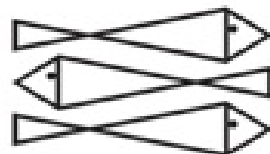


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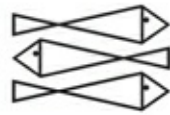
WILHELM REICH
TRANSLATED BY
PHILIP SCHMITZ



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VOLUME ONE

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Also by Wilhelm Reich

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Love, work, and knowledge are the wellsprings of our life. They should also govern it.

WILHELM REICH



Foreword

Publication of Reich's early writings at this time is not merely to provide the evidence that established him as a pioneer in psychoanalysis but primarily to enable the serious reader to become familiar with studies which form the essential links in the evolution of his work from psychoanalysis to orgone biophysics. Confusion about the logic of this development has contributed to the skepticism that has greeted his discoveries and to the hostility which surrounded his person and led to his untimely and tragic death. This confusion may in part be attributed to the inaccessibility of these early writings. Some of them were never published; others were banned in Nazi Germany; while still others were dispersed throughout Europe in the troubled circumstances preceding World War II. Moreover, prior to his immigration to the United States in 1939, Reich had already separated himself from the psychoanalytic movement and had committed himself to the biophysical investigations which led to the discovery of orgone energy. He was therefore more interested in the publication of his later work. Now, from the vantage point of this later work, we have the opportunity to examine the early writings in a manner that will enable us to discern a direction previously overlooked.

In 1920, when Reich became a member of the Vienna Psychoanalytic Society, this was the situation in psychoanalysis: as long as Freud entertained the idea of the metabolism of a sexual energy (as ambiguous as it was) in connection with the diagnosis, treatment, and prognosis of neurosis, he remained in touch with a hoped-for physiological explanation of psychological phenomena. However, when he concluded that he could not apply the idea satisfactorily to those neuroses which appeared to have an exclusive psychic content—the psychoneuroses—as opposed to the “actual” neuroses, which he considered to have a somatic origin, and when he was unable to solve the question of how sexual excitation is transformed into anxiety, or how a psychic disturbance is converted into a bodily disturbance, his enthusiasm for an organic theory of neurosis evaporated and he turned instead to psychology. Unfortunately, the changes he introduced did not improve the prospects for effective therapy. In fact, the metapsychological modifications he propounded, such as the sublimation of genitality, cultural adjustment, and the death instinct, seemed to reflect his disenchantment with the possibility of cure and the need to reassure those who were apprehensive that psychoanalysis would encourage antisocial “acting-out,” thus constituting a threat to culture. Although it has been stated that Freud never entirely discarded prior concepts, thereby making it possible to argue about what he really did say and often to select what one wanted from his revisions, it is clear that his theory of neurosis became a psychological one and that “libido,” deprived of its original sexual definition, became nothing more than an innocuous metaphor now on the verge of extinction.

When, in view of the extreme prevalence of neurosis and the impracticality of mass treatment, the question of its prophylaxis inescapably arose, Freud appeared reluctant to place the burden of responsibility on society. Conceding no possibility of a fundamental change in human psychic

structure, which he decided was inherently evil, and resigning himself to the inevitability of human destructiveness, he pessimistically concluded that social existence demanded instinctual repression, even though he simultaneously affirmed that repression is the source of neurosis. In acquiescing to the need for adjustment to what he knew to be a sick society, he unfortunately failed to make a distinction between an authoritarian society and societies based on natural self-regulation, as described for example by the anthropologist Malinowski. His biologically deterministic view of society, e.g., the idea of a universal Oedipus complex, eliminated any hope of preventing neurosis on a mass basis.

Just as Freud had essentially abandoned any expectation of finding a somatic basis for the psychoneuroses and was inclined more and more to “psychologize biology,” the youthful Reich appeared on the psychoanalytic scene with his enthusiasm for the idea of a “sexual energy.” In 1923 he presented a paper to the Vienna Psychoanalytic Society in which he took issue with the neglect of the genital function, specifically in the treatment of psychoneurosis. This signaled the beginning of his sex-economic approach to neurosis and psychosomatic disease. Thereafter, we are assured of an unrelenting effort to comprehend genitality as a biological function apart from the function of procreation and to establish its relevance in health and disease. In 1924, at the psychoanalytic convention in Salzburg, he categorically stated that there could be no neurosis without a disturbance of the genital function, thus taking exception to Freud’s broad sexual theory in which genital dysfunction was viewed as one isolated symptom among many and not as the primary etiological factor. Years of investigation followed in an effort to establish the exact nature of the genital function. The initial result, still within the framework of psychoanalysis, was the unifying economic concept of orgasmic potency. This concept with which Reich undertook to clarify the libido theory of neurosis was not understood by most psychoanalysts, who stubbornly viewed genitality as an exclusively local phenomenon and entertained the erroneous notion of the “mutual independence of the erogenous zones.” Similarly, his technique of character analysis, although considered to be his most important contribution to psychoanalysis, was never understood in the context of its relationship to his orgasm theory.

While Reich continued to adhere to the libido theory and to emphasize the “quantitative factor in psychic life,” Freud was moving away from it and emphasizing his new ego psychology. The divergence this created between them proved to be a mixed blessing for Reich. As he later pointed out, it was not very comfortable to find himself in disagreement with the master, who sarcastically referred to his student’s orgasm theory as a “hobbyhorse” and a simplistic universal “antidote to every neurosis.” At the same time, the questions that Freud’s revisions raised helped Reich refine his own position and defend Freud’s original thesis regarding sexuality. Questions of culture, prophylaxis of the neurosis, the negative therapeutic reaction, which Freud was unable to solve in a practical way, found clarification in Reich’s theory based on the principle of a biological energy—a principle which he hoped would eventually be demonstrable and measurable.

By the time he was presented with substantial evidence for viewing genitality as the central issue in neurosis, Freud had already extended himself too far into psychology. He received Reich’s *Die*

Funktion des Orgasmus (1927), which had been dedicated to him, almost indifferently. It amounted to an offhand rejection, the sort of response often encountered today when a sincere attempt is made to present the facts that have been accumulated confirming Reich's bioenergetic theory.

As already noted, psychoanalysis raised many questions which Freud tried to solve by resorting to conjecture—his metapsychology. With his formidable background of knowledge and his mental legerity, he may have been entitled to indulge himself in such a manner, particularly when the complications that arose from advocacy of the libido theory threatened the hard-won acceptance of his work. However, the modifications he introduced, even though he admittedly viewed some of them with skepticism, created contradictions which, because of the authority he commanded, have not been resolved within psychoanalysis to this day. Reich, on the other hand, was rarely inclined to engage in the luxury of speculation; when he did so, he frankly admitted it. In general, he hewed carefully to clinical observation and experimental investigation. Thus, it should be possible to examine the evidence of his discovery of biological energy, to attempt to duplicate what he observed and investigated, and to determine whether, in fact, it is as he found it. If responsible scientific inquiry does not confirm his claims, they can be rejected. It should not be necessary to attack his findings and conclusions with uninformed and arbitrary opinions. One may be for or against Freud's metapsychological revisions, which he did not necessarily offer as final solutions; but one cannot be for or against Reich's experimental findings as a matter of personal prejudice. One need not resort to pejorative condemnation if scientific refutation is possible. Reich sought to rescue the physiological libido theory from what has been referred to as the "quagmire of the metaphysical tradition" and to place it on a firm scientific foundation through biological experimentation. His results are available for conscientious scrutiny by biologist, physicist, and clinician alike.

Viewing his work retrospectively, as we are now in a position to do, it is easy to see the logic of its development from psychoanalysis to sex-economy and, finally, to orgone biophysics. Its continuity is so apparent that any tendency to fragment it or to ignore the relatedness of all his findings indicates a failure to comprehend its essence—the energy principle which unites all aspects of his work. In 1952, while preparing a bibliography on orgonomy, Reich referred to this relatedness and its basis when he wrote that the subject of his work, despite its ramifications, constitutes a "functional and logical whole" and that in comparing the "first endeavor toward a biophysical formulation of instinctual processes in *Zur Trieb-Energetik** (1923) with the latest orgonomic work in 1952, [one] will easily discover the red thread which, in a work period of a third of a century, runs through all the clinical, experimental, and theoretical labors: *The theme of the bioenergetic function of excitability and motility of living substance*"

To grasp this "red thread," and to follow the process by which Reich arrived at his discovery of orgone energy, is absolutely necessary to an appreciation of its significance. Reich never failed to emphasize this fact. He wanted to establish that his work was not "pure invention," "that every part of it owes its existence to the peculiar course of scientific logic," and that he was nothing more than an "executive organ of this logic." An impartial examination of the step-by-step progression of his clinical and experimental investigations would soon convince one that the findings were not mere

accidents but the result of a consistent thought process at first employed intuitively and later recognized as particular to the thinking of an individual who is unencumbered by the mechanical and mystical restrictions characteristic of the average human being. As a corollary, we may also assume that the capacity to comprehend Reich's theoretical conclusions and the often intense emotional reactions to them must depend to some extent on the biological structure of the inquiring individual. How to contend with this "subjective" factor in any attempt to arrive at an objective evaluation of his discoveries is a problem that will not soon be solved.

Even before coming to Freud and psychoanalysis, Reich had been preoccupied with thoughts about the nature of the force that governs life. To be thus absorbed is not an unusual phenomenon; at one time or another most self-conscious beings have reflected on this question. In the absence of a verifiable answer, or because of the customary reaction of indifference to the question, it is almost always discarded, or else a mysticized answer is provided. For Reich, however, there was an enlivening of interest that gradually replaced his vague, desultory ruminations. He found metaphysical constructs evasive and unconvincing, but the idea that a life force could be demonstrated and have practical application did not seem implausible to him.

The failure to realize that, despite Reich's identification with psychoanalysis, his paramount interest always lay in the search for this life force has caused many to look upon his advancement into sociology, biology, and physics as immodest and evidence of an inability to recognize his own limitations. They would have preferred that he confine himself to psychology and devote himself to the detailed investigation of psychological minutiae which turn out to be ivory-tower evasions of the real problems of life. Had they understood his purpose correctly, they would have anticipated that the search for manifestations of a basic life principle would of necessity lead to inquiries into seemingly diverse realms of natural science.

Some may have actually sensed his intentions, but in their skepticism they categorically rejected everything he said or did. Others, appreciating the value of one or another of his findings pertinent to a particular area of interest, appropriated it for their own purposes without making an effort to comprehend its relationship to the entire scope of his investigations. Thus, the psychoanalysts took over his characterology and awkwardly incorporated it into the body of psychoanalytic practice; the Marxists appropriated his sociology, referring to it as his "Marxist period" and retaining it in its unrevised or, as they prefer to view it, "undiluted" form; the so-called neo-Reichians and non-verbal technicians, his bioenergetics, while immodestly proclaiming their supersedence of Reich without any understanding of the basic energy theory but with naïve notions about improvements in the technique of therapy. What is not understood in all this usurpation of his work is that its fragmentation vitiates its essence, renders it sterile, and leaves behind only unrelated remnants to be exploited. This inability to appreciate the "red thread" that runs through all Reich's work is also responsible for the inconsistencies often expressed by critics who admire the work for a considerable distance and even recognize its direction, only to end by making a mockery of the discovery of orgone energy, despite the fact that this discovery so clearly and incontrovertibly unifies everything that preceded it.

In Reich's investigations into separate realms of science he was searching for a common principle. It was not a matter of psychology here, or sociology or biology there, without trying to reconcile them in such a principle. Discontinuity, on the other hand, is characteristic of the mechanistic way of thinking. It ignores functional interconnections; it compartmentalizes, looks for differences, is not interested in clarifying relationships on the basis of a common principle. Mechanistic thinking may examine every minute detail of a problem but be unable to draw a conclusion that is in accord with all the superfluous information accumulated. It reaches a dead end; it can go no further. At that point it could simply be admitted that a limit of understanding has been reached. But more often the inability to go any further evokes distress which is avoided or relieved by a retreat into mysticism—"the mysticism of divisive observation" (Reich); or, as with the critics, by resorting to innuendo, ridicule, and defamation of the one who finds it possible to proceed unhampered by the organismic restrictions that characterize unyielding, armored human beings.

Reich's discovery of the life energy has never been factually contradicted. Any criticism that has been expressed has been flagrantly emotional; it has never had the quality of a serious, scientific refutation. Indeed, it is monotonous to repeat over and over again what Reich did say, only to find that his critics consistently ignore these efforts and choose merely to echo what others similarly uninformed have said; or to have to contend with tongue-in-cheek representations of the facts, designed to invite disbelief. If Reich had only philosophized about an *élan vital*, or speculated about a "psychic energy," there would be no occasion for a factual refutation. Rejection or even ridicule might then conceivably, if not comfortably, be tolerated. But when the discovery of a ubiquitous energy is made on the basis of observation and reproducible experimentation, then nothing but a factual refutation is permissible.

It is now eighteen years since Reich's death, but it can be stated with confidence that the hostile reactions to his work have not disposed of it; they have only delayed its rational evaluation. A new danger has been developing, however, which can only encourage those who seek to fragment his work or, without sober inquiry, to reject his discovery as a "biological myth." With the passing of time, the negative reactions are being displaced by an enthusiasm that invites distrust because of its unobjective and mystical quality. It represents the same sort of approval that prompted Freud to warn that "the world is accepting me in order to destroy psychoanalysis." It is readily discernible, for example, in the sudden enthusiasm for "Reichian therapy," a euphemistic term that raises grave doubts about the genuineness of the therapy being employed or, in any case, represents an exploitation of the least important aspect of the science of orgonomy.

Reich felt less distress over the inevitable, mindless rejection of his discovery than over "truth peddling," which he defined as "fake admiration that takes over a discovery and through its language and terminology so infuses it with ... emptiness that confusion and contempt spread out in all directions." Evidence of this type of response has appeared increasingly in articles, journals, books, etc. Immodest claims of priority are also occurring, and the assumption of a mantle of authority by unqualified persons is an additional, irresponsible consequence of the pseudo-scientific interest in his

work by those who nibble away at it for their own selfish gain.

Our society being as corrupt as it is, this unfortunate state of affairs is inevitable. However, some comfort may be gained from the expectation that these uncritical responses, whether positive or negative, are transitory and will eventually give way to an objective evaluation. It is to be hoped that such an evaluation will not continue to be restricted, as it has been, to the clinical and sociological precursors of the discovery of the life energy which, although they meet all the criteria of scrupulous scientific inquiry and deserve thoughtful consideration, may leave room for differences of opinion, but will be directed principally toward the actual *physical* evidence of the discovery. To assist in encouraging this direction is the primary purpose of publishing Reich's early writings, for they are not merely of incidental historical value, they are an integral part of the development that led to the discovery of orgone energy.

CHESTER M. RAPHAEL, M.D.

Forest Hills, N.Y.

1975

Papers first presented between 1920 and 1938 but subsequently incorporated by Reich in works now published—e.g., *Character Analysis*—will not be included in this or ensuing volumes of Reich's early writings.

MARY HIGGINS, *Trustee*
The Wilhelm Reich Infant Trust Fund
New York, 1975

*Libidinal Conflicts and Delusions in Ibsen's Peer Gynt**

*I teach you the Superman ...
What is the ape to man?
A laughing-stock, a thing of shame.
And just the same shall man be
to the Superman:
a laughing-stock, a thing of shame.
NIETZSCHE, Thus Spake Zarathustra*

Two facts must be mentioned in support of my attempt to subject Ibsen's verse drama *Peer Gynt* to psychoanalytic study. The first is the profound and singular nature of the work. The second, by no means of lesser importance, is the fact that *Peer Gynt* belongs to that group of poetic writings which, because of their obscure symbolism and the impenetrability of meaning and coherence in some of their thought sequences, have generated the most diverse interpretations and explanations. I feel that this last fact in particular constitutes a valid criterion of the depth of the work in question, and hence I dare to hope that my efforts are being put forth in the right direction, and that using the psychoanalytic method of inquiry for an in-depth examination will prove rewarding.

My interest will be engaged mainly by the notable congruence between *Peer Gynt* and a paranoid psychosis. This will be demonstrated in the course of my examination based on etiology, symptomatology, and tendencies toward restitution.

The long-standing inquiry of psychologists concerning the relationship between poetic and psychotic phenomena has been more than adequately answered in the psychoanalytic studies of Freud, Rank, Sachs, Jones, Sadger, and others. If further problems did arise, they were only the natural consequences of a research method that operates below the conscious level. If our comprehension of psychosis and neurosis has enhanced our grasp of poetic fantasy, we may now hope that the latter, in turn, will provide new insight into the nature of clinical psychoses. It is self-evident that science, with its rigid concern for cognition, cannot show consideration for those voices which, in defense of art, have been raised against the so-called "destructive" influence of science. It may indeed be difficult to make a decision in regard to this. Probably both sides are right. To the comfort of the defenders of art, it may be said, with Freud, that the fact that the poet's work has its roots in common human ground can never be a determining factor in literary evaluation.

Although the psychological nature of *Peer Gynt* is the prime concern of this undertaking. I shall also be able to obtain, as a secondary advantage, some insight into the intrinsic, continuous structure of the drama. It is precisely this continuity of structure that was denied by certain critics who made Ibsen and his works, especially *Peer Gynt*,¹ the subject of anagogic interpretation. (I shall return to this later.) The unexpected transition from Act III to Act IV (on the Moroccan coast), the experience in the Tronde Mountains with the three Saeter Girls and in the Kingdom of the Old Man of the Dovre,

the peculiarity of Peer Gynt's return, among other things, have all given rise to extremely divergent assumptions and made the work appear to be a series of short sketches of Peer Gynt's life.

Lack of space, however, as well as consideration that anagogic criticism is often subjective, forces me to forgo a comprehensive report on these interpretations.

I am inclined to divide the interpreters of *Peer Gynt* into two main groups. The first includes those who would like to see in Peer Gynt a personification of the Norwegian per se. The second, those who attribute to Ibsen the intention of presenting a certain type of human being, or even a being who represents humanity itself. In the latter group we would like to point to Eckart,² who adapted *Peer Gynt* for the German stage, and Weininger, who, by way of unconscious identification, devoted a great deal of attention to the drama, as expressed in his beautiful and often profound essay "Henryk Ibsen and His Work *Peer Gynt* (Concerning the Ultimate Things)." The first group, however, is the larger of the two. It includes Brandes, Schlenther, Ella Kretschmer, and Jaeger, all of whom engaged in work on *Peer Gynt*, either alone or in connection with other dramas.

