation and misery until he finally came for treatment. He was a person of intense pride, aristocratic superiority and hostile aloofness from society. In this case it was possible to induce a hypnoidal state in which he first of all was made to relate in a few sessions the chief traumata of his childhood. This anamnesis brought enormous abreactions of repressed fury and resentment against the deprivation of love which he had felt towards his mother after the birth of a younger brother, and for which he had over-compensated by stubborn rebellion and the assumption of the role of the "man of iron." He was then given hypnotic suggestion in every respect similar to that given to the alcoholic mentioned earlier, and, after several years, he had not had a relapse. He did take to alcohol temporarily, but this was easily dealt with by further suggestion. He was now able to earn his living as a sports coach, and although suffering from tempers and occasional alcoholic excesses, he became once again a respectable member of society. He was not available for long analysis, and his fate after 1939 is unknown.

Conclusion

To sum up, we see that drug addiction is the expedient resorted to by neurotic personalities of various types, when their other defences or compensations have broken down. It has the twofold purpose of serving the repressing forces (the ego-ideal) and the repressed tendencies which appear to be impulses belonging chiefly and ultimately to the oral phase of development at which level the original trauma appears to have occurred, and to which the thwarted love impulses of later stages regress.

Drug addiction appears, in point of fixation, to lie on the border-line between the phase of oral projection-introjection mechanisms, i.e. psychotic reactions to instinct frustrations and mastery, and the phase of obsessional reaction-formation, allying it to the magical rituals and concealing the same ambivalencies. In Case No. 60 we find even a sense of depersonalization suggestive of the depressive position. Drug addicts, on the other hand, can belong to almost any of the known groups, and it is questionable whether the fact that these various types may make use of drugs constitutes their chief common factor and peculiarity. It would seem that in essentials the response to instinct frustration, to inferiority, etc., is very similar in addiction to that in fetishism, and that its crucial constituent must have been a psychic event of displacement of a very fierce oral ambivalency (and perhaps ambivalency towards other "dangerous" part objects, e.g., faeces), to ingestible substances. The superstitious, ambivalent social attitude towards drug substances aids their exploitation for symbolic ends. We know that under specific individual taboos innocuous substances may come to acquire the same value for the patient as the more pharmacotoxic substances, as for example tea, cocoa, or chewing-gum. For that reason it is difficult to account for the phenomena of drug addiction on any but psychopathological grounds. We must remember that every habit, good or bad, is, or has been at some time, emotionally determined and is broken when sufficiently powerful new motives or repressing forces are brought into operation. But while the pharmacological properties of drugs are important, the *magical* aspect of their action is that which is seized upon by the suitably predisposed unconscious factors.

There is reason to believe that morphine addiction is of special appeal to those in search of an equivalent for a dangerous, very

aggressive object, while alcohol would predominantly seem to meet the needs of libido and love deprivations.

My experience does not enable me to say anything about addictions to barbiturates and the lesser hypnotics, but there is no reason to suppose that the underlying mechanisms and conflicts differ materially from those I have here indicated.

It is the existence of early fixation points and the "getting more pleasure than the unconscious bargained for" which renders the complete psychological cure of the underlying conditions so difficult, and which would seem to make the treatment by hypnotic suggestion wherever possible the most practical method when rapid results are imperative. There is, however, evidence which I have tried to adduce that even a certain amount of analysis may have beneficial results. From the point of view of learning more about the psychopathology of these conditions the latter is the only method at present at our disposal, and further publications of full analyses would be welcome.

It is noteworthy that some morphia addicts, even of long standing, do not appear to suffer any ill effects, continue on the same dose for years, and do not deteriorate in their general habits, as, for example, the first of the two cases quoted; and it is just possible that with such cases the drug addiction may be the less catastrophic of two alternatives, the other of which is flight into psychosis. That is to say, addiction, like fetishism, can function as a reassurance system and represent an attempt at self-cure. The same is to some extent true of alcoholism, especially in the depressive states, and it may be the dimly sensed knowledge of the alternative that makes many of these cases so extremely resistant to cure, which superficially they desire.

CHAPTER X

SOME GENERAL CONSIDERATIONS AND CONCLUSION

THIS chapter will be devoted to the consideration of certain subjects which did not seem to fit readily into the framework of the earlier parts of the books, while the size of my contribution did not warrant special chapters for each of them.

The most notable omissions, among subjects that should form part of a discussion of the psychoneuroses and allied states, are the *reactive depressions*, the *character disorders*, including delinquency, and the so-called *organ neuroses*. The present book does not set out to be a complete account of the field of psychogenic disorder, but merely a record of such views as I have been able to form on the basis of personal analytic experience, which has been mainly confined to the psychoneuroses, together with some of the clinical evidence on the strength of which those views were held. It may be perhaps worth while to re-state here my general ideas on the reactive depressions and the character disorders, as they were part of this last lecture-discussion.

1. So far as *reactive depression* is concerned, we can be brief. Whatever may turn out to be the nature of manic-depressive psychosis—and there is much to be said for both the metabolic and the psychogenic aspects—there is evidence that depression may occur as a psychoneurotic symptom, which has its level of origin in the first year of life, at the oral level. It is said to arise when the baby, having experienced a severe sense of frustration and in vain tried to compel love and attention by an outburst of aggression, gives up the unequal attempt and lapses into a condition of hopeless apathy mingled with a feeling of self-hatred for its own impotence. That is to say there occurs a conjunction of "exhaustion of affect" and of introjection of affect. More often than not this depression forms *part* of other psychoneurotic symptom pictures rather than appear as a condition *sui generis*.