All of them agree that Peer Gynt is a dreamer who "was not always sure whether his dreams were reality or life itself a dream" (Schlenther). He was diverted from his search for identity, becoming first an idler and later a fortune seeker and (according to Jaeger) an unscrupulous egotist who sought his values outside himself, not balking at dealing in souls or even smuggling gods to reach his spurious ideal. Brandes and Ella Kretschmer both recognize the importance of his childhood influences (i.e., the debauchery of his father as well as the blind partiality of his mother) upon his adult personality. Ella Kretschmer³ states: "... In order to understand him [Peer Gynt] we must keep her [Aase's] fate in mind. She had seen better days and had been highly regarded and honored wherever she went, due to her lineage and wealth. But her deceased husband had led a dissipated life and become a drunkard. Thus it was no wonder that he lost his respect along with his fortune. When he died Aase and her son were left behind in the most dire circumstances. To make life more bearable for herself and her child she withdrew into a world of fantasy and encouraged her son to do likewise, giving no thought to how detrimental these endless daydreams are to an undeveloped youth. For this reason he always finds himself in a fictitious world. He comes to view this dream world as reality, and by relating as true the fairy tales he himself has fabricated, he is trained to become an inveterate liar. This then is the product of the principles by which his mother raised him." Her own upbringing and previous wealth had supposedly made her defenseless against the later heavy blows of fate, and the consequences that arose from this are said to have determined Peer Gynt's future. We can see what importance Kretschmer places on the fact that Aase, to put it bluntly, sought a substitute for her lost husband in the satisfaction that all kinds of fantasies provided, and allowed Peer to share in them. This explanation, however, remains completely superficial and does not reveal any of the deeper motives and tendencies of such modes of action. Eckart comes closer to understanding Aase's behavior (and in this he is in agreement with Weininger's concept of "mother love") when he states: "Mother Aase doesn't merely love Peer Gynt, she is in love with him." The correctness of this opinion (which could be inferred only indirectly in the final version of *Peer Gynt*) is completely supported by Ibsen in the unused first version of the drama.⁴

AASE: Your father was known as a man of honour,
The Lord was merciful and took him up
E'er you could disgrace his very blood,
You rogue! [*She cries*] Ne'er do you follow me
Obediently by the hand,
Like my Niels, your elder brother!
Alas, he heeded the call to arms
To perish in the king's employ.
Ah, Peer, you are the only one left,
You are tall and strong and should improve
Your poor old mother's wretched fate
By overseeing house and grounds.
Be my support, my stay, in place
Of husband and son now deep in their graves.

Schlenther also emphasizes the blind love of his (Peer Gynt's) mother and draws special attention to her attitude toward bride-rape, for which she admires Peer. "... His feelings for his mother, even if not deep-rooted, prove that his heart was not barren from the very beginning, and prepare us for the rapid flowering of his love for Solveig as well as for its premature decline..." His behavior toward her is viewed as the negation of all that is good within him. (We shall have ample opportunity to see that this deduction is incorrect.)

Peer's infidelity toward Solveig is said to climax in the wanton scene with the three Saeter Girls and his courting of the daughter of the Old Man of the Dovre in his kingdom. Eckart sees the goblins as personifications of Peer's passions and desires, which remain with him even when Solveig visits him in his seclusion. "Of course we never interpret the Troll scenes completely, for creatures of fantasy attain a life of their own when personified—they no longer simply represent, they *are*. It can probably be said of Peer's struggle with the Great Boyg, however, that it signifies his struggle with his own personality, with his own intransigent nature, which acts as a constraining band around his better self, not allowing it to break through to freedom and clarity."

In contrast to this, there is Weininger's interpretation of the Great Boyg as "the salvation negating principle" and as a personification of the "lie." "In this respect *Peer Gynt* is in conformity with the very concept of tragedy itself, and symbolizes more completely than any other drama in world literature the searching and striving as well as the erring and failing individuality which has reached the consciousness of its guilt and is struggling toward deliverance." Only Weininger's narcissistic constellation has managed, in unconscious identification, to approach the underlying impulse of this Ibsen drama, but still without achieving ultimate insight. Weininger arrives at his interpretation of the Great Boyg via the father-son conflict and his theory of "philanthropic" and "misanthropic" character types. He defines a philanthropic type as a person who sees his goal in the "affirmation" of life, the strong and persistent eroticist, of which fathers and teachers are the extreme examples. "He who feels himself to be a son can only hate himself; in other words, a son was *driven* to become a son, to allow himself to be engendered and to emerge as an empirically limited subordinate. He attributes the

choice of dependent status to himself and therefore hates himself. He feels he will be forever unfree, as though he had given up his own free will and sought a crutch in the act of being born. In this manner the self-loving and self-hating personality types develop father and son concepts.”⁵

I suspect that he is speaking of the eternal struggle between these two types when he says: “The Great Boyg is the entire strength of the empirical self, which continually wrestles against the conceptual self...” and then proceeds to reach the conclusions already mentioned. Peer supposedly represents all those people “for whom the other person always remains a standard—all the Jehovah worshippers in humanity (Jehovah being simply a colossal personification of the ‘other’ in that he exerts influence over the thoughts and actions of the individual).” If we recall Weininger’s misogyny, his attitude toward the Jews, and many other conspicuous peculiarities of his work, we shall understand his interest in *Peer Gynt* more readily, and having completed our study of the drama, we shall have reason to believe that the most successful steps toward understanding Weininger’s kind of misogyny are to be taken from this point of departure.

Although Weininger’s study seems to be most important and well worth a detailed review, I shall refrain, for my work would remain half completed if I were to risk becoming enmeshed in the tempting prospects that would undoubtedly present themselves, thus forgetting the task before me.

Perhaps this would also be a good time to address myself to the external circumstances surrounding the creation of *Peer Gynt*. But I shall postpone this also for a more opportune time and devote myself solely to the psychoanalytic study.

THE BUCK FANTASY

Before I begin, it must be emphasized that I can claim validity for my views only to the extent that they can be shown to pertain to the essentials of *Peer Gynt*’s libidinal conflicts by disclosing cohesive relationships in the context of the drama, with the assistance of experiences based on dreams, fantasies, neuroses, and psychoses. Furthermore, I am aware of my limitations due to the fact that I must face the problem of working with third-hand material. I do not have the original before me, but rather its translation by Christian Morgenstern, and there is reason to suspect that a good deal of it has taken on his subjective coloring. This will probably not prove detrimental to our understanding of the framework of the drama as a whole, but it will no doubt obscure its finer structure, from which justifiable conclusions about the poet might be drawn based on facts found in Ibsen’s original work.

For this reason I shall, at least for the time being, make *Peer Gynt* himself the object of my study, without consideration of whatever he may represent.

In order to make as clear a statement as possible, it will be necessary to consider not only the course of the play as it is performed but also to view it from above, so to speak, in order to see the work in its entirety and to select the material required for our study from wherever practicable.

We shall start with an event in Act I which is remarkable not only by virtue of its strange character but also because it introduces the plot per se and is an event which lends to the entire play a special texture due to the threads which weave throughout it. We refer to the Buck Fantasy.

Peer Gynt has spent a number of days away from home in solitude, apparently passing his time in daydreaming. Still under its effects, he relates one of the daydreams to his mother: Hunting a magnificent buck, he fells it with a single shot. “Straddling aloft” its back, he grasps his knife and is about to plunge it in. But the buck, with Peer on his back, breaks into a breathtaking gallop along the “Gjendin Ridge,” “sheer and sharp as the blade of a scythe” [p. 25],* until both plunge off the steep cliff toward the lake below.⁶ The end of the episode becomes increasingly unclear; the landing and the rescue are not mentioned at all. Analysts are thoroughly familiar with fantasies and dreams of similar content, although perhaps without the poetic embellishments. I therefore ask your indulgence for the following description of internal relationships, which are interconnected like links of a chain and necessitate an interruption of our study.

What I have in mind are those dreams of flying in which an increase of general tension (gasping for breath due to haste, etc.) ends in sudden release. I surmise they represent an unsatisfied coitus with typical depiction of fore- and end pleasure. In *Peer Gynt* the beginning of the fantasy containing the idea of “straddling aloft” and the symbolic significance of the knife lend our hypothesis an even greater credibility. Even if we view this fantasy as the strongly censored fulfillment of an unconscious desire, there still remain details which need clarification. In doing so I hope to gain access to the unconscious drives leading to fantasy formation. We shall come to see that they are the determining factors in the inevitability and specific character of Peer Gynt’s fate.

First our attention is arrested by the fact of the buck

leaping to his feet at once!
As he rose, the sudden lurching
jerked my sheath-knife out of my hand;
but his antlers held my legs pinned,
tightly gripped against his loins,
holding me as in a vice.
Then, with a sudden leap, he bounded ...
[p. 24]

How is this to be taken? The fantasized object becomes active, determining the course of what follows, and Peer Gynt himself, with his legs firmly pinioned, is delivered helpless to the object of his daydream. We must marvel at the fact that Peer, otherwise so full of his own audacity and prowess, appears atypical in being the “loser” or passive party in this fantasy, whereas daydreamers usually live out their heroic attitudes in their daydreams. This peculiar aspect of the fantasy has its unconscious basis, which can only be grasped when approached from a different angle.

If we direct our attention to the figure of Peer’s mother, Aase, to whom the story is being related, we are struck by several interesting aspects of her behavior. At first she receives Peer with abuse and accusations. It is her remark “That’s a lie, Peer” which is the opening line of the play. But soon her cynicism and rage turn into a terrifying vicarious experience of a situation in which her only child is exposed to the utmost danger. Her remark “Peer! For God’s sake tell me quickly!” [p. 26] expresses this and more; she wants to savor her terror to the very end. Soon, however, she reflects more

rationally, returns from Peer's world of fantasy, and remembers that she had heard the same story when his father "was still a squire."

We know, as stated earlier, that we have every reason to suspect that Aase is in love with her son and has taken him as a substitute for her lost (and, after all, unfaithful) husband, as well as for her deceased son (first version). But let us listen to what else she has to say. Aase scolds Peer for spending days on end idly dreaming and accomplishing nothing. While he was "confined" to his buck, Ingrid was promised to Mads Moen and the wedding was to take place the next day. Peer had let the final opportunity to improve his and Aase's fate pass by. Peer wants to rush off at once to make up for his neglect: "They will clear the field for me." But, as he says this, he does something which at first defies our understanding: He lifts Aase onto his back, "I'm carrying you over to the wedding-feast"—and then—"Now we'll play at Peer and reindeer"—(*prancing about*)—"I'm the reindeer, you be Peer!" [p. 34]. He sets her down, despite her rage and resistance, on the roof of the mill. Peer himself gives us the solution. The object of his desires is his mother, with whom he later identifies. He exchanges roles with her, and now she is at his mercy, just as in his fantasy he was the plaything of the buck (in other words, his mother).⁷ "I'm carrying you over to the wedding-feast" is the confirmation of our explanation.

The infantile incompetence expressed so clearly in the fantasy, as well as the added identification with the mother, allow us to conclude that Peer's attitude toward his father was passive. This passivity is in contradistinction to his aspiration to become an emperor on horseback, which dominates his later dream life.

The cause of the hypostatization of the Buck Fantasy was his mother's reproach that he had not won Ingrid despite the fact that she was well disposed toward him. Now we understand in part the motives which hindered Peer Gynt (i.e., his incestuous fixation), and also the manner in which his unconscious interpreted the accusation, as if it was directed to Aase herself.

But this incident is of even greater importance in the light of what is to follow. On the one hand, Peer Gynt's narcissistic libido has been stimulated by the reproach (*vide* Peer's indignation on hearing the news of Ingrid's wedding: "What? The man the girls all laugh at? [Mads Moen] How can..." [p. 33]). On the other hand, the news that Ingrid now belongs to someone else adds a new dimension to Peer's love. Freud saw this as being characteristic of the choice of a love object in many men: the woman whom one loves must belong to someone else. Peer rejected Ingrid as long as she was free, in spite of her love for him. Now that she is to belong to someone else, she becomes the object of his libido, which up until this time was fixed solely, as we have seen, on the object of his incestuous fantasies.

Here we meet with the first transformation in Peer's libido. This transmitting of libido toward an object, however, is erratic. Its fixation on the fantasized (incestuous) object is still strong enough to make this a transitory phase, as we shall see, for as long as the satisfaction of narcissistic libido demands.

On the road to Hægstad, Peer is already torn between his narcissism and his infantile inferiority. "That's Hægstad farm. I'll soon be down there." Shortly thereafter: "Hm, I'd do better to go home

again” [p. 38]. His return to realistic thinking is strongly jolted as a passing couple speaks of his father as a drunkard, calls his mother insane, and refers to him as a simpleton (perhaps this is a projection of his own feelings of inferiority). His libido, which had just begun to venture forth, now regresses to a narcissistic level in order to revel in fantasies once again:

PEER GYNT: Oh well, let them gossip—it doesn’t hurt *me!* ...

That’s a funny shaped cloud—why it’s just like a horse!

(Staring into the sky)

There’s a man on its back—and a saddle—and bridle.

Behind it there rides an old witch on her broomstick ...

it’s mother! She’s shouting and screaming “You beast!” ...

(Gradually closing his eyes)

Aha, now she’s frightened!

Peer Gynt rides ahead with a whole host behind him,

four gold shoes on his horse, silver crests on his harness....

... but never a one sits so well on his charger,

and none of them sparkles like him in the sun....

Womenfolk curtsy, for everyone knows that

it’s Emperor Peer with his thousand retainers.

[pp. 39–40]

For the moment I do not wish to go into the significance of this fantasy, but one should note that the content of his subsequent delusion (emperor in Cairo) emerges here for the first time.

The ridicule of the smith tears him away from his fantasies and brings about his decision to carry out his plan, even if not entirely without a final struggle.

I wish that I’d had a butcher’s training,

I’d cut the sneering out of their throats!

(Suddenly looking around)

Who’s that? Was there somebody laughing behind me?

I was certain I heard ... No, there’s nobody there.

I’ll go home to mother.

[p. 41]

Weininger considers Peer’s perception of the whistling and laughing to be his only moral impulse. It is also my opinion that this laughter can be nothing other than a projection of Peer’s conscience, which seems to be saying “*quo vadis?*” Freud’s theory was—and psychoanalytic research has proven the point time and time again—that the auditory hallucinations in cases of paranoia and dementia praecox are in part projections of negative desires and thoughts and partly the voice of one’s own conscience. We shall have ample opportunity to deal with this and other paranoid formations of the Peer Gyntian psyche. But let us first return to the story.

After diverse experiences in the inn, Peer Gynt carries out his plan to abduct Ingrid. We are now aware of the underlying motives for this, but here we must direct our attention to the fact that this act, too, contains at least one of the characteristic traits we saw earlier in the Buck Fantasy:

ALSAK: That's the *steepest part!*

My God! He can climb like a *mountain goat*.

[p. 54; italics added]

Even this very real bride stealing is marked by the character of the Buck Fantasy, and its lingering effects have Peer Gynt carry Ingrid off to lonely, steep, rocky regions. His unconscious does not see her as Ingrid but as the woman of another man, i.e., the mother image. The content and significance of this deed lie in the second realization of the Buck Fantasy and the fulfillment of its basic unconscious desires.

PEER GYNT'S MADNESS

We must now advance into the plot and put ourselves in Peer's place in the stage of his development of which Schlenker says: "Act IV, set in Africa, not only removes the hero from the plenitude of normal life into the desert, but the reader is also led into the desert of allegory and caricature. With the selective, carefree genius of a romanticist of the earliest school, Ibsen portrayed the three experiences: Peer's being robbed on the Moroccan coast, his life as a prophet with an Arabian tribe, and finally his coronation as emperor in the insane asylum in Cairo. But Ibsen's brilliant display of intellect and imagination fails to comfort or delude us as to the lack of *credible* progress in the plot and we are inclined to greet his return to the more natural artistic means of the previous acts with heartfelt applause." I will not succumb to the temptation of fleeing this world of "allegory and caricature," but intend to linger in these regions as long as is required to clarify the relationship between each of the separate sections of the drama.

In the interest of clarity, I shall also separate Peer Gynt's adventures into three large consecutive periods. I have already mentioned the Buck Fantasy, which falls into the first period of fantasy formation, the stage (expressed in terms of the libido) in which the individual, as a consequence of an unconscious incestuous fixation, withdraws his libido from the external world, leaving a small portion which is directed toward the object of his fantasy. We know from the theory of neurosis that this condition cannot last long due to the increasing stasis of sexual energy, which finds no real outlet in the object of the fantasy and is replaced by a neurosis or psychosis. Neurosis occurs when the repressed drives are at least partially satisfied by symptomatic actions; psychosis, when the libido is withdrawn from the fantasized objects and directed toward the self. In the latter case, a regression to the narcissistic stage of sexual development takes place (megalomania; dementia paranoides).

Among the interpreters of Peer Gynt, utter confusion reigns as to whether Act IV was indeed experienced by the hero at all, or whether it is a digression into fantasy on the part of the poet. This is, however, completely irrelevant for our discourse. Peer Gynt may live alone in the woods at this time, imagining himself to be an emperor while existing on herbs, or the dramatist may actually have him experience this part of the plot. In the first case, we can understand Ibsen; in the second case, we will withhold our belief, and may even be able to prove that in this instance Ibsen's unconscious ran away with him and that he still owes us the evidence on which his interpretation is based. Personally, I

cannot make a decision in favor of one or the other. The fact that Ibsen suddenly makes his hero a millionaire, without preparing us in the least, speaks for the first possibility, and several weak attempts at rationalization speak for the second. For instance, at the very moment in which Peer Gynt has been robbed by his so-called friends, he feels himself confronted by an absolute void and wishes for a horse. Ibsen then inserts a scene in which thieves abandon a horse out of fear and Peer suddenly takes possession of it. The dramatist cannot erase the impression, however, that this is an unsuccessful attempt at rationalization. I prefer to think of Peer Gynt's delusions of grandeur and the "omnipotence of thoughts" in the same way as in the incident where Peer's prayer causes the stolen ship to sink, replete with all its treasure and his criminal friends, and a sheet of flame plus the dull sound of an explosion give evidence of the destruction.

The second period is the Peer Gyntian madness, which shows a marked intensification from millionaire to prophet to emperor.

In regard to the third period, I shall mention, for the time being, only that it begins with the scene in the insane asylum in Cairo and that it is the stage of restoration.

I ought also to mention that the transition from the second to the third period is more clearly defined than from the first to the second. If, with the scene on the Moroccan coast, we mark the beginning of Peer's madness (which actually dominates the entire representation), then we must also remember that we found traces of his future insanity earlier, running through the fantasy-formation stage.

It is now our task to view Peer's delusions in a purely descriptive manner; later on we shall have to inquire into their connections with his previous experiences, and for this we shall adopt the medical approach, i.e., from the symptom to the anamnestic reconstruction of explanatory material.

Peer Gynt gives us a few brief, not exactly detailed, hints as to the origin of his wealth. He had gone West empty-handed and had had to work hard and struggle. But good fortune favored him. He had been diligent and amassed his present fortune. Peer seems to have forgotten the past altogether. Only once, in an allusion to his experiences in the Kingdom of the Old Man of the Dovre, does he mention a lady of "royal blood" toward whom he had been inclined but whom he had to give up because of the unacceptable demands made by his "father-in-law." Further, we discover that he is by no means disposed to remain at his present level on the road to success. Peer himself describes the core of his being better than we possibly could:

The Gyntish Self—it is a sea
of fancies, cravings, and demands;
in short—what stirs inside *my* breast
and makes me live my life as Me.
But as the Lord has need of clay
to make a world He can be God in,
so I, in turn, require some gold
to make myself an Emperor.

Peer doesn't want to be a "little King of some little place." He wants to be an emperor with wealth, power, horses, and men (the result of the revelry and ostentation he experienced at home during his youth)—as rich and mighty as his own father and even more so. However, we find Peer miserable and abandoned, disgracefully defrauded by his friends, and robbed of his wealth, sitting in a tree, the victim of hunger, like a primitive, helpless child, in strange contrast to his previous abundance of wealth and power.

It may be that the dramatist, in this comparison of Peer before and after, is trying to demonstrate the frailty of all misconceived striving for perfection. The following scene draws our attention to this error and delusion in no uncertain terms: Armed with a stick, Peer is trying to defend himself from a black ape (the primitive state). Soon others appear and begin to throw their excrement at him—

It's the old one—with paws chock-full of filth!...
... The brute!
The whole lot—all over me! Ugh, how disgusting!
Or perhaps it was food! It hasn't much flavour ...
still, that's all a question of what you're accustomed to.
[p. 124]

But daydreams transport him from coarse reality, and the sight of the immense ocean of sand awakens in him the desire to advance himself in life again by means of some grandiose scheme: By breaking through the row of sand dunes which hold back the sea in the West, one could turn the desert into fertile land, cities would arise—"On a rich oasis set in my ocean/I'll settle men of Nordic stock"—and Peeropolis would be the capital of the new land of Gyntiana. Just one thing is lacking for the realization of these dreams—"My Kingdom—*half* my Kingdom for a horse!"⁸

(The horse whinnies in the ravine) ...
Impossible! Yet true! I know I've read
somewhere that faith can move a mountain,
but not that it can produce a horse!
Absurd! And yet the horse is there.
[p. 129]

We are amazed: Peer Gynt desires a horse for the realization of his fantasy. The wish he expresses just prior to this seems more comprehensible—"Some money—and the thing is done—/a golden key to the ocean's door!" [p. 129]. At this point, we recall the ride in the Buck Fantasy. But how strange this present daydream seems! We automatically think of a small boy at play in the sand, making lakes, breaking dams, and building cities—naturally naming his creations after himself. He builds a special castle for his own dear parents and tries to prove his gratitude to them by a gift of "enfranchised land." But by this he is attempting to fulfill a different wish—that his own power and glory may now eclipse that of his parents!

Peer's feeling of helplessness impresses us as a "lucid moment" in the course of his megalomania. Here he becomes conscious of his situation and of his childishly retarded ego, even though this takes

place through a psychotic projection onto a toad he is observing:

Here's a toad! Hidden deep in a block of sandstone—completely immured—just his head peeping out as if through a window.

And there he sits watching the world ... and he is to himself—enough!

(Thoughtfully)

“Enough...?” “To himself...?”

Now where does that come from?

Did I read it when young, in some so-called “good book”?

Was it the prayerbook? Or Solomon's Proverbs?

Dear me! How I find, as the years go by,

that my memory fails me for dates and places!

[pp. 126–7]

His experience with the Old Man of the Dovre still haunts him, but he is not able to attain clarity. Are we to understand his remarks as a regeneration fantasy, as a first step toward recovery? It might be wiser to wait until we have more material to confirm this assumption.

Next we encounter Peer as a celebrated prophet surrounded by a circle of beautiful girls, among them Anitra, and we learn from him that he has fallen into this role quite involuntarily but that he seems to feel entirely at home in it.

This period would have nothing remarkable to offer if it were not for a few striking indications. We refer to the sudden ending of his career as a prophet and to a certain scene inserted here into the course of the plot. In this, a woman (Solveig) sits at the distaff in front of her hut in the woods and sings a song that definitely refers to Peer's return.⁹ Lastly, we must note the predominance of erotic elements in this period in contrast to the previous one in which he played the part of a very rich man.

Remorse overtakes Peer; his conscience begins to bother him and he is ashamed to have courted “that little goose” (Anitra). Soon enough, however, he comes to terms with himself again and begins to scheme:

So ... something new! Some enlightening quest!

Some goal that is worthy of money and pains.

[p. 146]

This gives him the idea of becoming a man of science. He has already discarded the idea of writing for a living as beneath him:

to bid farewell to the pleasures of Love ...

and *all to solve the riddle of Truth!*

That is the test of a man of Science.

[p. 147; italics added]

Perhaps we already have some idea of the meaning of his delusions in regard to being a prophet or a man of science. Still, at this point, we must restrain ourselves and leave Peer Gynt at the statue of Memnon, where he is about to put his plan into practice, while we turn to an examination of the events which occur between the Buck Fantasy and the onset of his madness.

EARLY SYMPTOMS

We left Peer just as he had successfully abducted Ingrid, and we recognized in this act the realization of an unconscious incestuous wish. The Buck Fantasy and his mother's ridicule of his masculinity had preceded it and functioned as causal elements. Let us now attempt to fill in the omissions in our understanding of the causal relationships among the facts we already know.

First of all, our attention is drawn to the result of the episode with Ingrid. Peer has abducted and seduced her, and now wants nothing more to do with her. He himself gives us the reason for this: In the inn he had met Solveig, the daughter of an immigrant couple. At first she had been willing to grant his request for a dance; but later, after having been warned about him by her mother, she reluctantly declined. It is understandable that Peer fell in love with Solveig when he returned from his fantasies to the world of reality. We may also assume that he would not have carried out his plan to abduct Ingrid had he not been rejected by Solveig. For this reason, his reaction to the obvious rejection of his newly elected libido object was all the more vehement. Perhaps this last point was a determining factor in the violence of his bride-rape. This manifest rejection may very well have been reminiscent of his youthful choice of an incestuous libido object and therefore also a decisive factor in his later behavior toward Solveig, which clearly bears the mark of deep inhibitions.

Can your eyes be pure? *Can you deny my*
request? Will he who beholds you become pure?

These lines provide sufficient explanation of the reasons for his withdrawal from the passion he has experienced and his turning to pure, innocent, and virginal Solveig.¹⁰ The significance of the connection between his denied request and the intensity of his attachment to Solveig cannot be overemphasized. This love conditioning is familiar enough in the life of mankind in general, and especially among neurotics.

It is interesting to see Aase's reaction to the heroic deeds of her son, whom she had, up to this time, credited with nothing but:

... lies and stories,
his greatest strength was in his tongue—
he never *did* anything in his life!
He—oh, I want to laugh and cry!
[p. 57]

Her delight in Peer's daring masculine coup rings through her words, and we may assume that she identifies with the stolen bride. In the light of her apologetic remarks to Solveig, which follow directly, I must admit that in this particular case Weininger was right. I realize that Ibsen, whose works elevate the problems of women to such central importance, has understood the relationship of this mother to her only son correctly.

We clung together in want and sorrow—
for I must tell you, my husband drank,
roaming the district with foolish chatter,
wasting and trampling our wealth underfoot
while I sat home with Little Peer ...
What could we do but try to forget?...
some try lies, and some try brandy,
but, ah, we took to fairy tales
of princes, trolls, enchanted beasts,
and stolen brides ... But who'd have thought
those devil's tales would stay with him?

[p. 58]

We cannot overlook the ostensible coincidence in her incidental mention of the bride stealing (which is actually basic to her entire confession). As an analyst, I have become accustomed to directing my attention to the inconsequential and correctly assuming that the significant lies behind it—in this case it would be Aase's inhibitions springing from her own desires, with resulting consciousness of guilt.

Peer's subsequent three experiences (the Saeter Girls in the Tronde Mountains, the kingdom of the trolls, the Great Boyg) present us with a problem that is not easy to solve. These are the most beautiful but also the most profound and confusing events the dramatist has Peer Gynt experience. They represent for the layman and the theatergoer, as well as for Ibsen's ingenious interpreters, a weak spot in the comprehension of the play, a misunderstood and often obscure literary passage. In spite of their difficulty, these experiences allow enough scope for widely divergent reactions. As impartial onlookers, we ourselves can scarcely suppress a compassionate or amused smile at Peer Gynt's lies, or even his megalomania and his experiences in Morocco, while the scene with the Button Molder or the death scene aboard ship give us an uncanny feeling. Although these experiences make a lasting impression on us, we find ourselves no better able to account for our own reactions than to explain the responses of an entire audience in the grip of Sophocles' *Oedipus*, or any other momentous tragic drama which brings into play the deepest elements of human life.

Freud has taught us how such works can best be understood, and I shall therefore attempt to illuminate this portion of the drama using the methods and understanding that psychoanalysis offers.

Most interpreters are inclined to view the scenes with the Old Man of the Dovre and the Great Boyg as dreams—but the scene with the Saeter Girls as actual reality. I feel justified in classifying this last scene with the former two, especially since it derives a certain significance from its connection with them. We shall see later on just how this significance supports my claim. Furthermore, we must note that it is not at all important which way they are viewed, since we have undertaken to find the etiologically meaningful moments of Peer Gyntian madness. Psychoanalysis teaches that delusions and dreams are at least equal to real experiences in regard to their causal effect.

Peer Gynt is in a cheerful and self-confident mood after having abducted the bride. He is in the Tronde Mountains trying to escape from his pursuers and has recognized the value of reality (or desires fulfilled in reality) as opposed to fantasy, when he exclaims:

Yes, this is life! It uplifts me and strengthens.

The devil may take all my worthless lies!

[p. 60]

But even here we are forced to observe that this desire, which has been fulfilled through an object in the external world, contains a prodigious amount of narcissism and that the underlying reason for his gloating is delight in his own prowess. It is possible to view this as an intense reactive ebullience in contrast to his previously empty fantasies, for Peer seems to be convinced that they had no real content. We are more inclined, however, to suspect that Peer's narcissistic constitution, with which we are already acquainted, lies behind this. We have in mind the Buck Fantasy and his later decline into a narcissistic psychosis.

The following scene can be viewed as the continuation, so to speak, of a little heroic episode experienced in reality: "I'm a three-headed troll—just the one for three girls," Peer calls to the three Saeter Girls. In answer to their question "Are you man enough?" comes Peer's self-confident reply, "Try me and see." As I mentioned before. I look upon this scene as a dream or a fantasy. Therefore, I must now inquire into the unconscious thoughts which underlie it. Perhaps the sketchy histories the Saeter Girls volunteer will provide the key to our understanding: The fiancé of the first married an old woman; the fiancé of the second remained with a gypsy in the North; the fiancé of the third killed their offspring and was hanged. We must confess that we cannot make very much of these stories as they stand. If we consider them in context, however, realizing that this fantasy follows fast on the heels of Peer's three most important experiences (i.e., Buck Fantasy—mother, rape of Ingrid, meeting with Solveig), we may assert quite confidently that this fantasy represents not only a repetition of those three experiences but in addition presages the following: In reality, Peer had possessed Ingrid only; his fantasy now brings to fulfillment his desire for the other two women. In this light, the lament of the first girl appears as a greatly disarranged accusation of Aase's husband by Aase herself; the tramp of whom the second girl speaks is an allusion to the fact that Solveig and her parents were actually not native to the terrain but settlers; finally, the tale of the third, pertaining to a murdered child, connotes that Ingrid is the only one Peer possessed. I shall return to this point, but we must mention first that here a consciousness of guilt begins to take root which is to be the decisive factor in the onset of Peer's psychosis, as well as a hindrance to his final union with Solveig. Once again a remark by the third Saeter Girl, "Like the mountain trout from the blackest pool," is a far cry from the rejoicing of the other two. Peer's answer, on the other hand [p. 62], "Dismal bodings and wanton thoughts—laughing eyes and a sob in the throat!" gives rise to serious doubts as to whether this scene is purely pleasurable in character. It is surely much more likely to be the beginning of a long sequence of rampant conflicts and, as we shall see, of libido regressions. For the moment it is still directed toward fantasy objects. Along with the other two experiences which we must now examine, it is full of the characteristics of his future psychosis. Peer seems to sense this as he storms around in the mountains, "wild and distraught":

Palace on palace is rising!

See, how that gateway glitters!
Stop! Will you stop! Now they're drifting
farther and farther away!
The cock on the weather-vane's spreading
his wings, as if he would hover....
Now all is blue haze in the gorges
and the mountain is locked and barred....
A gleam like the bands of the rainbow
pierces my sight and my senses.
What is that distant chiming?
What weighs my eyelids down?
Ah, how my head is aching....
That ride on the ridge at Gjendin
was a tale—a damnable lie.
Climbing the steepest hillside
with the bride ... drunk a night and a day ...
hunting with kites and with falcons ...
threatened by trolls and their kinsfolk ...
sporting with crazy women ...
all a lie—a damnable tale.

[pp. 62–3]

We see that Peer himself has found the cause of his agitation and that he puts his most important experiences and fantasies in a very close relationship to one another. This is the same conclusion we reached circuitously by other ways and means.

But he goes a step further. In a vision he sees his father's palace and recalls the wild orgies held there:

I must be off. I'll saddle my *horse*
and ride *where my fancy takes me*; [vide Buck Fantasy]
I'll storm across the sea and become
Emperor of England.*

This precedes the vision. The quick sequence of these thoughts and the direct connection of his sexual drives and his lust for power provide the final link in our comprehension of the meaning, cause, and goal of his delusions as described above. At the same time, we see confirmed here the suspicion mentioned earlier. We might also note that his oedipal attachment to his mother has found nourishment in the conditions prevailing at home, which were augmented by the behavior of his mother, also discussed earlier. His desire to become as rich and powerful as his father [p. 65]—"Peer Gynt, you have sprung from greatness, and to greatness shall you attain" (closing remark of this scene)—and his incestuous ties to his mother (which remain unconscious) are the underlying reasons for the continuing fixation of his libido on the object of his first choice and for his later regression to the narcissistic phase.

By this analysis we have now come to an understanding of his insanity in broad outline. We hope that presently an analysis of the two dreams which follow¹¹ (the Old Man of the Dovre, the Great

Boyg) will enhance our understanding of its subtler structure. In dealing with them we shall confine ourselves to the manifest content of the dreams and attempt to divine the latent thoughts from the material with which we are already acquainted.

Peer finds a Woman in Green, whom he follows home after much pride-inflated conversation. Her father is the Old Man of the Dovre, who reigns over his subjects, the trolls, and Peer is to be her princely groom. In her father's kingdom he asks for her hand in marriage, but also demands the kingdom as her dowry. The Old Man agrees, but makes a series of stipulations on which the marriage is to depend. First, Peer must solve the riddle of the difference between a man and a troll. Peer cannot find the right answer and the Old Man instructs him thus: "Outside, among men, where the skies are bright, there's a saying 'Man, to thyself be true'; but here among trolls, the saying runs: 'Troll, to thyself be—enough'" [p. 69]. This is not quite clear to Peer. "Enough, my son! That shattering word of power must be your battle-cry." He finally agrees, though unwillingly. The second stipulation is that he must try the troll cuisine, the dung of the cow and the mead of the ox, not asking whether it is sweet or sour but rather keeping in mind that it is homemade. Peer also agrees to this unpleasant condition after some hesitation. Further, he must run about naked and allow a tail to be fastened to him. But the Old Man imposes only these external demands, and Peer's beliefs are left unchanged.

The Woman in Green and her sister begin to dance, but when Peer is asked his opinion, he compares them to "a bell-cow who plucks with her hoof at a catgut, while a pig in short stockings cavorts to the noise." The wrath of the trolls is unleashed and the Old Man orders Peer's left eye to be plucked out. Peer agrees to this too, but asks whether it will grow back. When he hears it will not, everything within him rises against this unreasonable demand. Shortly thereafter, the Old Man's daughter informs Peer that he is to become a father, and at this Peer tries to flee as quickly as possible. However, the trolls overpower him, and buried beneath a pile of them, he cries out, "Help, mother, they'll kill me." At the sound of church bells the nightmare vanishes. But the next dream follows immediately: Peer is struggling with something which, when asked "What are you?" identifies itself as the Great Boyg. Just as Peer thinks he has subdued it, he again finds himself struggling with something unconquerable. In desperation he calls out:

Backwards or forwards it's just as far,
out or in, it's just as narrow.
He's here, he's there, he's all about me!
When I'm sure that I'm out, then I'm back in the middle!
What's your name? Let me see you!
What sort of thing *are* you?
[p. 79]

He challenges the Boyg to an encounter, but it declines, saying that time is on its side. Peer is in utter distress, although the Boyg remains completely passive, while preventing his breaking through the circle. Suddenly Peer thinks of Solveig and implores her to save him, but in vain. He collapses and the Boyg is about to fall upon him when the bells toll again and the dream ends with the cry: "He was too strong. There were women behind him." Peer is asleep in front of Aase's hut in the mountains.