It is especially encountered, in my experience, in association with sex-perversions, when we find that the sexual activity (masturbatory, fetishistic or sado-masochistic phantasy or act) supervenes

as an attempt at the relief or cure of this intolerable state of "inverted hate" as we might describe infantile reactive depression. Clinically, in the analysis of patients exhibiting the symptoms, we are often able to establish a link between the occurrence of the depression and some *antecedent* frustration, as well as with a *consequent* outbreak of some consoling sexual compulsion—a link which may be conspicuously absent in true manic-depressive psychosis. Reactive ("neurotic") depression also fails to exhibit cyclical or episodic variation such as is found in the psychotic type.[1] Of the cases quoted in this book, the following showed the symptom and the early reaction described: Case Nos. 33, 34, 35, 38, 39, 42 (all in Chapter VII). Their abnormal sexual indulgences almost invariably followed a period of tense, dejected feeling when life seemed unbearable to them. In several, the analysis of this feeling was the occasion of the greatest resistance.

This resistance often turned out to be due to underlying intense aggression of a sadistic character, directed against the mother or other indispensable but frustrating love object and subsequently introjected with resultant piling up of guilt. During the recent war psychiatrists have been able to see the connection between reactive, transient depressions in combatant soldiers, not of a manic-depressive make up, where the mechanism of the symptom was held to be based on a similar access of unconscious guilt provoked by the experience of destruction and carnage. Early sadistic phantasy-relationships had been reactivated, probably at levels comparable to those described here, and were dealt with by introjection, with resultant self-blame and leaden emotional apathy.[2]

If the symptom exists as a general attitude evoked by difficulties in human relations we are perhaps justified in calling it a *character trait.* We will therefore now turn to the general plan into which I try to fit character traits and their clinical anomalies, when the reason for this statement may become apparent.

2. *Character Traits.* For my original orientation in this subject I am indebted to Hadfield, and I still consider that his views tend to the unification of psychopathological theory. What is stated

[1] E. A. BENNET, in contributing to a discussion on "Depressive States," at the B.M.A. Conference, 1938, made this point, and showed also a qualitative difference between "psychoneurotic" and "psychotic" depression.

[2] ELIOT SLATER ("The Neurotic Constitution," *Jl. Neur. and Psych.*, vi, Nos. 1 and 2, 1943) has demonstrated a statistical difference between endogenous and reactive depressions.

below, however, must now be taken as my views, without attributing to him any distortion that may have occurred.

In my view, then, certain character traits may be *simple,* native equipment, arising out of the sum of inherited dispositions of the individual, without any pathological modification as the result of later experience. These could hardly give rise to conflict on their own account unless they clashed with some fantasy in the ego-ideal system, which latter would then be the really pathogenic factor. We must, however, bear in mind that some simple traits are very strong and liable to lead their owners into difficulty, especially in primitive human types, and are not analytically reducible.

Secondly, there are *exaggerated character traits,* which may be pathological in the sense that hypertrophy is a pathological change.

We could probably call some of the sexual *aberrations* (not perversions) persisting exaggerated character traits (see Chapter VIII). Similarity timidity, curiosity, possessiveness, and so on, are often of this nature. They are the result of mere emphasis in childhood, and though subject to normal mechanisms of displacement and sublimation, they have not formed part of a pathological conflict, are accepted by the ego as part and parcel of the personality, and are often amenable to educative influence, but not modifiable by analysis.

The further distinction arises as between merely *exaggerated* character traits and true *reactive* character traits, which are of much greater importance in psychopathology. For example, in the obsessional boy (Chapter IV, Case No. 13) the rage and rebelliousness were really the result—the reaction to—a feeling of loneliness and shut-in-ness; he *reacted* with fury, and this became his attitude to his mother, replacing an underlying wish for love and spoiling which he repressed.

Suppose that this boy, for reasons which must remain hypothetical, had not repressed his temper and rebellion. He would then have remained with the condition which would be called a reaction character trait, with attacks of fury if thwarted, and with a hostile, truculent bearing towards his mother and most likely towards his whole environment. This actually occurred as a temporary phenomenon in the course of treatment, as happens frequently when the reaction traits are liberated through the analysis of the morbidly severe ego-ideal (super-ego) by which they were ultimately repressed.

His " repressed " would at that stage merely have consisted of the cravings for love and attention. We get the impression that a reaction character trait is formed as the result of some dramatic climax in the psyche ending a conflict and producing the dominance of a new ego attitude, similar to the nuclear experience in which the super-ego crystallizes (see Chapter II). On the other hand the exaggerated, non-reactive character trait is most usually the result of long-continued environmental influence without conflict.

An oral erotic trait of this latter kind is, e.g., illustrated by a case known to have been breast-fed for well over a year. The characteristics pointing to exaggeration of the oral tendencies in this case are gourmandism, an inclination to smoke or nibble something most of the time, oral-sadistic chatter with neologisms and subject to a rhythmic repetition-compulsion, over which there is *no conflict*, but on the contrary the subject indulges in them when he feels particularly pleased with life.

Similarly, an exaggerated *anal-erotic* character trait is illustrated by the case of a woman who is frankly and semi-humorously over-interested in excreta, purgatives and everything that pertains thereto, the sole evidence of guilt being an occasional exclamation, " Aren't I dreadful! " On the other hand there is the example of a man who is worried over the action of his bowels, has an extra lavatory built in his house " in case of need," is meticulous, scrupulous, and painfully fastidious. The former case represents chiefly an *exaggerated* trait with a little guilt; the latter a *reaction* with guilt and anxiety to excretory interest and, in my opinion, typical of the reactive character trait, resulting from repression.

As between psychoneurosis and character disorders[1] there is, therefore, an important distinction. The individual with some abnormal (exaggerated or reactive) character trait may lament its existence but accepts it, indeed may be proud of it (as many rebels are), whereas the psychoneurotic does *not* accept his symptoms. They are always resented and thought of as foreign and disturbing to the ideas of the patient's self, or as an organic illness. This distinction is of great diagnostic and therapeutic importance, for example, in the differentiation of psychogenic delinquencies. Thus, a sex-perversion which is a *reaction character trait*, i.e. a compensatory morbid reaction to, say, the sense of love deprivation, is difficult to eradicate, as there is no conflict between symptom and

[1] I prefer this term to the more generally used " psychopathic state."

the ego-ideal. The type of sex perversion which breaks out compulsively, against the individual's conscious moral values, is more accessible fundamentally. The same may be said of tempers and other anti-social conduct, or of the comparison between timidity as a character trait and anxiety as a psychoneurotic symptom. In other words, in the reaction character trait ego-ideal and "symptom" are in agreement, whereas they are in conflict in the psychoneurosis. Sometimes the distinction is difficult. For example:

CASE No. 62. A boy of 18, who, the moment he set foot in his home, provoked quarrels with his parents, especially his mother, and had done so since he was quite small. His bearing and attitude *outside* the home were quiet, retiring and polite, but always suggestive of superiority and proud aloofness. The wish to pick quarrels, etc., was a reaction to the feeling that he was not loved so well as his brother, and so he exaggerated all his grievances. Thus, he said, "I don't see why the devil I should feel under any obligation to my parents—I didn't ask to be born," and so on. He had a minimal sense of guilt over these characteristics, and felt resentment and hostility freely towards his mother. His conduct in the world was different merely from expediency because he knew the other would not achieve his purpose—the feeling of significance and power—but would only make him look stupid—so he retired lest he should make a fool of himself.

This fear of betraying weakness was also traced to an underlying sense of insecurity, i.e. a feeling of deprivation of his mother's love, which made him unconsciously *want to cling* to her. He was for a long time unemployed, refused or threw up good openings, "purposely" failed in examinations, and always returned home, demanding complete "freedom" and financial support. His technique was to cloak his wish for "omnipotent dependence" by being a nuisance and a constant source of worry to his mother, in revenge for the greater care that had been lavished on his more delicate elder brother.

His rebelliousness thus succeeded in serving as an ambivalent expression of both sides of the conflict.

Adler would have called this boy "neurotic," for that is his only label—and he was wise perhaps in not seeking after further differentiations.

The argument in favour of the diagnosis of character trouble rather than a neurosis is the patient's approval of his own attitude which he regarded as quite natural and self-evident, though for some reason or other not conducive to success and happiness, which to him were quite secondary considerations by comparison with the wish to be of unpleasant importance to his mother and yet safe from any suspicion of being weak or foolish in other people's eyes,

i.e. betraying his dependence on her. To achieve this end he paid the price of a career, for which by intelligence he was well fitted. This failure, it is true, gave him a certain sense of shame.

I feel that this case might perhaps even deserve to be called a psychoneurotic character trait, since the *general* attitude and aims of the patient (the wish for success and power in the eyes of the world) are in contrast to a specific, circumscribed aim—that of revengeful domination over his mother, which thus has the features of a "foreign" reaction, but also has the sanction of the ego-ideal which is modelled on the power-pattern.

To sum up—character traits may be *simple*, e.g., vivacity; or *exaggerated* by environment without conflict, e.g., the oral traits we mentioned; thirdly they may be *exaggerated as part of a compensatory reaction* against the frustration of some other trait, in which case they tend far more to motivate conduct and general attitude to life, to the point of being at times indistinguishable from psychoneurotic traits by which we ought perhaps to denote any psychoneurotic symptom of circumscribed, localized import. For example, the compulsive dread of strangling one's wife is an obsessional neurotic symptom. The same wish, unconsciously expressed by some habit, such as squeezing a sponge dry after ceremonious and very thorough ablution, or by addiction to militant anti-feminism, constitutes a psychoneurotic character trait, partaking as it does of the usual ambivalent representation of both the guilty wish and its expiation, but without arousing anxiety or self-criticism in the ego.

The psychology of crime seems especially subject to all that has been said regarding character traits, and hence a clarification of the above categories becomes a matter of practical as well as theoretical interest, for the simpler a physic structure the more unshakable it is by therapeutic attack. The description given of the reaction character trait seems to fit the cases of criminals in Healy and Alexander's interesting clinical studies (*Roots of Crime*).

3. *Organ Neuroses.* Turning now briefly also to the third of my omissions, I find that from the psychopathological point of view these conditions do not form a separate category. Their isolation under a separate heading seems to me to be purely descriptive, and perhaps more determined by the view-point of general medicine than of psychopathology. From my standpoint the majority of

organ neuroses seem to belong either to the group of anxiety states or to conversion hysteria.

Several examples of both have already been mentioned under those headings. It will only be necessary for me to recall the case of the young man (No. 6, Chapter III) who after humiliation developed a cardiac neurosis (an anxiety state), or the fisherman (Case No. 21, Chapter V) who developed symptoms of duodenal dyspepsia after the repression of acute fear, or, again, the woman with the "neuritis" of the arm (Case No. 16, Chapter V), to illustrate the rôle and the significance which such displacements and/or conversions from the mental to the physical fulfil in the patient's mental economy. Wittkower, in many papers, has aptly summarized the mechanisms at work.

In the anxiety cases perhaps the most obvious is the displacement of a general fear to a *locus minoris resistentiae,* either by way of previous organic disease in the part selected or simply through an increased awareness of the over-action of the organ as the result of autonomic stimulation, when the emotion as such conflicts with the patient's ego-ideal. Under such conditions the part may represent the whole man. Or, again, there may be an individual childhood anxiety attaching to the part selected as the result of old memories (e.g., palpitations and infantile masturbation), or, lastly, there may be a symbolic process at work, as when the heart comes to represent emotional life, or the right arm power, etc. This symbolism is perhaps of a supra-personal (racial) significance, allied to metaphor in general, and constituting what Adlerian psychology calls "organ jargon," and psychoanalysis "somatic compliance." It will be seen how easily such stuff lends itself to regressive flights, so that such symptoms are sometimes part of severely narcissistic states.