At first Peer's experience with the Old Man of the Dovre seems to be a continuation of the episode with the Saeter Girls, as well as being the fulfillment of his two greatest desires, namely to become a rich king and to marry the Old Man's daughter (who is without doubt a personification of his mother). When he meets her in his dream she is a princess—in other words, he elevates his mother to this status. It would be well to recall here the scenes after the Buck ride in which Peer sets his mother on the roof of the mill. Everything points to the fact that this apparently senseless deed is full of deeper meaning. His mother is uplifted by being put on the roof—(note the exclamation of the Old Woman when she sees this, "Aase, you've moved up in life!"). The fact that the Woman in Green herself leads Peer to the Old Man of the Dovre, so that he can ask for her hand, gives rise to the thought that Peer feels justified in his own eyes when the Old Man (who can be none other than a personification of his father) actually does give him "his mother" in marriage. As we know, his father's behavior in Peer's youth gave rise to the unconscious idea that he (Peer) was married to his mother (alone with her)—that she had been bequeathed to him. We also know the results of this relationship. (Quite recently I had occasion to observe the same thought sequence in a paranoid patient.)

But these desires of Peer are not to be fulfilled without considerable difficulty. We can distinguish a twofold nature in them from the stipulations made by the Old Man: Peer's own infantile desires and his anxieties. The first appear to be demands made by his father and therefore complied with.

One other thing must be stressed. It is easy to see that the Peer as he appears in his dreams, combined with the trolls, equals the real Peer. The trolls are personifications of the unconscious desires and thoughts¹² of his own infantile pleasure ego, whereas the dream Peer, who is struggling against the trolls (we need only to think of his superior critical attitude toward them), seems to coincide with his real personality or, better said, with the part of him which is striving toward a real personality. No one could have depicted the arduous struggle between the sex- and ego-oriented components of his personality better than did Ibsen in this scene. All of the concessions Peer makes to the Old Man of the Dovre symbolize the sacrifices which the moral self has to make to the libidinous drives of the individual, at least up to a certain limit. In people who, unlike Peer, have not remained in an infantile stage of development, people who have succeeded in progressing from the pleasure principle to the reality principle, the sexual drives have to make many concessions to the tendencies which do justice to the real self (through repression, sublimation, condemnation), but again, only to a certain degree. Perversion (sexual conquest) or neurosis (miscarried ego conquest) will inevitably result as a consequence of the interference of extremely dynamic and strongly libidinous drives.

This dream contains a regression to the phase of sexual development in which the oedipal role, the castration complex in connection with it, and consciousness of guilt begin to take root. From this point on, they are repressed, and from the unconscious they exert influence on the life of the individual in a very definite manner. The dream Peer is one part of the critical Peer, one part of his will to repression and recovery. The struggle of this part of Peer with its infantile unconscious counterpart evolves clearly.

It is hardly necessary to go into greater detail. The symbolism behind the pinning on of a tail is

clear enough. The remark of the Old Man of the Dove “Don’t come courting my daughter with no tail on your rump” is clearly the desperation of the infant Oedipus because of his small penis, and simultaneously the fulfillment of his desire for a larger organ. It is obvious that Peer cannot solve the Old Man’s riddle as to the difference between man and troll (adult and child) because at this time neither of these components has prevailed in him, although the pleasure ego seems to be favored.

Peer is not acquainted with the phrase “To thyself be true” since it pertains to the formation of a self by the adult who has progressed from the pleasure ego to the real ego, while always keeping an eye on the ideal ego.¹³ “To thyself be enough,”¹⁴ namely, pandering to the pleasure ego and withdrawal from the external world, is his solution.

Even the common custom of the trolls of walking around naked does not surprise us. In the challenge to eat cow dung and drink ox mead, the nourishment of the trolls, we can see anal- and urethroerotic traits. Whoever has willingly followed me up to this point and knows how much attention children pay to their primary body functions, and also how important this attention is in the development of later reactions (as well as being symptomatic in a number of neuroses and psychoses), will not be surprised by what follows. But I also hear voices raised accusing me of arbitrary interpretation, voices of those who are ready to close their ears. Let us recall the scene in which we observed Peer after he had been robbed by his friends. It is not surprising that we can now grasp the meaning of his struggle with the apes. It is simply a reoccurrence of the cow-dung episode when the ape dirties him from head to toe. The correlation between the two becomes even more apparent if we recall that still another element of the troll dream appears in this scene:

“Enough...?” “To himself...?”
Now where does that come from?
Did I read it when young...?

All this after he had just been as rich as Croesus. The connection psychoanalysis has found between money and feces as well as between avarice and anal-eroticism is to be seen here also. If the anal-eroticism we see in the dreams was a determining factor for a specific element of Peer’s insanity—wealth—then the scene following the loss of his wealth represents a reversal of the process. After the disappearance of his madness comes the return to the phase which gave birth to it, although we must also see this as an important rung on Peer’s ladder to his highest goal, to become an emperor (father).

Now let us return to the dream. As punishment for his blunder and the crime of calling the Old Man’s daughter a dancing, cat-gut plucking, belled cow, Peer is to have one of his eyes put out. This threat is well known as a castration symbol in the dreams of neurotics and portends punishment by the father for the incestuous desires of the son. The latter are repressed in the dream and hence my interpretation must temporarily be considered only an assumption. I might add, however, that I shall be able to prove the correctness of this supposition later. Peer resists this demand with all the strength he can muster. When the Woman in Green tells him he is going to become a father (at which he makes an effort to flee), we must think of the third Saeter Girl, who, on two occasions, mentions the murder of her child. In the future I shall subject this singular point to a closer examination.

Peer's rescue from the trolls by calling to his mother can be defined as a dream element in three ways: first, as a course of action in accordance with his unconscious thought of protection by his mother in time of danger; second, as the fulfillment of a desire which can only be satisfied by the mother, to which the trolls (i.e., his unconscious desires) are urging him; and, finally, as a reconstruction of the incest barrier, which had been broken down in the dream, that is, a new repression of the unconscious desire by mentioning its designation ("mother"), which in turn contains the inhibited incestuous relationship.¹⁵

From what we now know, we shall not be able to approach the significance of the Great Boyg because we haven't the slightest clue to guide us. Let us make an attempt from another angle and return to Peer Gynt in the situation in which we left him, standing in front of the statue of Memnon, about to carry out his plan to become a man of science.

Peer hears a rustling and the statue begins to sing:

From the Demi-god's ashes rose songbirds
bringing back Youth.

Zeus, the All-knowing one,
shaped them for conflict.

Oh, Owls of Wisdom,
Where are my songbirds sleeping?

You must die unless you fathom
this, my song's riddle.

PEER GYNT: I honestly do believe that the statue was singing. This must
be Antiquity's Music!...

(Writing in his notebook)

The statue sang. I could hear it distinctly,
though I failed to interpret the words of the song.

It was all a hallucination, of course.

[pp. 149–50]

Soon thereafter standing before the Sphinx:

Now where in the world...? I seem to remember
meeting something that looked like this hideous object ...

Yes, certainly I've met it. But where? North or South?

Was it a person? And if so, who was it?

That *statue of Memnon*, I realized afterwards,
resembled the so-called Old Man of the Dovre—
the way that he sat there so starchy and stiff ...

but this quite remarkably hybrid beast,
this changeling, that's lion and woman at once,

did I get it out of a fairy tale,
or is it something I really remember?

A fairy tale...? Ah, I've got it now!

It was the Boyg whom I cracked on the noddle ...

Do you still talk in riddles? Let's try you out:

Hi, Boyg, who are you?

[p. 151; italics added]

We feel that we now understand. If the Boyg was the sphinx who asked Oedipus the famous question, then what can the dream mean other than the reliving of the infantile stage in which the child sees himself confronted for the first time by the problem of sexuality and perhaps even experiences the first big lie (stork fable, etc.). Anyone acquainted, from analysis, with the struggle of the child between what he is trying to understand and what he already understands will not underestimate the meaning of the question “Who are you, disguised one?” which Peer in his dream hurls in desperation at the Great Boyg.

Now we also understand the meaning of Peer’s delusions of being a prophet—and a man of science. First, it was his belief, or rather his desire, to know everything or even to predict the future; and second, his desire to continue his infantile sexual investigations on a pathologically enlarged scale. (Analytic practice provides us with a sufficient number of cases which show very clearly how drives of this nature determine the childhood and sometimes even the adult choice of a vocation. A patient once told me that at the age of eight he was motivated to become a doctor so that he could see a great number of naked bodies without punishment. As to the importance of such infantile brooding on the formation and specific character of philosophic thinking, the reader is referred to the penetrating commentary of Winterstein in *Imago*, 1913).

Just as this period of Peer’s insanity corresponds to the third dream, we may consider the first two dreams as the forerunners of the first and second periods of his madness.

CAUSAL ELEMENTS

Now that we have succeeded in discovering a significant causal relationship between Peer’s madness and his experiences, it must be our task in the ensuing account to point out the inevitability of his lapse into psychosis and the factors which contributed to it. If the conclusions drawn from our inquiry have been correct until now, then we shall also be successful in adding the last links to our chain.

Peer has fled the world and the consequences of his wrongdoing and is preparing himself for a long stay in the wilderness. While vacillating between his fantasies and reality, he is felling timber and building himself a hut. But even here:

There must be a bolt. I must bolt the door
against trolls. Against men and women, too.
There must be a bolt—a bolt that will hold
against little goblins and all their spite.
They come when it’s dark, and they rattle and knock:
“Open up for us, Peer, we’re as nimble as thoughts!
Under your bed you will hear us rustle—
among the ashes you’ll hear us scuffle—
we’ll fly in your chimney like dragons of fire.
Ha, Peer, do you think that your nails and your planks
can keep out the spiteful goblin-thoughts?”

Poor Peer!...

He is overjoyed when Solveig, who has left her parents' home, comes to share his lot in exile. He wants to start a new life, everything will turn out for the best—but no, the malicious goblin thoughts!

An old woman appears with an ugly, crippled little boy and reminds him of his fatherly duties. Peer is amazed as the Old Woman provides further information:

THE WOMAN: As *your* hut grew, mine rose beside it.

PEER GYNT: (*starting to go*): I'm in a hurry—

THE WOMAN: You always were, lad;

but I plodded behind, and I've caught up at last.

PEER GYNT: You've made a mistake, woman.

THE WOMAN: Yes—long ago!

Back on the day when you promised so much.

[we think of Ingrid]

PEER GYNT: I promised so much? What the devil is this?

THE WOMAN: You forget the night when you drank at my father's;

you forget—

PEER GYNT: I forget what I never knew!

What nonsense you're talking! Just when did we meet?

THE WOMAN: The last time we met was the first time we met.

[p. 91]

Now we understand! The woman, an apparition of the Woman in Green, is again a concentrated blend of Aase and Ingrid, a vision resulting from a projection of his first incestuous love object. Peer cannot find peace. His conscious inclination toward, and love of, Solveig is inhibited by an unconscious, disturbing, and now projected incestuous fixation of his libido.

Still worse, his guilt feelings about his oedipal transgression are personified by the boy and accentuated by the child's physical and mental deformity (based on popular belief in the detrimental effects of a consanguineous marriage upon the offspring: inbreeding).

THE WOMAN: [in response to Peer's threatening to kill her]

You try it—I dare you!

Aha, Peer Gynt, I can stand hard knocks!

I shall come here again every single day—

I shall peep through the door and watch you both.

When you sit with that woman beside the fire—

when you're loving, and wanting to play and embrace—

I shall sit beside you and ask for my share.

Yes, she and I will divide you between us.

Goodbye, my dear. Go and get married tomorrow!

PEER GYNT: (*clenching his fists*):

And all this comes—

THE WOMAN: Just from thoughts and desires!¹⁶

You're unlucky, Peer!

[pp. 92–3]

Once again Peer tries to rid himself of the disturbing thoughts and longs to repent, but is finally overcome by despair [p. 93]. “‘Go round about,’ said the Boyg. So I must ... there’s no way now that passes straight from you to her [Solveig].” He fears that Ingrid and the other three he “pleasured up there” will come and ask to be taken and held close just as this woman, and that he will not be capable of this [p. 94]. “To speak, yet keep silent—confess yet conceal.” Asking Solveig one last favor, to wait for him no matter how long he is gone, he flees to his mother, only to find her on her deathbed.

The following scene of Aase’s death has little new material to offer other than the deeply moving, remarkable poetic embellishments. For our purposes this scene falls clearly into the same class as the Buck Fantasy. Now as then Peer draws Aase into the world of his fantasy and reminisces about former happy times in the Gynt household. He succeeds in making death easier for her, but he himself lapses into madness directly thereafter.

Let us now try to summarize the circumstances which led to his madness. In the seduction of Ingrid (the unconscious personification of his mother), Peer had committed the crime of incest. This resulted in the awakening of guilt consciousness, the first signs of which already became evident in the lament of the third Saeter Girl and in the troll dream. The first strong eruption of these guilt feelings occurred when Peer’s libido was in the process of fastening itself upon a real love object. But guilt and unconscious fixation on his mother emerge victorious from the frantic battle in which we watch the unconscious and the conscious wrestle within him. We recall Peer’s begging Solveig to wait for him, and view this as another loss of reality, having believed up to this time in a possible resolution. With the death of his mother the last bastion of the libido falls and he subsequently regresses to the narcissistic phase in which we eventually find him. All of this corresponds to the psychoanalytic concept of world destruction in schizophrenia; the ego merges with the external world and a new world of insanity is constructed.

RESTITUTION

Our task is still not completed, since the dramatist is less relentless than reality and allows his hero to recover. After what we have seen up to this point, it will not surprise us to trace exactly the same psychodynamics in Peer Gynt’s recovery that we would ordinarily observe in attempts to treat clinical paranoia (although in cases of this kind total restitution *ad integrum* is very rare indeed). After countless observations, psychoanalysis embraced the concept that an attempt at restitution is conceivable only if the withdrawal of libido from objects of the external world, and its subsequent regression to the narcissistic phase, is not complete. In other words, a few borderline connections must remain (Freud, Nunberg). Recovery takes place through these last remaining strongholds, from which the external world is then reconquered. If these strongholds are lacking, we are confronted with the picture of “catatonic stupor.”

Each withdrawn connection with reality corresponds to an intensification of the narcissistic ego (or vice versa). Hence the self-sufficiency (an indication of auto-eroticism), the remoteness, and the omnipotence of thoughts and desires observable in small children in the narcissistic stage (and, as

Freud points out, in primitive peoples). We have come to know Peer as the victim of his own incestuous mother fixation and of the identification with his father, which resulted in failure to progress from the pleasure principle to the reality principle. We have also seen that a constant intensification of the narcissistic self continued, with progressive libido withdrawal, up to the total manifestation of delusions of grandeur (hence, “narcissistic psychosis”). We were able to see the death of his mother as a loss of objective reality, and finally to recognize how the guilt feelings resulting from an Oedipus complex (and realized in the abduction and seduction of Ingrid) were responsible for the lapse into psychosis.

The unconscious is also aware of punishment for the crime of incest. It is castration in the strict sense of the word, and in connection with it a wide range of symptoms appear (inferiority feelings, etc.), just as in a castration complex in the broader sense. We succeeded in finding traces of this punishment in Peer when we recalled the command of the Old Man of the Dovre that one of Peer’s eyes be put out for ridiculing his daughter’s dance. (What we have in mind, aside from the typical symbolism, is Oedipus’ self-castigation by blinding himself after becoming cognizant of his incestuous deed.) Here we are dealing with an attempt at rationalization and a secondary processing of the manifest dream content to enable it to reach the conscious level.

In the first version of *Peer Gynt*, we find a passage not included in the final one. It contains Peer Gynt’s punishment by Solveig’s father. After seducing Ingrid, Peer asks Solveig’s father for his daughter’s hand in marriage. He is told, however, that he must first free himself from his self-imposed burden of guilt by voluntarily giving himself up to the law. I quote the passage:

SOLVEIG’S FATHER: Go down and give yourself up to law and order,
demand the punishment for the deed yourself,
take mankind’s scorn and spite upon your shoulders.
Seek strength in humility’s power.
Seven years will be meted out to you,
take them as penance for your sins.
When you have done this and come home to us at last
You shall have my daughter if you still desire.

SOLVEIG’S MOTHER: Husband!

AASE: You’re insane!

PEER GYNT: Off to prison!

SOLVEIG’S FATHER: Yes, straight through the middle. Will you do it?

PEER GYNT: No, thank you very kindly!

SOLVEIG’S FATHER: Hear me, lost soul, hear me for your salvation.

The devil lurks behind you, don’t you notice it?

Already he has robbed you of your better self

Now your last footholds are slipping ...

Never again will you have the chance

to choose damnation or peace, rejoicing or gnashing of teeth!

Allow life’s hard blows to crush you

and *melt* you down to cleanse your pitch black soul.

Be consumed by fire and arise pure white from the ashes.

Man, in the name of God, choose, choose, choose!*

We see that the above passage is dominated by an emotional outbreak on the part of Solveig's father which is not commensurate with Peer's deed. This supports my viewpoint. (I shall return to another aspect later on.)

I was also inclined to see the solution of the riddle "To thyself be—enough" as an intimidation by the father. Now that we have been enriched through new insights, we can progress to a broadening of these concepts by taking the solution literally. Peer is in no need of the external world due to his narcissistic self-elevation. He finds complete satisfaction in his narcissistic libido, like a self-sufficient infant, and this is the stage to which he has regressed. I said that the motto of man (adult man) "Be thyself," as it is conceived by the Old Man of the Dovre, stands in opposition to the riposte "To thyself be enough." In a sense I was forced to admit that the Old Man was right, for I lacked clues to a different or more profound interpretation. Certain doubts as to the adequacy of this explanation must have arisen in me at the time. The scene in front of the Sphinx, where we left Peer, confirms my misgivings and casts some light on the subject. The question concerning "what he was," which Peer had posed to the Sphinx (whom he agnosticized as the Great Boyg), is not a direct one and receives no answer, but, so it seems to Peer, only a kind of echo. Professor Begriffenfeldt enters and, to our utter amazement, we hear Peer pretending to him that he *did* receive an answer, namely, "I am myself." At this point we must add that this is the answer given by the Great Boyg in Peer's dream, in response to the question "Who are you?" It seems understandable now that he remembered the Boyg's utterance at the sight of the Sphinx. But by this we are taking the liberty of anticipating an interpretation which we shall later confirm by way of a different approach. We shall supplement the answer of the Great Boyg as follows: "I am myself—(be thou thyself!) and do not desire to be my father!"—which, by the way, coincides with our original concept. The adult has renounced the pleasure principle and along with it his desire to be equal to his father and even surpass him. When the reality principle is followed, self-identity is the only solution. Therefore, these two solutions are nothing more than verbalizations of the libido conflicts in Peer Gynt, the struggle between the pleasure principle and the principle of reality. This is the same conflict we saw in the dream of the Old Man of the Dovre and can be recognized again in the cynical attitude of the "dream Peer" toward his infantile unconscious desires, the trolls. Therefore, the Great Boyg, in the light of his answer, also represents the principle of reality, which Peer has not succeeded in attaining. Its solution, "Be thyself," was projected outward as a verbalization first by the Great Boyg and now by the Sphinx. If this projection was a liberation of the pleasure ego from the harsh demands of the real ego, we shall glimpse in what follows the first visible sign of successful recovery. In response to Begriffenfeldt's question "What are you?" Peer answers, "I have always striven to be myself." The matter is quite simple. Peer makes the answer of the Sphinx his own. Here we recognize the process of reversed projection; the original projection has been taken up once again. It is obvious that restitution must take its first steps on insane ground.