At this point we enter the largely unexplored field of psychosomatic medicine. Besides those relatively intelligible cases of conversion at the hysterical level or displacement at the anxiety level which have just been mentioned, there are all those conditions in which clinical observation and a minimum of psychological inference can clearly point to a connection between mental stress and physical symptom. Not only rheumatic pains, but every sort of digestive and respiratory disturbance, and several skin conditions, are apparently evokable by emotional influence, though these quasi-structural syndromes are not to be so readily interpreted or resolved

by analytical methods. We are left with an impression—yet to be proved as objectively true—that in some people the somatic sphere takes the brunt of psychic distress, whereas others "live out" their conflicts either in a predominantly psychological neurosis with a demonstrable emotional pathology, or else "act out" their stress on the environment as character disorders. Thus there seem to be three levels of externalization, of two of which we have a fair understanding. The third, which we are now discussing, offers immense scope for research. It bids fair to throw entirely new light on the obscure origins of structural disease, in which infection seems to play only a secondary rôle, after spasm, stasis, hyperaemia and similar basic functional disturbances have prepared the soil.

Conclusion

The reader will no doubt by this time have formed a fairly clear picture of the general point of view from which this book is written. Yet because it is a book with a limited objective, it might not be out of place to try and present at least an outline of the canvas of the author's present approach to psychiatry upon which the particular corner of the pathogenesis of the psychoneuroses and allied disorders has been singled out for detailed treatment. To some extent this canvas—and therefore the detailed work upon it —must be a subjective matter and, as such, liable to change in the light of experience and of the work of others. It is not yet possible to write a completely objective psychiatry, let alone psychopathology, in *any* terms. We must admit at the very outset of our career as psychotherapists that our observations—the clinical facts on which we base our concepts—are subject to fallacy, that we are tending to give to our patients' statements and behaviour certain unconscious valuations. Therefore, unless we are careful, we are apt to get out of them what we put into their mouths—quite apart from the fact that many of those who seek psychotherapeutic treatment are both intelligent and acquainted with one or more of the psychopathological doctrines which therefore influence their utterances. Freud, Jung, Adler and their followers started by being confronted by the same "facts" which, after a time, nevertheless became so selectively interpreted that they fitted the widely divergent concepts of these three differently constituted men. For this reason we must, especially in the early stages of our careers, be prepared to resist a strong temptation to prejudge the psycho-

pathological content of cases that come to us for analytic treatment and only concede a minimum of preliminary diagnosis, but on the contrary always remain on the alert for fresh, unique combinations of forces and mechanisms in every individual patient. Having endeavoured to follow this course in the clinical practice from which the series of cases in this volume are culled, one has been led to admit ungrudgingly in the face of a mildly negative initial bias how much one's own clinical material has confirmed the fundamental broad formulations of Freud. The concepts of his school are now profoundly embedded in our views of psychogenic disorder, for the reason that practice again and again shows these formulations to be correct. Any amount of detail can be fitted into the psychoanalytic scheme of mental structure and dynamics, even where some of one's own evaluation of the content or meaning of such details differs from this school.

In 1946 it may already be questioned, as it could not be when this book was first published, as to what constitutes "official" Freudian doctrine. That orthodoxy which for a time surrounded and perhaps helped to preserve psychoanalysis as a separate entity has under stress of war and widening contacts largely disappeared, and the conceptualization and reformation of psychopathology in the second 50 years since Freud's pioneer work was first launched will proceed along a much broader and more united front of so-called psychoanalysts and so-called "free analysts" than would have been thought possible seven years ago.

So far I have seen little need to revise my general presentation of psychopathology, which I believe is somewhat simpler theoretically than the more standardised views hitherto regarded as the official Freudian doctrine, but which in point of fact is very near to the sort of formulation towards which present-day psychoanalytic thought is tending. Whilst one does not like to divide the motive forces of the human mind too rigidly into instinct categories, I feel that I have made out a case for the existence of three early biological needs which seem clearly discernible by the methods of study delineated in this book and which have also been amply demonstrated to exist in animal and child behaviour: (1) a self-preservative tendency which, I am inclined to think, is the most fundamental and perhaps earliest in its domination of the field of behaviour and therefore likely to motivate the morbid deviations or changes in the other two tendencies, which are (2) the sexual tendency (Freud's

libido) and (3) aggressiveness, which for not altogether convincing theoretical-biological reasons was named the "death instinct" at one stage of Freud's work.

At the risk of repetition I would emphasize that, when I state that the self-preservative instinct motivates morbid developments of the personality, I mean that infantile fear lies at the root of repression and other earlier and later mechanisms by which the developing psyche meets intolerable inner or outer tensions. Therefore the essence of psychotherapy consists in the restoration of the sense of security for the expression of emotional needs of any given individual. This security is first re-established through the power of the analytic transference, which becomes the pattern for the development of real personal relationships of the patient with his environment. The preconditions for spontaneous emotional unfoldment to the levels of maturity which long ages of evolution have conquered for the adult of our own culture are thus established.

This view on the pre-eminent need for emotional security—always implicit in the work of all the main schools of psychopathology—is gradually receiving the explicit priority which it deserves and may be said to provide the common denominator of them all. In Freudian terms the notion of castration fear (even where that term is used in the very broad sense adopted by Glover[1]) is being gradually ousted by the concept of dread of loss of love as the determinant of the backward flow of libido or of its arrest at early stages of development. Such fixations, as we have seen, correspond clinically in many cases ultimately to defences or consolations against a threat to the secure possession of the guarantee of life of the human infant—the good, protecting, nourishing mother. Among such threats the father figure, as he appears to the child, looms large. In Adlerian terms the same phenomenon is described simply as the fear of insecurity or insignificance for which abnormal compensations are sought in worthless substitutes; in Jungian terms we find the concept of dread of advancing towards the next stage of development demanded of the individual by the banished, because feared or rejected, "unconscious." It is always this fear with its withdrawal of interest from present object-relations and tasks to the self or to earlier "safer" object relations which renders the psycho-neurotic socially ill-adapted, despite his apparent worldly

[1] GLOVER, E. "Aetiology of Drug Addiction," *Int. Jl. of Psycho-An.* vol. xiii, 1932, p. 307.

advancement in some cases. Fear, hate and suspicion of original love objects may outweigh the forces making for secure and smooth adaptation to mature object relationship. In these original guilt-laden relationships with now internalized objects the patient may spend much of his available energy and remain fixed. Our patient is cured when he has gained the conviction that he can expend his love and his power securely and without false opposition to each other, when he is no longer disturbed by the inner or outer representatives or symbols of his archaic parent figures, or by the unreasoning valuations of the frustrations and dangers which they at one time signified to his unconscious.

I believe that when we have apprehended the significance of this view of human relationships with all that it means for individual and social existence and translated it into clinical and social political practice, many present difficulties in the dynamics of civilized group life would disappear.

Whilst therefore in one sense we have produced evidence for these views only in so far as the psychoneuroses are concerned, the work of psychoanalysts and allied observers has shown that this generalization may turn out to be applicable also to a number of psychotic disorders in so far as they are not determined by gross structural disease. There is no reason to assume on psychopathological grounds that there is a hard and fast dividing line between psychoneurotic and certain psychotic reaction patterns. In the course of analytic treatment we sometimes observe a transient phase of regression towards the psychotic end of the scale, and we also see fluctuations in the firmness of the hold on reality in the same individual at various phases of his life. For example, it is not infrequent to find manic-depressive patients stabilizing themselves at the obsessive-compulsive level in the intervals between their exalted and their depressed episodes. Fairbairn has also reminded us of the similarity between hysterical dissociation and those more profound cleavages in personality structure that constitute the schizophrenic position.

In the welter of clinical detail, often of bewildering complexity, it is useful to have some sheet-anchor of generalization if direction is to be maintained towards the analytic goal. I propose the following: that every patient with a psychogenic mental illness was at some stage in his life—usually in infancy—more afraid than he could tolerate, and the faults in his psychic structure represent the

gallant attempts to allay this intolerable feeling by the various inadequate means at his disposal.

Psychopathology and the Body-mind Problem

The preceding statement of assumptions underlying the reading of our case material may be challenged as an inadequate interpretation of even those mental disorders with which this book deals. It may be asked: Is this not a proximate explanation? May not the biological inadequacy implicit in these patients' flight into regressive mental positions be taken as evidence of an innate deficiency? Is not all this talk about mental mechanisms and content of neurosis putting the cart before the horse? Should we not rather concentrate research effort on the study of constitutional factors: heredity, quantitative estimation of salts, endocrine secretions in the blood stream and so forth as affording indices of humoral dispositions; into micro-histology of nerve tissue and chromosomes, and electro-encephalography?

The achievements of those who have followed this physical approach have been noteworthy. Nothing so discovered has, however, removed the necessity for binocular vision, especially in the field of the psychoneuroses which contains the greater part of psychiatric disability. Because I feel that far too much emphasis has been laid on the ever elusive physical factor in the study of mental disorders, I venture to stress the side which deals with the meaning and content of these states, concerning which physical methods are powerless to tell us anything. There has been among the medical profession, and even within the psychiatric speciality, a resistance to the acceptance of psychological dynamics which astonishes not only the growing band of psychoanalysts and their like-minded colleagues but, more significantly, the intelligent lay public. In part—but only in part—this negative reception of the remarkable access in insight and systematization achieved by Freud and his followers can be ascribed to "shock." The impact of his methodological and conceptual revolution in psychiatry was analogous to the bombshells of Galileo's or Darwin's discoveries on the thought stereotype of their time, producing reactions on their contemporaries at which we now smile.

The British distrust the philosophical approach to Medicine. Let me then hasten to assure my reader that when I propose a very brief

digression into philosophy, I mean by this word only a general standpoint about the nature of human beings and their psychological processes. This is necessary to help us in defining our position in the body-mind controversy which still so deeply—and as yet unsmilingly—divides medicine and psychiatric practice in this country.

Prinzhorn[1] points out that we cannot, as physicians, evade taking up some attitude, consciously or unconsciously, towards certain basic positions if we wish to retain any clarity of thought and consistency in therapy. Now the majority of physicians (not to mention surgeons who have more justification) continue to take for granted as proven the mechanistic "philosophy" of medicine—that anachronism of the nineteenth century when it was still confidently expected that the laws of physics, as then understood, would explain the phenomena of life. Though Sherrington, doyen of British neurological research, has given us his conclusions on the issue between physiology and psychology, there are still many doctors who deep down believe and hope that it will be found to be true that the "brain secretes thought as the liver secretes bile." In their professional behaviour doctors with this attitude show a characteristically defensive attitude both towards patients "without organic findings" and towards those of their colleagues who are able to take an interest in such patients. Accordingly, even psychiatrists, whose usefulness in disposing of these despised cases with "no disease—all imagination" they cannot doubt, are apt to be divided into "sound" and "cranky." The "sound" psychiatrists *do* things, stick needles into people and administer shocks. They admit only grudgingly that sometimes that artificial entity of their scientific imagination "reflex physico-chemical man" can be coaxed into change of behaviour and disposition by words spoken, without drugs, electric currents or other "real" treatment. It is likely, as we said, that this curious attitude is in part a "cultural lag"—the inertia at the medical tail end of the mechanistic philosophy which once dominated the great advance in physics and chemistry, in the wake of which medicine followed. It is not easy to change the tacit underlying assumptions made about human nature. But in part we must also regard this defensive attitude—the entrenchment behind neurological mechanics—as a reaction against the very nature of the insight which psychoanalysis brought

[1] PRINZHORN, H. *Psychotherapy*. Eng. Translation, London, 1932, p. 65.

to a complacent world. This "neurological defence" would presently reduce "desire, zest, truth, love, knowledge and values"[1] to Pavlov's reflexes, and these in their turn to simple "physical laws." It is relevant to this issue that Freud's researches were first published in terms of a severely taboo-ed field—that of sexuality, and it is interesting to speculate how the progress of psychiatry might have been affected if he had early stumbled on a case with a preponderant security problem instead of dealing with a girl suffering from a frankly sexual hysteria. It was no accident that Freud's works were ordered to be publicly burned in Nazi Germany within a few days of Hitler's accession. Insight into the motivation which makes us adhere to a static, mechanical view of man's nature is intolerable to the representatives of a culture built on the rejection of tenderness and the assertion of aggressive Oedipal drives. It is much more convenient and less anxiety-provoking to feel that these repressed forces do not exist, but that if perchance they manifest in the clinic or the mental hospital they can be ascribed to structural causes.