I agree with Eckart that Begriffenfeldt is a personification of Peer's newly awakened conscience, but am not completely satisfied with this interpretation and suspect complications that can be fathomed only with the help of someone intimately acquainted with the unconscious dynamics of the

human psyche. At first we are surprised that Peer's insane desire to become an emperor is finally granted, although not in the same way he originally anticipated. He is recognized as emperor by someone else, and then actually becomes one—in an insane asylum. The solution is given us in the dread Peer experiences in the following scene, when he recognizes his own insanity. In other words not only does his recovery begin with the acknowledgment of the reality principle, but an exchange takes place. That which was formerly projected is now drawn in again, and in turn, his insanity itself projects. In the finest possible manner, the dramatist reveals this complicated process in the words of Begriffenfeldt:

It's that Absolute Reason
dropped dead here last night at 11 p.m....
for till that emergency, this institution
was really a madhouse....
But no longer, of course....
I said Reason was dead, that was not strictly accurate.
He's beside himself—he has got out of his skin ...
Now it's perfectly clear, beyond all contradiction.
that this "Outside-oneself-ness" will have the effect
of complete revolution by land and by sea.
Therefore all persons formerly held to be mad,
since last night at 11 p.m. have been normal
according to Reason's most topical phase.
And, if one considers the matter aright,
it follows that, at the aforementioned hour,
so-called intellectuals started to rave!

[pp. 155–6]

Let us follow the dramatist a bit and assume that this scene is not a product of Peer's projection but takes place in reality. What do Begriffenfeldt's words mean to Peer, or rather what must he think when he hears them? When Begriffenfeldt proclaims that those who once were normal are now insane, Peer, who had considered himself normal up to this time, feels that it is he who is meant, thus recognizing his madness. My calculations are correct. But we must note in continuing our examination of Peer's recovery that it does not come about with insight. That is, Peer does not recognize his insanity in himself but in an outward projection. This and also, we might add, the following scenes of his progressive recovery are most favorably to be compared with physical alleviation in the sense of "dropping ballast overboard," and not viewed as completely conscious introspection. But with Peer's "awakening conscience" (Eckart), which suddenly allows him to realize his madness, conscious introspection cannot be far off. Even our Peer must take the difficult but definite and required road to recovery.

Now that we understand these relationships, we shall lose no further time in interpreting the subsequent deeds of the "Fellah" and "Minister Hussein," which impressed Peer as such atrocities. They conveniently fill the hiatus in what we already know. Peer projected the ill part of his ego and thus achieved his final goal, i.e., to become an emperor (father). This is followed directly by

punishment by castration for this portion of his desire, indicated by nothing other than the hanging of Fellaah and the slitting of Hussein's throat. The projection is obvious in Fellaah's case when he says, "That *I* am this god Apis is as clear to me as daylight ... by birth I am Apis of Egypt, though in other men's eyes, a mere fellah. Can you tell me what I must do ... to become the renowned, though deceased, King Apis?" [p. 161] Peer recommends to him that he hang himself. While Peer's punishment is voluntary atonement, at the same time it is self-punishment (akin to Oedipus' blinding himself), carried out by Peer's pleasure ego by order of that part of him which is striving toward the real ego. The blotting out of guilt has begun and the consciousness of guilt which played the most important part in the onset of his psychosis is beginning to recede.¹⁷

Peer's recovery is still not complete. The obstacle which kept him from reconquering the external world has, for the most part, been removed, but the battle is not yet won and it would be inconceivable to expect this until he has regained his only mainstay (Solveig). But from this time onward, he presses toward home. All occurrences until his final "absolution" may still bear the mark of his madness, but it is madness in the grip of recovery.

Peer has grown old. In the fullness of his longing he strains toward home and Solveig, at the same time troubled by the fear of death. He does not want to die without forgiveness. It is a storm at sea that intensifies this fear to the point of causing a hallucination—that of the strange passenger who personifies not only death but likewise Peer's own self-reproach for his late return.

[At Peer's question as to what he is, in addition to being a *friend*]

PASSENGER: What do you think? Who else do you know
that looks like me?...

Is it his way to *show a lantern*
on life's dark journey into fear?

[What is meant here is Peer's return to Solveig at the very end of his life.] ...

Friend, have you—even *twice a year*—
honestly known what terror means?...

Well, have you ever—even *once*—
known that triumph that follows fear?

PEER GYNT: (*watching him*): "*If you've come to open a door for me*
you were stupid not to come before;
there's not much choice left to a man
when the sea's about to swallow him!...

Clear out, you monster! Go away!

I *won't* die. I shall reach the shore!

PASSENGER: Oh well, as far as that's concerned,
don't be alarmed—one doesn't die
right in the middle of Act Five!

[pp. 177–8; italics added]

The pangs of remorse in the face of death are clearly to be seen. This is where the widely divergent attempts at interpretation (which we casually touched upon earlier) come into focus. I do not intend to question the correctness of these interpretations unless they are subjectively colored to excess, in their specific constellations. For instance, I agree when it is stated that Peer is only "half human," excelling

in neither good nor evil (Weininger). I also acknowledge the fact that Peer is motivated to “repentance”—his return home being the sign of an inclination toward the “good.” But these are abstract generalities, terms we can grasp emotionally but not intellectually, just as it would be difficult to give reasons for our pleasure in a certain piece of music in terms other than emotional. This manner of unconscious understanding, or better said, unconscious resonance to the perception of an external stimulus, is of the greatest importance in the fields of poetry and the visual arts. Our conscious recognizes this only to the extent that our reaction is characterized by feelings of delight or displeasure (the conscious as a sensory organ).

The psychoanalytic approach has given us the means of making a different kind of understanding possible. It hardly seems necessary, for example, to go into the details of why I am in complete agreement with the terms “half human” and “repentance.”

Peer is shipwrecked, and after a long, hard struggle with the ship’s cook, he manages to survive by holding on to a floating plank (or boat). Mythological studies by Rank¹⁸ and most recently by Winterstein¹⁹ have shed some light on regular occurrences of the “hero’s rescue from the sea” theme. The successful interpretations of this motif as a rebirth fantasy have been sufficiently verified so that I feel I can use it in this case without fear of being accused of arbitrary interpretation. This rebirth fantasy occurs on several occasions. We run across it first in Peer’s plunge into the lake (Buck Fantasy), and again in the hallucination of the toad buried in the sand (“only his head showing”), looking out at the world in wonder and amazement.

Rebirth, or “setting foot on home soil” after the shipwreck, is to be seen in contrast to “world destruction” at the onset of psychosis.

Peer has reached home, but the road to Solveig is still not completely unobstructed. His self-punishment is over, but his moral self now places a much greater demand on him: He must prove that he has always tried to be himself. These considerations, which originate in his guilt consciousness, take on the form of castration threats from without. There is only *one* punishment for the crime of incest, as well as for the desire to become an emperor, because both stem from the same root. Let us consider the Button Molder, who makes the second demand on Peer. If we are to view him as a personification of the reality principle, then we must view the Man in Black (the Devil) as a personification of the pleasure principle. Establishing the proof of this would enable Peer to struggle through to the principle of reality, but as this is not yet the case, Peer remains only “half human.” On the other hand, he has already forsaken the pleasure principle, so the Devil wants nothing to do with him either.

The roots of the Button Molder hallucination go even deeper, and this is also determined by childhood experience. We hark back to the time after Peer’s escape into the mountains when Aase, whose last possessions have been taken from her, finds a chain with which Peer had played Button Molder as a child. Melting iron (or silver, in better days) had been his favorite pastime. What unconscious ideas could have been so active and so emotionally emphasized in the boy that they could reappear as a determining factor of this hallucination in later life? We recall Solveig’s father’s demands (after the abduction of Ingrid): “Allow life’s hard blows to crush you and *melt* you down to

cleanse your pitch black soul.”

Must we not suspect that the boy was oppressed by the “gravity of life,” i.e., by reality’s demand for abstinence; that he was desperately tormented by the two conflicting forces within himself; and that he may well have wished himself dead, i.e., unborn, and then newly born to avoid making a decision? Since “melting down” also implies punishment for the crime of incest, we can now see that Peer’s awareness of guilt does not originate in the rape of Ingrid, as I was forced to assert earlier due to the constraint of this methodical study. His guilt is deeply rooted in his earliest childhood and remains latent until brought to the surface by the realization of an unconscious desire in his stealing of the bride. Thus Solveig’s father, as well as the Button Molder and the Great Boyg, as we shall see, are all embodiments of reality (that is, of his father), which places harsh demands on the pleasure ego of the child.

The Button Molder confirms our assumption in his answer to Peer’s question [p. 209] “What, after all, is this being one’s self?”

THE BUTTON MOLDER: Being one’s self means slaying one’s Self.

But that answer’s presumably wasted on you,
and therefore let’s say: “Above everything else
it’s observing the Master’s intentions in all things.”

PEER GYNT: But what can one do if one’s never found out
what the Master intended?

THE BUTTON MOLDER: One just has to guess.

[p. 210]

Time and space do not permit me to go into the details of the following scenes. The dynamics in the alleviation of madness progress by throwing delusions “overboard” one by one. By this we are referring specifically to the scene in which Peer unravels the strands connected with his wealth, his career as a prophet, his crown of “glorious straw,” and his horse. One might say he relives all his well-known dreams, fantasies, and delusions—no doubt to prove that he was indeed “himself”—contrary to the implications of his indictment. The most interesting part of Ibsen’s intuitively correct portrayal of Peer’s recovery is the following: Peer is forced to nourish himself from onions, and in doing this becomes involved in all kinds of reflections upon himself:

You astrologer’s dupe!

You’re no Emperor! Why, you’re simply an onion—
and now, my good Peer, I’m going to peel you
and tears and entreaties won’t help in the least.

(Taking an onion, he strips it skin by skin.)

There goes the battered outer layer—
that’s the shipwrecked man on the dinghy’s keel.

This layer’s the passenger—scrawny and thin,
but still with a bit of taste of Peer Gynt.

Next underneath comes the gold-mining Self—
the juice, if it ever *had* any, is gone.

This rough skin here, with the hardened patch,

is the fur-trapping hunter from Hudson's Bay.
The next one looks like a crown. No thanks!
We'll throw that away without a word.
Next the archaeologist, short but vigorous;
and here's the prophet, juicy and fresh—
it stinks of lies, as the saying goes,
and would bring the tears to an honest man's eyes.

[pp. 190–1]

Then he sees Solveig's hut and hears her singing a familiar song:

SOLVEIG: All is made ready for Whitsuntide.

My dearest lad, though you're far away
will you still bide?

Is your burden great?

Then pause and rest—

still shall I wait

as I professed.

PEER GYNT: There's one who remembered, and one who forgot;

there's one who squandered, and one who saved.

Oh. Destiny ... There's no turning back!

Oh, Sorrow! *Here* was my Empire set!

[pp. 192–3]

After long, tedious, unsuccessful attempts at obtaining his "Record" from the Old Man of the Dovre and the Man in Black, proof that he was innocent and that he had been "himself," Peer returns once again to Solveig's hut and makes the following statement depicting his entire frightful struggle:

Backwards or forwards, it's just as far.

Out or in, it's just as narrow.

No! like a wild unceasing lament

something bids me go in ... go back—go home.

"Round about," said the Boyg!

No! Now for once

the way runs straight, though it's ever so narrow.

[p. 221]

In the utmost despair, Peer rushes to Solveig as his last hope of finding the solution to the riddle of where he has been all this time:

PEER GYNT: Where was I? Myself—complete and whole?

Where? With God's seal upon my brow?

SOLVEIG: In my faith, in my hope, and in my love.

PEER GYNT: (*recoiling with a start*):

What are you saying? You juggle with words;

you are mother yourself to the lad who is there.

SOLVEIG: I am—I am! But who is his father?

It is He who forgives when a mother prays.

PEER GYNT (*his face lights up, and he cries out*):

My mother—my wife! Oh, purest of women—
hide me, oh hide me, within your love.

[p. 222]

His head in her lap, Peer sleeps, while Solveig sings the moving lullaby:

Sleep now, dearest son of mine,
I will cradle you, I will guard you.

Child, you have nestled on your mother's knee
we two have been playing all the livelong day.

Child, you have lingered at your mother's breast
all the livelong day. God bless you, my joy.

Child, I have held you close against my breast
all the livelong day. You are weary now.

Sleep now, dearest son of mine,
I will cradle you, I will guard you.

[p. 223]

We now understand that Peer's redemption can take place only when Solveig has become as old as his mother was at the onset of his psychosis. We can also complete our interpretation of the dream in which he struggles with the Great Boyg, who personifies his father, the overpowering obstacle on his road to deliverance. The discerning reader will have had his doubts for some time as to whether I have given ample explanation of the initial impulse for Peer's recovery. I should like to supplement this by calling to mind my interpretation of the scene (from the Prophet Delusion stage) in which Solveig is sitting at her spinning wheel. This scene represents Peer's only remaining hold on reality, which, latent until this point, was released after his disappointment with Anitra, only to sink back again into *seeming* latency, shortly thereafter. Actually, however, all the delusions which follow are results of this aroused emotional drive, and thus it is understandable that this scene is followed almost directly by the one in front of the Sphinx. The libido in its new thrust toward an object encounters the old obstacle once again—the Great Boyg. Its conquest is contingent on the fulfillment of two conditions—first, the self-punishment we see in the insane asylum scene, and second, Solveig's, or rather his mother's, forgiveness. ("Who forgives him for his mother's sake.")

IBSEN IN PEER GYNT

We may now assume that the deeper meaning of this drama has been understood and that by uncovering some of the obscure correlations in its various parts a thread of continuity has been shown to run throughout the entire course of the action. I am unable to suppress a kind of questioning wonderment at the etiological congruence of the character and course of Peer Gynt's insanity with a clinical paranoid psychosis. All my painstaking proofs notwithstanding, one could almost begin to

formulate a theory that my interpretation is arbitrary, forced, and artificial. But it would be rash to draw such conclusions, which arise as a result of ambiguities in the work itself, and apply them to this definite new proof. I will not venture even to suggest the beginning of a solution at this point for the very obvious reason that psychoanalytic findings are not sufficiently substantial in this field as yet, although we must be grateful for the advanced research of Freud, Rank, and Sachs (among others), which has augmented and deepened our comprehension of the artist's psyche. For the moment, we have still not succeeded in coming closer to the more subtle dynamics of artistic productivity by way of a direct analysis of the artist.²⁰ It is obvious that an investigation which must necessarily employ this method of studying an artist's work can provide us with a discerning clarification of the product. Due to the acute danger of drawing false conclusions, however, this clarification toward final understanding of the artist and his motivations must progress at a snail's pace. One need only think of the unreliability of many biographies which are colored by individual experiences of the author, and of the fact that some autobiographies are not faithful representations due to their having been revised by a second party.

I feel justified in assuming with increasing certainty that poetry and the visual arts are forms of conflict resolutions and that the roots of these conflicts are to be sought in childhood. But is that really saying a great deal? I have in mind the recurring accusations by the opponents of psychoanalysis that it is forever finding an Oedipus complex somewhere, or finding this or that form of eroticism. I must concede that this accusation is correct to the extent that it indicates our willingness to find typical conflicts which have become dispositional, so to speak, through phylogenetic development. None of these things surprises me in the least. The question is, however: Does finding these typical complexes enable the physician to understand—or the patient to recover? What is not taken into consideration is that the *quantity* and the distribution of energy is the determining factor, and that understanding and curing a neurotic structure is possible only from this vantage point. We must also consider this: it has been sufficiently proven that infantile emotional drives are at the basis of poetry, but the important question is—how strongly are they charged with energy and in which specific cases?

Even considering all the difficulties involved, I may still be permitted to formulate an opinion as to the possible causes of the perfect congruence I have found between poetic fantasy and clinical psychosis. I shall, at the same time of course, mention the internal discrepancies.

Since Freud formulated the three developmental phases of all psychic occurrences,²¹ we know that repressed, emotionally charged experiences and desires (which are therefore always active and operative) must be present to act as *determining* factors of a fantasy. They, along with significant experiences—the basic creative factors involved in fantasy formation—result in the tendency to seek pleasure or alleviate unpleasurable tension due to libido stasis. Real satisfaction is impossible with the unreal fantasized object, which increases the stasis, causing release in neurotic pathology. The artist too has his fantasies, but is protected from mental illness by his ability to sublimate, not to mention his narcissistic satisfaction in the work he has created. This satisfaction cannot be underestimated in its function as a release. But this line of reasoning merely emphasizes the age-old story of sublimation without giving any precise information about its nature.

Perhaps we may hope to gain some insight into the problem by proceeding from a very common observation: In many cases poetic fantasy shows fewer traces of unconscious censorship than neurotic fantasy does. But what can we conclude from that? Our next step is to consider the dream interpretations which are rightly designated by Freud as the *via regia* to the realm of the unconscious. Here we discover that there can be dreams with relatively little censorship of forbidden drives in their manifest content, provided they are not recognized by the dreamer as belonging to him. This dissociation from the dreamer's personality can be a correlate of dream distortion, another dynamic of dream functioning. It is possible that the essence of poetic creativity (sublimation) may function similarly.