Yet it is almost incomprehensible how such a philosophy of denial of the reality of mind and of feeling can still be the current undertone of medical theory and practice. Do not the men who hold these views surprisingly often go to Church? Do they really inject vaso-constrictor drugs into the lachrymal glands of their children when they cry? Or do they perchance permit themselves the unscientific liberty of soothing and hugging their little ones, contrary to their cherished physical theory of mental states? Why do they even bother to defend their views, if the world of the mind is but an "epiphenomenon" of a fortuitous movement of the electrical particles and therefore of no consequence?

Clearly, we are dealing with a deep irrationality—a split between a professional ex-cathedra mentality and the rest of behaviour. The clinical approach resulting from this split is bound to be illogical. Mental vagaries, even though they are found to have no demonstrable structural basis, are on this view expected to be amenable to physical influences, but if these fail they become liable to be dismissed as no longer worthy of attention, or condemned as irrational and the sufferer from them judged morally inferior—however disguised this judgment may be.

The mechanistic approach to human problems seems like the

[1] SHERRINGTON, C. S., *Man on his Nature*, London, 1940.

attempt to explain the music of a violin by the effect of the horse-hair scraping on cat's entrails. There is nothing wrong with such an attempt except that it misses all that is essential. The analogy with the neuro-physiological theory of mind and its disorders is, in my opinion, exact. Because in some instances—and they are statistically very few within the total volume of psychiatric disabilities—structural defect or disease prevents adequate mental function, it is assumed that mental abnormality must have a structural, or at least a "constitutional" basis. Eliot Slater[1] has argued in this sense in a war-time article with the help of statistics based on a series of military patients. This is a valuable and interesting paper. It is only with certain aspects of the point of view he adopts that we join issue, because they illustrate the underlying bias. On scrutiny of his figures, we find that only the clinical categories labelled psychopaths, epileptics, endogenous depressives and schizophrenics yield high and significant correlations with "abnormal mental constitution." Slater's further finding of "abnormal personality," which he cites in evidence of the constitutional theory of the neuroses is, in my view, not an argument. Of course there must be an abnormal personality structure for breakdown to occur—but this need not necessarily be based upon physical constitution. He is in fact driven to admit the ambiguity of this correlation, as when he says "the two effects, environmental and hereditary, cannot be disentangled and are necessarily bound up together." His first statement rests on a bias towards the problem of mind, in which most of the evidence can be interpreted according to the philosophical standpoint of the observer.

With Slater's general statement of his conclusions we can only agree, except for certain premature emphases.

He says that

"neurosis represents a special case of a generalized type of behaviour, and signifies a failure of adaptation. The two primary reagents are the individual constitution and the environmental set-up of the moment. The individual constitution is *in greater part* (my italics, H.V.D.) determined by hereditary factors, to a lesser degree by environmental circumstances of the past producing their effects by organic lesion and psychological and physiological conditioning. These factors, *especially the first* (my italics, H.V.D.) determine the form and the severity of the congeries of symptoms, which are the so-called neurotic states or neuroses. The momentary environment determines the time of manifestation, and to a lesser extent the severity and even the

[1] SLATER, E. "The Neurotic Constitution." *loc. cit.*

form of the symptoms (e.g. the association of military stress and anxiety). Other factors, such as physical illness or physiological upset and intellectual incapacity, can have an adjuvant effect and may also influence the form of the reaction. . . . The clinically convenient distinction as to whether an individual is subjectively or objectively ill or not appears to be only a crude quantitative measure, and of secondary biological importance."

In coming to this hypothesis, Slater marshals as his evidence the high incidence of a positive family history, neurotic traits in childhood, an "impoverished" sex-life and the already mentioned presence of an abnormal "pre-morbid" personality which in great part consists of such things as the presence of "anxious" traits in the anxiety cases and "hysterical" traits in hysterics. He further adduces the argument that the outcome of treatment and prognosis for adjustment are more determined by "what a man is by heredity" than by any "trifling alterations . . . brought about in him by psychotherapy and mental and physical rehabilitation."

We should begin by acknowledging all that is unexceptionable in Slater's statement. Here we concede the rôle of organic and toxic damage in causing some small proportion of the total mass of mental trouble. Nobody can deny that if the fiddle has lost its strings or there is no horse-hair left on the bow the quality of music produced will almost certainly be affected rather detrimentally. Such cases apart, no clinical psychiatrist can fail to be impressed by the relationship between the facts of mental abnormality in the family background of patients and their own neurotic behaviour. Again, we cannot deny the existence of some "poor specimens," psychopathic personalities or mental defectives among the people who constitute the clientele of our practice. Sometimes it is the somatic aspect which strikes us, sometimes the psychic—more frequently the total *Gestalt* of such individuals. In this respect the psychiatrist with a predominantly institutional training and experience may, however, be unduly influenced by the fact that the more heavily handicapped sample of the population is likely to arrive in mental hospitals. The factor of intellectual defect is the only one in which there is strong evidence of correlation with genetic determinants.

But even in this field we find stable, happy, constructive, non-neurotic personalities in plenty, whose response by neurotic symptoms to exceptional stress is only such as will suffice to restore them to that level of living where they can usefully compete, and hence appears psychogenically produced and biologically purposive.

When it comes to "affective constitution"—the field that concerns us chiefly here—we are on much less certain ground. Slater has to be satisfied with hypothesis and is in no stronger position than ourselves. He finds, in fact, no significant correlation between positive family history and anxiety cases, hysterics and reactive depression. It is his bias, his predilection, which makes him emphasize the place he assigns to organic damage and the primacy of constitution, and moreover constitution regarded as an unalterable, structural, static matrix, on which events act mechanically as "conditioning" forces, *à la* Pavlov.

Slater slurs over a great mass of psychoanalytic experience and insight with these few words: psychological and physiological conditioning produced by the environmental circumstances of the past. How convenient, and how revealing of that attitude which in our view represents a philosophical error based on a virtual rejection of the psychological approach to man.

Slater also mentions the failure of the psychotherapeutic approach in significantly altering personality, and adduces Curran's civilian out-patient experiences and the results of a strongly psychotherapeutically oriented Army Hospital in support. That psychotherapists of the way of thinking which I claim to represent also lacked success in the circumstances of war, is not an argument in Slater's favour, though he uses it as such. It was precisely the hurry and pressure of military psychiatry that made it necessary to abandon much of our hard-won method in favour of slap-dash superficial patchwork with diluted personnel of unequal training. This reduced the level of psychotherapy to that of an average "out-patient" department.

The argument in this chapter is not, however, primarily an apologia for the present adequacy for mass purposes of analytic therapy which is still an over-lengthy and uneconomical weapon. We are concerned, rather, with a certain viewpoint about human nature and some of its ills which the psychoanalytic method of research has ushered in and has made possible. But for the advent of this method the mechanist neuro-psychiatrists would likely have been still looking for punctate haemorrhages in the brain as the cause of anxiety states even in the Second World War.

The main body of this volume has tried to illustrate and discuss in relevant terms the kind of forces that are dismissed so airily by Slater as constituting "environmental influences of the past."

Analytical study has driven home the lesson that in the approach to what matters most to human beings scientific formalism has to be supplemented by a readiness to share with the patient the kind of emotional events and experiences which result in his current personality and behaviour. It is, indeed, largely a matter of secondary importance whether a patient feels subjectively ill or not, as anyone who has undergone the rigours of a training analysis will be able to confirm. The point of view which is distilled as the result of this penetration into the dynamics of the psyche is bound to differ greatly from the attitude of those who elect for various reasons to remain outside observers of the mere behavioural results of that drama which is enacted for the most part silently within the depths of the mind. It becomes clear that the most "normal," respectable and successful parents may also have the effect of distorting the psychic structure and function of their children. At what stage in the progression of generations does this distortion become handed on in the genes? We discover that there is a functional, dynamic relationship between people which in the causation of happiness or misery and neurosis is no less important than "heredity," whatever the latter may be. J. F. Brown, in "Psychology and the Social Order," suspects that it is a cloak for ignorance, to account for the phenomena we cannot (or will not, H.V.D.) explain.

We are also clear that there is *necessarily* a correlation between neurotic traits in childhood, abnormal personality structure, disturbed or inhibited sexuality, and the tendency to manifest neurotic symptoms, without seeing the necessity of calling upon the hypothesis of inheritance to account for it, though this may play a part. Psychopathology has taught us this correlation if it has taught us anything.

When we study the life of mankind, we are struck by the primacy of a new realm. This is the existence of emotional rapport or tension between human beings, based upon instinctual need such as the infant first has for protection and for the assertion of its individuality. Analytical research has not only illuminated the rôle of these tensions in the creation of conflict, but has also shown how these instinctual forces may influence the somatic sphere. Man may balance his tensions endo-psychically in silent inhibition, or displace them on his body in psycho-somatic disorder, or else vent them creatively or destructively on his environment. Out of his

primary family relationships and their projections into wider social space have grown those complex patterns of behaviour regulation which we call social institutions: custom, taboo, law, religion, social groupings. These culture patterns, impressed on children as frustrations and introjected into the super-ego are sufficient in themselves to account for the toll taken by neurosis and anti-social manifestations not only among those who are unfitted to adapt by genetic handicaps, but also among those whose essentially creative individualities refuse to put up with the retarding, dead-hand uniformity or conformity demanded by the cultural milieu which may be more neurotic than the deviant whom we label as abnormal.

I am satisfied that deep analytic study reveals the "influence of past environment" which in this broad and dynamic context is seen to be a far greater source of unhappiness and maladjustment than neuro-psychiatry within its restricted framework of reference can envisage. Its methods cannot touch this dimension which extends from nursery prohibitions via school and factory atmospheres to national ideologies and religious ecstasies. Nervous systems do not marry nor are given in marriage, neither do they have angry bosses or fussy mothers. These relations belong to man as a whole—and man not in isolation but as a member of many intersecting and clashing groups, in which he participates, identifies, loves, hates, introjects and projects and in which psychological space he has his being. Psychology has not only the right but the inescapable duty of formulating its own concepts, in order to study this sphere.

To the interaction between body and environment, which alone can be adequately described in terms of physiology, there is added the interaction between mind and body and mind and environment via the body which cannot be so described. The most significant and psychologically important among environmental factors for the human being are other human beings, with whom he enters into dynamic relationship from the moment of birth, if not before. An equally important factor in the environment is his own organism which reflects and responds to the human needs for expressing relationship in behaviour.

It is arguable that in living Nature the need for function determines the creation of structures serving these needs as much as the existence of structure constrains function. In the purely biological realm this has long been accepted as a determinant of organ-adaptation—for example in the case of protective colouring.

Reverting to our metaphor of the violin—horse-hair and catgut are the *vehicle* used to meet the need to make music. Coghill[1] has shown that an amphibian embryo "is perfectly integrated before it has a nervous system," and that the latter's functions emerge as partial patterns giving discreetness to local areas of behaviour, subserving rather than dominating integration. We also think of the integrated behaviour of uni-cellular organisms which lack a nervous system.