We cannot dismiss the idea that the hero of an artistic fantasy is, unbeknown to the artist, a projection of his own ego. As such its origins remain unrecognized, in contrast to the neurotic fantasy, in which the hero is regularly recognized as belonging to the self. This affect, which is strictly pleasure-oriented and egocentric, could possibly be transformed into interest in the hero it has "created." It need not be stressed that the unconscious charging of the hero with the artist's own conflicts provides relief due to the transition from subjectivity to objectivity. The process can be clarified by stating the problem thus: In both types of fantasy formation, the content of the fantasy and the one who fantasizes bear a reciprocal relationship to the ego with regard to the conscious mind. The neurotic is aware that he is one with the figure he fantasizes. He is not aware of the content of the fantasy, however, but only of its heavily censored appearance. The dramatist, on the other hand, is *not* aware of his identity with his hero, but he can and must be conscious of the content of his representation (in the case of *Peer Gynt*, for example, it is incestuous ties to his mother)—to the extent that it is not recognized as his own.²² Wherever heavy censorship in the form of symbolism and disguise takes place in the fantasy of the poet, we may suspect a breakthrough of his own unsuccessful repression, as we had ample opportunity to do with *Peer Gynt*.

On the one hand the poet protects himself from mental illness by means of sublimation. In this case he has a stranger (a stranger because he does not recognize himself in the hero) execute his own unconscious desires. Actually they are conscious desires, but the poet sees no relationship between them and himself. On the other hand he recognizes some complexes as his own, although they may be heavily censored (as in the case of a neurotic). Thus the finished work is lucid and resolute on the one hand, and obscure and impenetrable on the other.

But we also recognize the fact that these considerations have done little more than redefine our limitations. We are now confronted by another question: if poetic sublimation²³ consists in a projection of a part of the poet's ego, then what is the specific nature of poetic projection? In other words, what compels the poet to project? For the moment we must be content with the not very comforting information that this question is one part of the inquiry into the dynamics of projection in general (including pathological projection) and that one of the two polarities, i.e., displeasure, may be greatly involved here.

The varying degrees of effectiveness of unconscious motives and significant experiences have

resulted in the varying views of *Peer Gynt* by his interpreters. Those who saw him as a representative of humanity in general (Eckart, Weininger) did so as a result of their own unconscious understanding of the infantile conflicts of the hero. Others saw only the significant experiences which caused the drama to be written in the first place, but not the copious material which flowed into the work from the poet's pen by way of association. We agree with both views, and feel that Ibsen could never have written a *Peer Gynt* (at least not in its present form) had not events in Norway borne witness to the inadequacy and diffidence of the Norwegians, which in turn found an echo in his own personality. It has been known for some time that profound interest in external events rests on identification with them—or transference.

Our task would not be complete if we did not attempt to see the relationship between the puerile temperament found in *Peer Gynt* (and attributed to Ibsen) and the significant experiences responsible for the work's creation. There are times when it is impossible not to take an anagogic position. However, and this must be especially emphasized, I shall proceed within a framework of analytic facts. I do not deceive myself that by exceeding these limitations I will avoid the same mistakes made in most other attempts of this kind; namely, in familiarizing myself with the dramatist's desires in regard to an ideology, I might very easily impose my own views on the matter. We were able to gain some slight insight into the motives Weininger wanted to emphasize in his paper, which engendered such heated discussion. Even after a first reading of Eckart's study of *Peer Gynt*,²⁴ it is painfully obvious that it is a compromise between his own interest in the drama (due to identification with the hero) and his tendency to suppress portions of the work which betray this too overtly. Furthermore, we can see that wherever unconscious agreement was lacking, his comprehension also left something to be desired. (See Schlenther's explanation of *Peer Gynt*'s relationship to Aase and Solveig.) I have no way of proving whether the conclusions drawn by the interpreters of the drama in regard to its impulses are right or wrong, but I suspect that in some ways and in some areas each is correct in his own view.

Let us compile now all the known facts pertaining to the times and experiences from which the drama originated. *Peer Gynt* was written in Ibsen's revolutionary "Storm and Stress" period (along with *Emperor and Galilean*, *Brand*, *The Pretenders*, *The League of Youth*, 1864–70). Passarge, Jaeger, and Schlenther inform us that Ibsen borrowed the material from the folk tales and fairy tales of Asbjørnsen and Moen. (The obvious objection, that one cannot therefore make an analytic study of the work resulting in conclusions about the author, is not valid seen in the light of a closer examination. It is possible that the dramatist used the material contained in the fairy tales in a fashion similar to that contained in dreams, using unconscious thoughts to express their unconscious [dream] content. It is well known that frequently material which has been heard or read is utilized by dreamers in this very manner.)

Schlenther writes: "The first work Ibsen sent home from abroad was the poetic drama *Brand*, March 1866. It was received in the wake of the events of 1864. Here, as in the dramatic poem *Peer Gynt*, he is at his most 'Scandinavian.' He begins his attack on the Norwegians' inadequacy in word and deed, and against their isolationism and self-sufficiency. From so great a distance [Italy] he

begins to see life in his homeland more clearly and distinctly than would ever have been possible from close range, and he begins to become 'himself.' He could never have been 'oppositional' at home; he would have had to 'buckle under' or be ground down by the powers that be." The dramatist valued the life of the nation, that is, its spiritual and cultural life; more than the existence of the country per se. He does not consider the existence of a nation, and the contemporary "political and social concepts," as belonging to the necessities of life on this earth. Revolutions in his opinion can win certain liberties but cannot win freedom itself. Therefore he favors only a revolution which does away with the nation entirely. "And why? Because it would insure the individual an unlimited measure of independence and freedom for all time."

Peer Gynt is the complete antithesis of its predecessor *Brand* in every respect, and this is most clearly to be seen in a comparison of the death scenes of the mothers in *Brand* and *Peer Gynt*. We also discover that Ibsen's own youth and parents are lurking behind *Peer Gynt*'s home life and his relationship to his mother. *Brand* represents the removal of obstacles originating from that time in Ibsen's life. After he had completed *Brand* (note *Brand*'s solitude) it does not amaze us to hear that Ibsen changed from his withdrawn existence. "Suddenly he lost the appearance of a Bohemian, donned almost elegant clothes, and adopted a new attitude of sedate formality and reserve toward the world."

Work on *Peer Gynt* progressed well abroad. The author had fled in disgust over the political situation at home, and traveled with the aid of a state grant and the material assistance of an art-loving supporter and a liberal party leader. But life away from home was also not easy. The bad times he had lived through in Grimstad and Christiania (as a druggist's apprentice) were followed by sickness, misery, and also emotional storms during that era of opposition. Ibsen often felt he would have to act on his suicidal tendencies, he told his friend Ditrichson. His wife Susanna was obliged to carry the full weight of the household and serve as a pillar for him to lean upon as well. "After one of his tempestuous moods had subsided, he was often moved by a feeling of veneration for his wife, with all her deeply human qualities" (Schlenter). *Brand*, and shortly thereafter *Peer Gynt*, issued from this kind of turbulence.

"The rise and fall of the house of 'Gynt' is told from pleasant and unpleasant childhood memories," Schlenter continues. "Ibsen was born into a family of well-to-do merchants, and until he reached the age of eight the household prospered. They belonged to the 'aristocrats' of their small town and lived in high style." Then came the collapse, bankruptcy, and social decline. Ibsen was apprenticed to a druggist in Grimstad and somehow managed to struggle through to a university education in Christiania. But as a poor apprentice he found the doors to upper social echelons closed to him and thus hate for the wealthier classes was understandably kindled within him. This manifests itself in his early satires and caricatures. His first drama, *Catiline*, is clearly a sign of the era of opposition. "Ibsen now makes contact with labor leaders and takes an active part in the current social and political confusion as well as in rallies and demonstrations. He even writes for the labor union's political sheet. In July 1851, he barely escaped arrest" (Schlenter). Full of radical ideas he stood in the midst of the political uprising of 1848. The weekly paper "for literary satire and political

opposition,” which Ibsen founded with two friends from earlier days in Christiania, as well as *An Enemy of the People*, supported contemporary ideas regarding the relationship of the individual to the state and give us a good picture of the polemical, struggling, activist Ibsen.

If we see this in contrast to his later withdrawal from unnecessary social intercourse and his inhibitions among people, which Paulsen mentions in his *Memories of Ibsen*, we can see a parallel between this superficial portrayal of Ibsen and *Peer Gynt*. Ibsen’s development, his dramas, and his attitude toward women are too familiar to be examined more closely at this point.

As we have seen, what is most apparent in *Peer Gynt* is the importance that woman assumes for man. It is no less elaborated here than in most of Ibsen’s other dramas, especially the later ones. In this connection we know too little about Ibsen’s personal experiences, and the barriers surrounding the sanctity of sexual experience prohibit any possible further research. Idealization of women and belief in their moral strength characterize all of Ibsen’s dramas (even the pessimistic social works such as *Ghosts*) and give us reason to suspect his own strong incestuous fixation. But it is not this which strikes us most forcibly in *Peer Gynt* but rather the many indications of creative poetic genius which enable him to depict the struggle between the pleasure and reality principles in the hero (i.e., in the author himself). Can this be brought into connection with the revolutionary period from which *Peer Gynt* sprang?

Psychoanalysis has revealed the dynamics operating in the psyche of revolutionaries, and it has demonstrated that expressions such as “King and Fatherland” or “Mother Earth” are nothing more than a child’s (or an adult man’s) newly interpreted, expanded concepts of his relationship to his father and mother. Revolution is nothing other than the rebellion of the son against his father. Every urge for freedom is a continuation of this resistance to authority and constraint arising from restrictions placed on early pleasure drives. The emotional effect of these restrictions is the source of this continued resistance and also a decisive factor in the development of the strength needed to achieve later mature goals. But we can already hear voices raised in objection: “What then are our most beautiful and highest aspirations? Are all our moral demands for self-realization to be viewed simply as typifying pleasure drives?” Our narcissism is reluctant to make concessions. But after drawing objective conclusions we feel that knowing the origins of our aspirations can never cause us to underestimate their value—any more than we slight the wonderfully complex, highly developed human body when we assert that it evolved from a single cell, or from sexual fusion. Or is all our striving for freedom simply a farce, a comedy man is playing out before his own narcissism, causing him to be indignant when the play is interrupted? Ibsen was an *intellectual* revolutionary who had been taught a lesson by physical hardship. As such, he did not see salvation in material revolution alone. He strove for awareness, self-identity, and spiritual maturity, in Stirner’s sense, and was bitter about the burdensome fetters of his incestuous fixation. When Peer’s mother died he left his homeland (which had become a mother to Ibsen). Ibsen in turn saved himself from despair by his flight to Italy (which amounted to renunciation) and by creating a hero through projection who relieved him of the danger of going insane. Rarely is the inner involvement between political-personal striving and early attitudes so clearly to be seen as in *Peer Gynt* and *Brand*. Peer struggles with the chains of his past;

the ethical demand “to become himself” is the goal Peer must reach. He is only partly successful due to the strong incestuous tie, and as he strains toward home and Solveig, he is purified but not victorious. In this respect he is different from Brand, who concentrates his whole impulse toward freedom in his final steely “no” in answer to the call of his mother from her deathbed. Peer’s illness stems not only from his infantile, incestuous mother fixation but also from his identification with his father. Every identification with a dominant person, however, implies an intimate connection which, in the case of a father-son relationship, can be none other than one of dependency. Inability to achieve this relationship results in a masochistic-passive attitude. The first prerequisite for wanting to become “one’s self” and not one’s father is the renouncement of the father, followed by the building of one’s own strong personality. The second prerequisite is a striving for the capability to carry any and all responsibility. That is why people with a strong desire for independence, individuality, and self-identity often have very loose ties to family and home—or no ties at all; they react against the pull of early drives, which are in opposition to those mentioned above. (It is a known fact that Ibsen severed all ties to his family with the exception of his sister.) The same feelings nourish thoughts of patricide, which in itself is a source of guilt consciousness.²⁵ This guilt can urge the individual toward repentance and reconciliation or, by way of compensation, can be transformed into the aspiration to become one’s self. Ibsen’s demand for self-realization is an expression of the brother-clan principle.

Perhaps Ibsen, who was shaken by the upheavals in his era, made the same observations we make time and again in our day and age, namely that the spiritual phylogenesis of mankind has not yet reached the stage of the mature man who is “himself” (the ideal leadership type), as thousands have succeeded in doing, each in his own individual ontogenesis. Mankind as a whole, in other words, has remained in the infantile stage of needing protection and being entirely open to suggestion. The analogy is clear in the individual child’s rebellion and in his simultaneous need for discipline, which account for the contradicting tendencies in infantile humanity in general. From this viewpoint, socialistic progress (by this I mean the attaining of spiritual individuality, immanent in the concept of a material community) means becoming human, maturing phylogenetically, and having the capability to take on total responsibility, the lack of which accounts for the propensity for reaction that we see in the masses.

Thus Peer Gynt is not only the opposite of Brand but much more—a preliminary step to Brand, who has attained selfhood in spite of the sacrifices which had to be made. Patricide must be followed by renunciation of the mother (as we see in the death scene of Brand’s mother) or by castration, self-punishment (Fellah, Hussein). Only then has the goal been reached. The first instance requires forgoing one’s claim completely; the second requires concessions to the pleasure principle. (An analysis of the ideology of chastity in the German Wandervogel Movement yields similar results.) The meaning of *Peer Gynt* and *Brand* can only be discerned from their connection with one another. The two dramas form a single entity. It can never be a case of *Peer Gynt* or *Brand*—but rather via *Peer Gynt* to *Brand*.

To avoid any misunderstandings, I must state quite clearly that my views on *Peer Gynt* depend to a

great extent upon whether one sees it objectively or subjectively, that is, whether we allow it to affect us emotionally. I am aware that I would not be justified in saying that the dramatist, due to his own experiences and external circumstances, intended to call out: “This is the way it is” and “This is the way it should be” (which, incidentally, is the starting point of most anagogic interpretations). Every work of art is a projected portion of the artist’s personality, a part of his ego in the actual external world, but it is even more than that. It can never become an object to the creator (during the act of creating²⁶) nor can it become a mediator between the self and the external world, as is the aim of a scientific or philosophic work. The nature of a drama like *Peer Gynt* is determined by exactly the opposite concept—a flight of the artist from reality into his own spiritual realm, in which the world of appearances itself is animated by its own spirit. In that realm exist those fulfilled and transformed ideas whose highest form is still veiled in mystical darkness, although it is the essence of the simplest acts of perception. Again, only the quantitative factor of animation is important for productive artistic activity (the transformed force of drives in the form of sublimation). It is this factor we can define approximately, for example, according to the exclamation of delight a beautiful landscape produces in a person. Another person might be moved to write a poem or a romantic portrayal; still another might be inspired to express his feelings on canvas. If we may differentiate still further, it is the same quantitative factor that is responsible for a realistic reproduction of nature or the expressionistic disjunction of the viewer’s own intellectualized material and the perceptualized object. The artist draws on reality for objects he subsequently animates with his own fantasies and desires; he flees with them into his own spiritual world. The psychotic succeeds only in animating the objects but not in escaping with them, and thus reality and ideas collapse in a chaos of unsuccessful attempts at inner freedom. The spiritual world—the direct antithesis of reality—which finds its ultimate manifestation in expressionistic poetry and painting, and especially so in the nonverbal mysticism of music, can never be subjected to a scientific study. It can be empathized, however, and this, after all, is the very foundation upon which all artistic expression rests. We are able to recognize the relationship of the poet to the external world in the aspects of reality he chooses to draw upon, and to ascertain their genetic counterparts—unconscious fantasies and desires. In doing so we make the artist and his work our external reality and repeat the process all over again in building our own spiritual world.

With the assistance of unconscious processes, our spirit communes with that of the artist at the roots, or foundations, of the work of art. The giver and the receiver momentarily experience a new synthesis of a completely different kind.

Considered in this light, any attempt at interpreting the relationship of the artist to his own work seems inconceivable—saying that the artist means “this or that” seems absurd. What I undertook in this respect was not to interpret tendencies by considering the conscious intentions of the dramatist but to detect the autonomous emanation disclosed by analytical facts. This emanation was caused by developmental factors and directed toward a certain goal. Every interpretation attempting to achieve insight into the spirituality of an artist is, depending on the methodology, no more than a personal confession of an attitude, or merely a discovery of the portions of reality which the artist chose to use. We are not forgetting that a work of art is only a product, a proof of existence of the indefinable

spiritual world that we can only grasp emotionally, or introspectively, and not the spiritual world itself. It need not be expanded upon that the intention of a work is only a secondary result and that a drama such as *Peer Gynt* (*Hamlet*, *Don Carlos*, *Oedipus*) is never written with intent as its main purpose. It might even be said that the closer a poem comes to being a “purposeful” work, the greater the transmutation from content animation²⁷ to content reality—that is, the intent is expressed most clearly when stark reality is unaltered in the artistic portrayal. Common usage takes this into account: we use the term “poetry” when speaking of *Hamlet* or *Peer Gynt*, but we know intuitively that this term is incorrect when it is used in connection with *Die Schiffbrüchigen* or *Professor Bernhardi*. In differentiating between purpose as a central objective and as a by-product, we could formulate our views thus: In *Peer Gynt* a certain intent is visible, in *Die Schiffbrüchigen* it is forced upon us. The more animated a work is in content, the more egocentric it is; the closer its connection to reality, the more altruistic it is (as is especially the case in the social dramas of Russian origin). Between these two forms there are transitional ones of varying degree, for instance, the dramas of Strindberg or Wedekind.

I believe that I now see more distinctly the relationship between the intent of this work (in our sense of an autonomous emanation due to a certain course of development), its origin, and its critical result. The revolutionary upheavals, both material and spiritual, which so strongly characterized the era in which Ibsen lived, resounded in his own distress, and were re-echoed in early childhood rebellion against his father. Because this early rebellion was most deeply linked with an oedipal attitude, it was consequently drawn into the plot as a deterrent to despair (Ibsen’s flight) and even given central importance. This allowed the struggle for a clearly defined, freedom-oriented personality to play itself out on the ground of sexuality battling over wife and mother.

To formulate it once again: The intent of the work, originating in critical experiences (or rather made manifest therein), builds the framework for the actual plot. The individual parts of the play give us a picture of how such intentions may be formed in the unconscious and show us how they are rooted in the author’s earliest childhood.

APPENDIX

After I had finished this manuscript, it was brought to my attention that Dr. Wilhelm Stekel had recently published a treatise, “Analytical Comments on Ibsen’s *Peer Gynt*,” in the magazine *Psyche and Eros*. An examination of this article will prove an interesting and informative supplement to my views on the difference between anagogic and analytic interpretation, although it must necessarily remain a supplement. I must refrain from criticizing the contents of the article for a number of reasons (actually my paper has already covered these points). However, a short critique of the methodology does seem necessary.