These points have been dwelt on at some length because they are of vital importance to a just appreciation of an alternative view-point to that of scientific mechanism which is here rejected as incapable of dealing with the problem of human behaviour. Mechanism leads to a logical cul-de-sac, i.e., to the conclusion of the futility of its own formulations as meaningless "epiphenomena."

To the alternative view-point the name of "Psychosomatic Unity" has been given, and Russell Brain[2] uses the term "Interactionism" for a similar concept of the relation between mind and body. It has seemed to me to be a most fruitful theory of the human being, and one which is consistent with the trends in modern scientific *Weltanschauung* as represented by such notions as Holism and Emergence which have grown out of the recognition that science is concerned with "living events" and not "dead facts." It is perhaps no accident that the ancient doctrines of Advaita of Indian philosophy and of the Tao in Chinese thought foreshadowed these contemporary formulations.

The core of this way of regarding man the microcosm and the world in general is the idea of an inseparable union of opposites which in their interplay create an emergent whole. Neither can be thought of as having reality without the other, their conjunction alone producing the phenomena which we call life. Electric light is the resultant of energy (current) acting upon resistance (filament). Such a hypothesis, "unsound" as it may seem to some, has the advantage of closing no doors to any sociological, religious or metaphysical theories, except to mechanism, and does no violence to any known facts of biology, pathology or human experience. Basic psycho-somatic research is needed to test the "how" of interactionism, but the dynamic rôle of affective states in the production of bodily changes has been shown beyond doubt. Even in the only

[1] COGHILL, G. E., "Anatomy and the Problem of Behaviour," 1929.

[2] BRAIN, RUSSELL, "Brain and Mind," *Lancet*, 1941, p. 745 *et seq.*

recently "organic" field, the correlation between repressed emotion and such conditions as peptic ulcer, thyrotoxicosis, essential hypertension and a host of other diseases—some irreversible in later stages—has been demonstrated and accepted. The future of medicine seems to lie along this road, where signs are pointing to integration of body and mind as a pre-condition even of structural and local immunity, in short of health, which originally meant wholeness.

In the field of neurosis the evidence of psychogenesis is overwhelming, when we do not merely consider the effects of superficial therapy of symptoms (to which Slater's and most war-time treatment appears to have been limited), but the deep and lasting changes in the structure and dynamics of the personality brought about by analytical therapy. Radical shifts of libido distribution and so on occur under our eyes. The change-over from homosexual to heterosexual object choice, with all that this means to a man, is an obvious example. Even our catastrophes have their testimony to add to the evidence of the dynamic nature of the relationship between therapist and patient. Such alterations in the personality and its behaviour can be, and are, also brought about by other powerful experiences of human relationships such as falling in love, religious conversion, impact of an ideological group or other change in the psychological "magnetic" field around the individual. Successful analysis of an individual may alter the character of all his relationships with the field. The converse observation—of the alteration of individual behaviour in response to controlled change of his field—is most convincingly illustrated by child guidance techniques, where school or parent may be the factors altered in order to treat the child.

For these reasons we can and must apply to our patients criteria of diagnosis and therapeutic hopefulness which are cast not in any rigid descriptive or genetic terms, but in terms of the total "Gestalt" of the patient as a dynamic entity in a field of psychological forces with which he interacts or has interacted. The correlations between abnormal behaviour patterns of the primary human environment (the family group) and his own disorder we label—conveniently but in dangerous simplification—heredity. The resultant deviations from a postulated cultural norm of behaviour impressed by this interaction on the flow and structure of his intrapsychic processes we call his neurosis, of which certain pains,

stresses and externalizations constitute the symptoms and signs. Naturally, the more profoundly distorted and stunted the personality structure has become by the impacts of a morbid childhood environment, socio-economic stress and physical handicaps, the more cautious we shall be in assessing the prospects of any help we may be able to render in the given case.

But even in the face of much that seems hopeless, we owe a duty as therapists to the severely maladjusted. We are not going to be deterred by learned pessimists from trying new ways of resolution of, and psycho-dynamic influence on, the problems in human relationship with which we are confronted. Proper selection of cases for the wise and economic use of our limited trained psychotherapeutic man-power is one thing, but abdication before the cliché of " constitutional psychopathy " is another. We owe this both to our patients as individuals and to research into psychopathology which means ultimately social measures of prevention and a re-structuring of group life at all levels.

Psychopathology and more especially its applied art, psychotherapy, will probably never become exact sciences in the mathematical sense. Qualitative insight precedes normative and statistical treatment of problems. The clamour for exactitude and figures in this branch of research, during a time when concepts are still growing and changing and the edifice is only partly built, is premature. It is often a form of flight from the confrontation of the scientist with the living, inescapable problems of the therapeutic relationship. In this branch of medicine with which we are concerned, a new form of clinical observation has come to stay, which does not shield itself from contact with its subject matter by more and more instruments, but which is endeavouring to sharpen and deepen understanding and tolerance as its tools for handling the unseen forces of human behaviour.

As psychopathologists we can take pride that, thanks to the pioneer work of Freud in attacking the " untouchable," we have made progress in restoring the human element to medicine, whence it was ousted by the omnipotence phantasies and Olympian detachment conjured up by microscope and test tube in the last century. The study of neurotic states by analytic techniques has liberated energies sufficient to revolutionize many vast fields of human endeavour and to raise psychiatry itself to its present flourishing, growing state.

The time is not now so far distant when the corpus of Medicine will once again achieve its own " psycho-somatic " unity. All round medicine the social sciences are converging towards an integration under the primacy of psycho-dynamic concepts. They have grasped the significance of psychopathology in the cultural and social stresses of the age. Unless medicine catches up with this movement it will find itself in a backwater, grappling with problems that bear but little relationship to the urgent needs of our time.

I can launch this volume in the knowledge that it deals with ills which represent no less than a third of the total sickness disability in our country, and that the studies to which it is a modest contribution are the spearhead of attack on the crisis in our civilization.

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