Since the essay appeared in a “Journal of Psychoanalysis, Psychotherapeutics and Applied Psychology” and was entitled “Analytical Comments,” one might almost assume the study was made in the interests of medicine, using a medical-psychological analytic method. Far from it! What we

have here is an anagogic interpretation which is equally imperfect in its methodological approach since it is flying the flag of “analysis.” In all efforts of this nature, the outcome is similar to falling between two chairs while trying to sit on both at the same time. A feeble approach to an analytic inquiry only serves to heighten our apprehensions and tensions; the result is lack of clarification of the prospective function of the drama. According to Freud, dreams are the fulfillment of desires. At many points, however, the aforementioned treatise is at variance with this concept. “Dreams,” it is stated—and poetical works too—“warn and advise.” Supposedly, we can only understand *Peer Gynt* if we view the work as “the poet’s concern for his immortality”—rivaling Goethe’s *Faust*, which the author of *Peer Gynt* is said to have mentioned in a somewhat slighting manner, referring to the scene with Anitra. I quote: “... as a notable author once put it, ‘The eternal Eve draws us like magic!’”

Aslak must therefore represent Ibsen’s rival Björnson, since Ibsen’s life was a continuous struggle with Björnson in every respect. I am in no position to question this analogy since I have as little knowledge pertaining to it as Stekel has proof. Nevertheless the validity of the quote as it is used in this context may be questioned, since the rivalry is not seen in the quote itself but, if at all, in the supposedly “slighting manner” in which Ibsen has Peer speak:

PEER GYNT (*captivated, as he hands her the jewel*):

Anitra, you natural daughter of Eve,
you draw me like magic, since I am a man;
and, as a notable ...

[p. 134]

Peer’s captivation and Stekel’s “slighting manner” seem incompatible. We must bear in mind Ibsen’s well-known overestimation and idealization of women. It seems more likely that this is *self-irony*, which is supported by Peer’s relation to Anitra, a soulless, avaricious whore. Stekel slides from Goethe to Björnson whereas he could have taken the easier, more direct road via *Synnoeve Solbakken*, if indeed competition of the dramatist, as the origin of the work, is of such central importance in an analytic study. Aslak may represent Björnson, or any other father image for that matter, but stressing this aspect so heavily is like making the ultimatum sent to Serbia responsible for World War I, or tracing a hysterical seizure to some recent excitement.

Solveig is said to be “the muse of the North” and Anitra “the muse of the South”—a premonition of *Emperor and Galilean*. But here are a few more choice examples of this type of interpretation, which consists of taking single passages, sentences, or quotes out of context and arranging them according to predetermined prospective function:

Peer’s extradition after kidnapping Ingrid was “probably an allusion” to Ibsen’s *Love’s Comedy*, which caused a wave of protest in Norway!!! How does Stekel arrive at that? He doesn’t say!

The three Saeter Girls are interpreted as “three unsuccessful vignettes”!

The wretched child born to the Woman in Green is said to be a symbol for another literary fiasco—*Catilina*. (The importance of this first work of Ibsen’s for his revolutionary period is completely overlooked.) The interpretation of Peer’s being blinded in one eye by the Old Man of the Dovre is

supposedly so that he will no longer see the world in a bipolar manner!

The comparison of the Great Boyg with Goethe's Mephisto is as unfounded as all the rest of this author's interpretations. I will gladly agree with him that the cry of the Great Boyg "He was too strong, there were women behind him" is an expression of the victory of heterosexuality over homosexuality in *Peer Gynt*. I accept this as a valuable explanation of an obscure passage for which I myself could find no meaning. On the other hand, I must disagree with him in the emphasis placed on the struggle between hetero- and homosexual drives and must adhere firmly to those most detailed accounts in my own work regarding Peer's vacillation between the pleasure principle and the reality principle, between narcissistic and object libido.

May these few examples demonstrate the value of a method which calls itself "analytic" but which does not hesitate to draw apodictic conclusions from isolated elements of a work like *Peer Gynt* (through which we toiled so painstakingly), neglecting to trace its sources back to the literary impulses of its author. In four printed pages it ventures to prove that *Peer Gynt* sprang from rivalry with Björnson. It overlooks the external elements, the motives for Ibsen's flight, his material distress, and so much more. But most important of all, it does not linger for a moment on Peer's phantasmagoria or the situation in the insane asylum, and misses no opportunity to carve out the analogy to Goethe's *Faust*, solely on the basis of the Great Boyg's saying "I am I myself," i.e., the "other companion," which supposedly alludes to Mephisto.

*A Case of Pubertal Breaching of the Incest Taboo**

In the following I should like to report a case history which will clarify the oft-debated problem of incest and show that under certain circumstances the incest taboo is breached by admitting to one's consciousness the desire to have sexual intercourse with one's own mother.

In this particular case we cannot use the terms "degeneration" or "psychopathic inclinations," as it involves a thoroughly intelligent, capable young man in his twenties. He was a student at the Technological Institute who came to me seeking an analyst who could cure him of the severe depression from which he had been suffering for several years. His depression was supposedly rooted in feelings of inferiority which recently had become so intense that he could no longer pull himself together sufficiently to do any work. He previously had been interested in everything and successful in all his undertakings, but he now began to fear the possibility of public disgrace. When called upon to speak he "felt all choked up" for fear of saying something nonsensical. He had begun to speculate on the meaning of all this and now his feelings of inferiority (which had not left him entirely) were replaced by the desire to be alone constantly and to brood. He was no longer able to explain the situation to himself. "Whereas I used to brood about my feelings of inferiority which, I kept telling myself, were utterly uncalled for, I now brood aimlessly, be it over the inanities of daily life or small irrelevant occurrences. No matter what they are, I attach too much importance to them. Needless to say, my previous ambitions don't even bear talking about."

From our short, superficial conversation I could only surmise that I was dealing with a compulsive symptom (a brooding mania). I readily offered to find him an analyst who would be sufficiently interested to treat him without charge, as he had originally made it quite clear that he could not afford a long-term analysis. Since none of my colleagues could accept the case immediately, I offered, for the moment, to help him over the worst of the depression. It is well known that even a few sessions of open discussion can often relieve depression, even if only temporarily.

Four weeks of daily sessions (one hour each) followed. The closer we came to a certain point in his development (puberty, the importance of which will soon become clear), the more reluctant he became to confide everything. One day he stayed away altogether and thereafter failed to return. Approximately two weeks later a long letter arrived in which he apologized for his behavior: "I was unable to put that one period in my life into words, and since I realized it would be senseless to continue without complete candor, I decided to carry on as I have before." Appended was a list of memories which had been awakened during our sessions, as well as many additions valuable for an understanding of that "period in his life," which I shall present verbatim.

Before I continue, however, a short sketch of his background is necessary. He was from a well-to-do family, the oldest of four children, all healthy and now holding public office. He was raised very strictly by his father, always having to achieve more than his siblings in order to satisfy his father's ambition to have industrious children. From earliest childhood a deep tenderness bound him to his

mother and it was she who often protected him from the violent excesses of his father. His parents' marriage was not a happy one; his mother "suffered terribly" because of his father's jealousy. At five or six, he had already witnessed horrible scenes of jealousy. Often his father had become violent. The boy had always been "on his mother's side." This is easily understandable since he himself was terrorized and loved his mother fervently. Because he had matured sexually at an early age sex was not a mystery to him, even at the age of five. He was also physically well-developed, which contributed to his being able to have intercourse for the first time with the maid at the age of eleven and a half; although, it should be mentioned, at her instigation. From fourteen to eighteen, there was a period of masturbation alternating with occasional sexual intercourse. At age fifteen, the first slight feelings of inferiority found expression. From the age of twenty-one on, these feelings began to increase, accompanied by depression. The compulsive brooding began after he had met and fallen in love with a girl much less intelligent than he, who then "betrayed" him. In the brief time I spent with the patient I could not determine exactly how much faith one might place in this last bit of information. I believe I am not far wrong in thinking it was probably a matter of his imagination.

So much for the most important, although certainly not the most interesting, elements of his life story. The "period" on which the analysis so quickly ran aground due to the patient's conscious inhibitions is that in which his mother had carried on an affair with his private tutor. The boy had observed it from its inception, and after a lengthy description of his mother's beauty, in which he seems to be offering excuses for her, he says in his letter:

N. [the tutor] began to court her. He arranged for pleasant drives and seemed to become bolder as he became aware of the situation at home [the outbreaks of jealousy between his parents, etc.] and also of the fact that she fancied him. I am not quite sure just how the affair began because I didn't notice anything. I first became conscious of the situation and began to keep track of it one afternoon when Father was asleep and I saw my mother going into the tutor's room. The feelings I had at the time were partly erotic curiosity and partly fear (fear that Father might wake up—I thought no further). From that day on I continuously played the role of *monitor* and *pursuer* but also that of *defender*,¹ in the event of a possible surprise by my father. I cannot explain to myself the reasons for my behavior. Either it was my unconscious hate of Father or the erotic tingling involved in being party to such a horrible secret that prevented my telling Father anything. I think both of these elements were equally responsible for my behavior.

The relationship grew deeper; not a day passed in which they didn't seek and find an opportunity to be alone. This situation lasted about three months. Their afternoon meetings were limited to just a few minutes and I never thought of the possibility of their having "sexual intercourse." One day, however, I became certain of it. Father had gone out about six o'clock and Mother had disappeared into N.'s room and remained there for a long time. During the entire period I waited in the foyer, struggling to decide whether to disturb them or to report it to Father. Some very vague feeling restrained me from deciding to do either. Then, when Mother (oh, what a terrible ring that word now has!) came out of the room, which I could see was completely darkened, with flushed cheeks and a wild darting look in her eyes, I knew for sure; it had happened, although I had no way of telling whether or not for the first time. I stood in a corner, cowering behind a cabinet with tears streaming down my face. I wanted to run to her. But it didn't happen that way, to the great misfortune of us all. I am still deeply convinced that seeing me at that point would have brought her to her senses, even though late, and saved us our mother and Father his wife. This would have been the only possible salvation.

Just what held me back at the time I cannot say, but at the same moment I began to feel pity for Father, and gritting my teeth, I crept away. (At the time I was eleven and a half or twelve years old.) ...

Shortly after Christmas Father went away for three weeks. During that time I had the most horrible and repulsive experiences imaginable, which buried themselves deep in my thought and emotions.

During Father's absence Mother slept in the back bedroom at the end of the hall, then came our room, the dining room, and

then N.'s, one connected to the other. The very first night (I hadn't shut an eye from excitement) I heard Mother get out of bed—even now disgust seems to be strangling me—and tiptoe through our bedroom in her nightgown. Soon I heard his door open, and close partially. Then all was quiet. I jumped out of bed and crept after her, freezing, with my teeth chattering from cold and fear and horror. Slowly I made my way to the door of his room. It was ajar. I stood there and listened. Oh, the frightful memories that drag each recollection of my mother down into the dust, that soil my image of her with muck and filth! Must I go into details? My pen refuses to obey me. No, it is I myself refusing with all my might—but I want to, I will, I must describe it.

I heard them kissing, whispering, and the horrible creaking of the bed in which my mother lay. Ten feet away stood her own child, a witness to her disgrace. Suddenly all was quiet. Probably I had made some sound in my excitement. Then his soothing voice, and then, then again, Oh!... [The last paragraph, and especially the last few words, appear to have been written under severe stress, with thick, confusing pen strokes.]

To bring some composure to bear on this nerve-racking tragedy, some equanimity—what a superhuman effort it takes! To view it objectively—what a mockery! What an undertaking!

All I remember of that catastrophic night is that I wanted to rush into the room, but was held back by the thought: They might kill you! I recalled having read that a lover will kill anyone who disturbs him. With a head full of bizarre fantasies I crept back to bed, without hope of consolation, my youthful spirit broken.

And so it happened, night after night. I followed her to his door and waited there until morning. Gradually I became accustomed to it (!!). My horror gave place to erotic feelings. *Once I even considered breaking in on them and demanding that she have intercourse with me too (shame!), threatening that otherwise I would tell Father.*²

During the final few days I visited the maid regularly.

There follows a detailed report of the tragic death of his mother, who poisoned herself after her husband discovered the affair. Two other points of outstanding importance are mentioned. First, after the death of his mother, the patient's relationship to his father showed marked improvement. Gradually he became "my best friend and adviser." Second, he wrote that he had recently begun to masturbate again, always imagining a certain woman in his fantasies (first one, then another), but he was never satisfied with the choice he made. "In my fantasies I was looking for one of the many women I had slept with, but none of them seemed quite right. Finally I wound up masturbating with the fantasy of a body alone, never visualizing the face belonging to it, and can recall feeling small compared to the immense body I imagined beneath me." On the days following this kind of masturbation, the depressions increased in intensity to the point of being intolerable, until at one time he was close to committing suicide.

Let us look past the tragedy of this case and examine it, to the extent the material allows, with regard to what is most noteworthy, namely, the patient's conscious desire to compel his mother to have intercourse with him and his struggle with the incest taboo. The latter called forth that outcry "shame!" and caused the conflicts which resulted from this situation.

From the very start I must abstain from etiologically correlating this traumatic experience with the compulsive brooding and depression which followed. The time available for analysis was far too short to provide even a partially successful glimpse into the development of the neurosis, but it cannot be denied that a connection exists between the two in view of the following facts: We recall that his compulsive brooding began when he felt betrayed by the girl he loved. The analogy of the father's betrayal by the mother comes to the fore. A young man will naturally feel at times that being betrayed is indeed tragic, but only very rarely does he react by developing neurotic symptoms. In this specific case, we must also remember that he felt the girl was intellectually inferior to him, and that we have

considerable evidence (for example, numerous capricious love affairs) that he did not take his love life too seriously. Once, however, he did confess that he ended these relationships “with a heavy heart,” but really only because he “felt sorry” for the girls.

His father was indeed “completely crushed” by the catastrophe; this could also indicate an identification with the father, which we can infer from still another angle. “The feelings I had ... were partly erotic curiosity and partly fear.” That he played the role of “monitor and pursuer but also that of defender” reflects the conflicts ravaging him at the time. It is not surprising that he played the part of monitor if we consider that he was in the midst of pubertal libido storms and that he had already successfully passed the first test of his sexuality (intercourse with the maid). Further, we discover that at age four, while sleeping in the servants’ room in his parents’ absence, he had often heard his younger brother’s nurse and her lover having intercourse. There is no justification for viewing this as a masked recollection and suspecting a hidden meaning, although, as Freud pointed out, memories of this kind do occur with regularity (for example, the memory of seeing two dogs copulating can conceal the repressed memory of hearing the parents having intercourse).

From his disproportionate tenderness toward his mother and his hate of his austere father we may, however, justly conclude that he suffered, not inconsiderably, from an Oedipus complex. When he assumed the role of the pursuer, it was because his mother had been untrue to him. He pursued her as his father’s proxy—a role which certainly must not have been an easy one, since he was at the same time defending her (“in the event of a possible surprise by my father”). The question that arises here is why he plunged himself into these conflicts to begin with. Wouldn’t it have been simpler to tell his father everything, thus taking revenge on his mother for her unfaithfulness? He may have had a number of reasons for not doing this. His conscious reason may well have been fear of his father’s terrible vengeance, since he was well acquainted with his jealousy and irascibility. We will not go astray, however, if we ascribe much greater importance to his unconscious. We may conclude from his desire to have intercourse with his mother (while he was standing behind the door) that this incestuous thought had been active in his unconscious long before he observed the beginning of her affair. Even earlier—as he mentioned during treatment—he had noticed that his mother always kept his father company prior to his afternoon nap, and always behind closed doors. He had assumed at the time that “they must be having intercourse.” We can now see that the occasions on which he listened for or observed or thought about his mother’s intercourse begin to show a certain similarity, and thus we may assume that they were a causal factor in his later brooding. His unconscious incestuous desire must have been all the more activated by his observing the affair since it did not involve sexual intimidation by his father (namely, fear and recognition of his father’s superiority). His unconscious reasoning may have run: “You will be able to dispose of him [the tutor] more easily.” It also occurs to me that although he had been aware of the intercourse between his father and mother as well as his mother’s affair, both when he was between eight and twelve years old, it was only during the latter that the incest taboo was breached. Perhaps a situation mentioned by Freud played a part here, namely, that a child who hears his parents having intercourse forms an unconscious picture of the mother

(previously so highly esteemed) as a prostitute. Later, he becomes a steady client of prostitutes, because it is only with them that he can find satisfaction.

His mother's extramarital intercourse may very well have affected him in the manner mentioned above, particularly after hearing his father calling her a whore in his outbreaks of jealousy. This outspoken humiliation of the mother may therefore have encouraged his unconscious incestuous desire, so that in the end it did actually break through into his conscious mind.

The improvement in his relationship with his father after his mother's death is still another proof of his oedipal inclinations. After the source of their rivalry was removed, the rivalry itself ceased, probably aided by identification with the father (notice his "pity" for him).

Finally, a word regarding the patient's recent masturbation fantasies. In the light of his own story and our present knowledge, there is absolutely no doubt that he selected his mother as the object of his fantasies during masturbation.

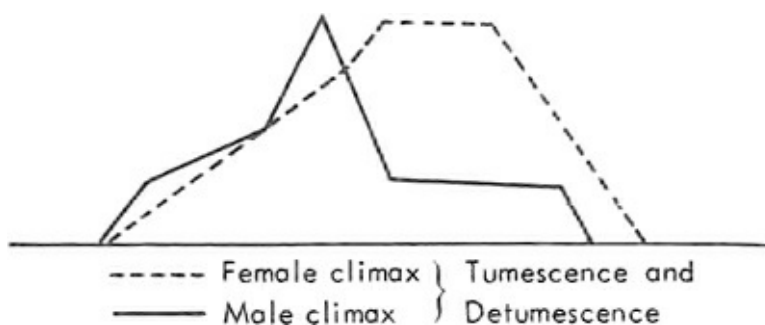
Furthermore, it must not go unnoted that, aside from guilt resulting from the Oedipus complex, another important factor contributing to his depression must be taken into account: He was the silent partner in this "horrible secret," and although he believed it lay within his power to save the family, he failed to rush out from behind the cabinet and bring his mother "to her senses."

In closing, I should like to formulate the possible conclusions one can draw from this case: In the male child between the ages of five and twelve, the period of sexual latency (Freud), sexual intimidation due to feelings of inferiority to the father plays a definite part in the development of the incest taboo. For this reason the intimidation represents, in a certain sense, a necessary cultural convention.

*Coition and the Sexes**

In a very interesting article, “Concerning the Time Differences in the Sensations of the Sexes during Coition,”¹ Urbach has attempted to interpret the interval discrepancy between the male and female climax stages as a phenomenon with a biological purpose. (He draws on the physiological research of Rohleder, Waldeyer, and others.) His reasoning is approximately as follows: In the male as well as in the female, one can distinguish three stages of coition: (1) intensification, (2) climax, (3) evanescence. (Stages 1 and 3 correspond roughly to Havelock Ellis’s “tumescence and detumescence,” whereas stage 2 would either have to be placed between them or moved to the beginning of stage 3.) Even if the quality of these stages is equal in both sexes, there is still a noticeable difference in quantity—rather, an increase in quantity per unit of time (see the inclination of the curves).

Aside from this, the climaxes do not coincide, inasmuch as the male orgasm takes place somewhat earlier—or the female somewhat later. There is little reason to doubt that Urbach’s graphs for the male and female orgasms are correct when viewed separately. They seem to be applicable (aside from occasional variations) to the average normal individual. My criticism is directed against: (1) the graphs being superimposed upon one another, i.e., I do not agree with the general validity of the statement “The female climax normally takes place later”; (2) the biological interpretation; (3) the assumption that the findings indicate a reasonable, biologically founded possibility of remedying this discrepancy with a second male orgasm during coition.



Urbach states that normally the male ejaculation and orgasm precede that of the female. It is further stated: “The more the female genitals assist, the stronger and fitter the sperm will be when it reaches the point of amphimixis and the better the product of the coition will be” (M. Vaerting). If, according to Urbach, the female climax were to precede that of the male, circumstances for conception would be especially favorable: The uterus would have moved downward, the mouth of the uterus would be open, and the mucous plug would protrude. The male sperm would then have a means for its transportation into the uterus immediately after ejaculation, and the time interval between ejaculation and amphimixis would be reduced to a minimum.

Hence the optimal conditions for conception would exist if the male orgasm were to take place later. The opposite phenomenon, the delayed female climax, appears to work against such ideal conditions. Urbach says: “Indeed, if we consider the strangely retarded course of the female

sensations, we receive the impression, rather, that nature intended a second male orgasm and with it of course a second flooding of the female genitals with sperm.”

In our opinion it is not feasible to resort to a means of scientific interpretation which has as its premise an a priori postulate (in this case “reasonable, biologically founded”) simply for the sake of adhering to the essentially reasonable in every natural phenomenon. Might we not as well ask why nature employed such complicated means to achieve her goals, as, for example, the male orgasm taking place sooner? This, however, is not favorable for conception. Therefore the course of the woman’s arousal must be slower and with a horizontal climax, so that the male can achieve a second ejaculation, thus finally bringing about the optimal conditions. If we are to chat with nature about her ways and means, we might ask her why she didn’t arrange to have the male orgasm follow the female in the first place. The observation is usually made that the natural way is the simplest and the least complicated. Why, then, would a natural phenomenon be complicated, especially in the realm of procreation, on which the very existence of nature itself is based. Does not every complication in means enlarge the possibility of failure of the entire undertaking? Let us also consider that if the retarded course of female sensations was correctly interpreted by Urbach as a means to evolve a second ejaculation of the male, we would notice a steadily progressing decrease in humans and animals. Among animals a second ejaculation appears to be nonexistent, and among human beings it is seen only in the abnormally potent or more often during the first years of frequent cohabitation and only in a state of complete psychic well-being. Did Urbach, in his search for nature’s meaning and purpose, consider that the “reasonable” never manifests itself in the extreme but always in the frequent and regular?

Let us recapitulate. The statement regarding the discrepancy between the climaxes is correct; its biological interpretation is not. I do not deny that conditions for coition would be significantly better if the sequence of events were reversed, or if the male were to ejaculate a second time. I think, however, that it is more important to attempt an investigation, not of the final outcome, but of the basic causes for this seemingly unreasonable discrepancy (to the extent that we accept the postulate of reasonableness, which I am inclined to do in a case involving the elementary natural phenomenon of procreation). The following comments are in support of this attempt.

First, we must inquire as to whether the climax interval, as described, may indeed be termed “normal.” In doing so, we shall not view “normal” in terms of biological intent but rather in terms of individual psychic well-being and the possibilities of mutual satisfaction. I must emphasize that I do not by any means consider a condition “normal” because it occurs in a great majority of cases. Even without further proof we are able to say that in the case of simultaneous male and female climaxes satisfaction is assured, and that in the case of separate climaxes—especially the premature climax of the male—the satisfaction of the woman becomes questionable. There are many otherwise completely potent men whose erections decline shortly after ejaculation, and others whose erections are prolonged for an appreciable time thereafter, in which case the time discrepancy of the orgasms has little effect on the woman’s satisfaction. In the former case, however, the woman’s satisfaction is affected, her orgasm being contingent upon the erection of the man. Thus, we may be permitted to use the term

“normal” from the psychological standpoint for simultaneous orgasms and for non-simultaneous orgasms with prolonged erection. If we proceed not only biologically but also psychologically, we shall see that above and beyond the automatic, physiologically conditioned result of the three stages of coition (as represented in the graphs), psychic influence is also exerted upon the acceleration or retardation of the tumescence. I am, of course, omitting cases of heightened excitability, for example, after long abstinence, or for certain endopsychic reasons. It can be said that a certain concord of the partners is necessary for normal coition leading to equal satisfaction. This concord can influence the purely involuntary reflexes during the act. Disturbances of this capacity to influence can spring from various causes and can occur, as we shall see, in individuals who are apparently completely healthy.

Essentially, there are two such causes, the psychological and the sociological, which have a strong reciprocal effect on each other. One can best orient oneself as to the premise on which a diagnosis of “healthy” or “normal” is based by examining cases in which the preconditions are pathologically distorted and consequently appear greatly magnified. Impotence in the male and frigidity in the female doubtless belong in this category.

Beginning with the mildest disturbance of potency—*ejaculatio praecox*—there is every imaginable intermediary stage up to the most severe cases of total incapability of having an erection. Psychoanalytic treatment of such illnesses regularly reveals one characteristic common to all patients suffering from impotence. (There are a host of other individual attitudes, usually responsible for the severity or the specific character of the condition, such as guilt feelings, conscious or unconscious homosexuality, etc.) This one characteristic is the split of all libidinous drives into a tender and a sensual component. This split is most obvious in cases of facultative impotence, where, for example, the patient is always unable to have intercourse with his own wife but never fails with a prostitute. Anyone previously amazed at the mention of social factors as a cause for the time difference between the male and the female climax need only consider that we can observe the same discrepancies at their most blatant in the structure of our society, namely in the double sexual standard and in the existence of prostitution.²

Concerning frigidity in women, it is amazing how much less frequently the psychotherapist is called upon to treat this ailment as compared to impotence. The sparsity of cases, and hence our lack of experience, renders impossible valid conclusions as to the nature of frigidity, as well as to its effect on male ability for coition. What has been gathered from analysis and other sources to date gives rise to the assumption that the factors involved are essentially similar to those in male impotence. Usually it is neurotic refusal of the intended or self-elected mate. In many cases male impotence seems to be responsible for protracted frigidity. In other cases frigidity can be readily overcome by the adeptness of the male partner if, for example, the necessary repression of clitoral sexuality, or rather its transference to the vaginal tract, was not successful during puberty. Suitable behavior on the part of the male can result in a subsequent transference unless deep-seated psychic disturbances are present. In the analysis of male patients one often discovers facts that are usually given too little attention or overlooked altogether. For instance, there are many women (it would be impossible, without detailed

statistical data, to say just how large a percentage) who are continually more or less frigid without ever feeling indisposed, women who aren't even aware of the existence of the female orgasm and who find compensation in their children. We may perhaps place most working-class* mothers in this category. In these cases social urgency (i.e., children and work), as well as the husband's lack of interest (but not impotence) in satisfying his wife, may be at fault. We shall come across lack of interest again later. Generally speaking, one cannot relate vaginal hypaesthesia to frigidity in women since—as is well known—other parts of the body may assume the function of achieving satisfaction, even in a healthy woman. Perhaps we may be permitted the following analogy: A woman may be compared to an electrically charged ball; a man likewise, but with a point extending from the ball (the penis). In the same manner in which a major portion of electricity will be centered at the point extending from the ball, male sexuality centers around the penis. Female sexuality would appear to be more diffuse. The predominance of artfulness in movement and dress in women, and the specifically female flirtatiousness, among other things, are indications of this and appear to be equivalents of penis sexuality. One might very cautiously postulate that vaginal sexuality on the one hand, and the sexuality of the entire body on the other, are reciprocally proportionate. Men frequently report disappointment in the erotic responses of very coquettish women but unexpected pleasure in those of women who appear outwardly cold. Thus the horizontal orgasmic line in the graph of the female is justified. The question remains, however, whether it is also as high (on the average) as that of the male.

Ejaculatio praecox closely resembles the earlier male ejaculation termed normal by Urbach. It contains somewhat pathologically accentuated elements which in the healthy male are the results of certain individual and social experiences. We might put it this way: All else being equal, the predominance of individual infantile experiences, combined with circumstances generally causing impotence, results in ejaculatio praecox. Predominance of social factors results in a lack of interest in the woman's satisfaction. As mentioned previously, a splitting of the unified libidinal drive into a tender and a sensual component is marked among impotent individuals and in our society. Let us first examine the former.

Ejaculatio praecox and facultative impotence usually occur together, but the former also occurs separately and in relation to all women. It is the expression of a certain unconscious fear, usually that of castration. The patient may also have inhibiting ideas, e.g., that a woman has teeth in her vagina, or that something exists at the end of the woman's "tube" that snaps at the penis, etc. However, when ejaculatio praecox is also a symptom of facultative impotence, these fears are augmented by an express antipathy toward coitus with a woman of the patient's own social class, even his own wife. The reasons for this antipathy and for the curiously undisturbed potency with prostitutes can be found, on close investigation, in a split of the first love object desired as a child (usually the mother, the nurse, or an older sister) into two opposing figures: first, the prostitute and second, the unattainable, idealized, "sacred" woman, to be approached only with the utmost reverence. As Freud³ demonstrated, the concept of the whore originates in that part of the mother figure which submits to the father. While still a bachelor, this kind of patient will indignantly reject any thought of having intercourse with the

girl he reveres. Should he subsequently marry her, he will prove to be facultatively impotent (assuming all other conditions for a neurotic illness are present). In severe cases he may be totally impotent; in milder cases he may only experience ejaculatio praecox. Men of this type suffer from overidealization of women.

The sexual habits of our contemporary upper-class youth show striking parallels to this kind of neurotic pattern. Conditions previously caused by experiences in early childhood now appear to be caused by external (social) influences. Let us take a closer look at socio-sexual connections.

A girl is raised in complete abstinence until she marries. If her husband suits her sexually, she experiences satisfaction. If not, either she remains unaroused and finds satisfaction in her children or (according to her temperament) she has an extramarital affair.

A young man, twenty to thirty years old, who cannot afford to marry early, lets off steam in brothels with prostitutes of “better or worse” quality, according to the size of his wallet (sensual component). Usually he will also carry on a platonic love affair with a girl of his own class on the side (tender component). Now it is well known that prostitutes are incapable of having an orgasm at all, or at least only with their pimps. A very few—usually young—simulate an orgasm, but this soon has little effect on an experienced man. Therefore, young men are quick to adopt a certain apathetic attitude toward women and attempt to compensate for the pleasure they should derive from the anticipated or desired participation of their partners by resorting to more or less perverse variations in coition. Needless to say, they dare not repeat the stimulating sexual practices later with the girl they marry. This results in apathy or disdain toward women (the opposite is the case in the impotent).⁴ The male behaves completely egotistically, as he did with prostitutes, since he has seldom if ever experienced an increase in his own pleasure through the orgasm of a woman. Consequently he makes no attempt to satisfy the woman, or voluntarily to modify his own reflex stages during coition, that is, to adjust to the woman. Despite the existence of other ample emotional ties, the relationship lacks psychosexual bonds, the egotistic-altruistic factor which leaves the man partially or completely dissatisfied if the woman is left behind. In other cases the man may miss the sexual finesse of a prostitute and the opportunity for the sexual variations he practiced earlier. At this point it should be noted that variation in the mode of coition represents a necessity for both parties if the general human need for sexual variation and polygamous tendencies are not to lead to dullness and mutual alienation. If we inquire as to the origins of this aversion to necessary variation in monogamous relationships, we receive just one answer: “The marriage chamber is not a whorehouse. A decent woman wants nothing of such filthiness.” This matter must, of course, remain a very personal decision, but it cannot be denied that the aversion does stem from the contrast between marriage and prostitution.

I should like to stress the fact that I do not view the earlier ejaculation of the male as a minor case of ejaculatio praecox within the realm of normality. In the latter, the distinguishing factors are fear of castration and idealization of the woman; in the former, disdain and lack of consideration for the woman’s satisfaction. In both cases the etiologically significant libidinal split accounts for their similarities.

Aside from this, the statement that the male orgasm takes place earlier physiologically can be confirmed by the time relation to the orgasm of the woman. Certain factors seem to be generally responsible for the prolongation and reduced intensity of the female orgasm: (1) diffuse sexuality; (2) lesser capacity for excitation due to relatively less well-developed muscles in the lower pelvic cavity (especially *M. ischiocavernosus* and *bulbocavernosus*), those responsible for the greater portion of male sexual pleasure; (3) repression of clitoral sexuality, a component of genital eroticism, which may result in the greater or lesser repression of vaginal sexuality (highest degree: frigidity); (4) the possibility of finding ersatz satisfaction in children or in a substitute for them—i.e., the male who has regressed to infantilism after coition;⁵ (5) finally, as the fifth factor involved, we might mention the socio-cultural demand for premarital abstinence so closely related to point 3 and the double sexual standard (division of unified drives in society) with which it has common roots. These same roots are indispensable in psychic impotence and are also responsible for male undervaluation of women.

Thus, the time discrepancies in the acme peaks and the relatively lower excitability in women (see height of curves on graph) seem to be caused by physioanatomical and individual psychosocial factors. Both of these are contrary to the consistent, biologically based, impulses of the male (that is, in their influence on the suspension or reduction of his involuntary coition sequences).

When the tender and the sensual components coincide, it is of course an entirely different matter. An experienced man who has equally strong physical and emotional ties to a woman is able, if he is fully potent, to modify his physiologically based coition sequences voluntarily, due to his feelings for the woman. Thus he will achieve his climax approximately simultaneously with her and in so doing also come close to fulfilling the optimal conditions for conception. When he is more quickly aroused or when the woman is somewhat slower, his ejaculation will take place earlier but his libidinal interest in his partner's satisfaction will enable him to maintain his erection until it has fulfilled its purpose. *What nature demands is therefore not a second ejaculation but that both tender and sensual impulses coincide.* In the light of circumstances mentioned superficially above, this is very rare indeed. Its significance, however, could not have been overlooked if the emotional factor had not been disregarded. Practical experience shows very clearly that complaints of not being satisfied are rarest in marriages conducted under favorable circumstances and so-called free love affairs, to the extent, of course, that deep-seated individual emotional problems are not present.

The behavioral differences of the sexes before and after coition are also worthy of a brief examination. Since it is inconceivable to take all possible variations into account, we shall limit ourselves to two frequent types of behavior. Here too the origins may be traced back to the division or coincidence of tender and sensual impulses.

A very common complaint of younger and older married men alike is that sooner or later feelings of indifference or even disgust toward their wives arise after they have ejaculated. In some men this feeling of disgust soon diminishes and makes way for a renewed tumescence; in others it suppresses any further libidinal impulses and can even drive them to flight. The latter is very often the case in men who visit prostitutes. Aside from early infantile ideas that the vagina and the anus are one and the

same, a lack of any tender impulses toward a woman bought with money (aided perhaps by the unconscious anal connotations connected with money) is often sufficient to give rise to distinct feelings of physical disgust. Similar symptoms are by no means rare in a neurotic context in hysterical girls and compulsive men. In the impotent they are very frequently expressed in flight from the wife.

When the libidinal impulses are undivided, the opposite is the case. There is no urge to separate, but rather an equally intense, although qualitatively different, desire after coition. Male behavior becomes more childlike, more infantile and passive, while female behavior becomes motherly and more active. Both are interesting phenomena with deep, unconscious roots which cannot be discussed here. I shall compare behavior before and after climax in a purely descriptive manner, and it must be emphasized again that I am making an abstract of all possible variations. In healthy individuals the following behavior may be considered more or less usual. Prior to coition the male assumes the overpowering, striving, and active role. The female's activity lies in her passivity (female passivity acts as a stimulus for male desire, in the animal kingdom as well). She wants to be sought after and overwhelmed (occasionally her desire is intensified by pubertal defloration fantasies). This reciprocal behavior continues throughout the 'stage of tumescence; only in exceptional cases under particular conditions can it be reversed. Gradually, male activity transforms the female's passivity into activity, which increases in unison with the male's until orgasmic climax is reached, at which point the reverse sets in. Now male behavior becomes passive, although not in the sense of flight. His nature becomes more infantile, he nestles against the woman, while she begins to show a previously obscured component of her inclination toward him. Now it is she who embraces him, whereas prior to coition, while she was the object of preorgastic male aggression, she may very well have kept her legs pressed together and her arms close to her body. The male's behavior corresponds to his deepest early infantile desires and fantasies. At that time he actively desired his mother but had to submit to repression. If he escaped this renunciation without harm and subsequently succeeded in breaking his attachment completely during puberty, there will follow a repetition of those first infantile actions. This is augmented by the fulfillment of his burning infantile desire: The mother has now been attained in the form of an image and the satisfied male immediately strives for gratification of still earlier desires; he is once again the child in his mother's arms. The woman's behavior, also determined by her own infantile experiences, complements that of the male. She too in early youth desired her father, perhaps just as actively as the male child his mother, and wanted to have a child by him. Her activity (clitoral sexuality), which had been forced during puberty to yield to an attitude of activity by means of passivity (vaginal sexuality), is now revived. The desire to have a child by her father rarely becomes conscious; if so, only after years of marriage. She does, however, find a child substitute in the male who responds as a child due to his own regression.⁶ Now she can play the part of mother. If her own oral fixation is not strong, her desire to *be* a child will flow into a desire to *have* a child (it reverses itself). Or these desires unite to form a very characteristic female attitude: she lies there embracing the man totally with her arms and legs, and pressing against him as if seeking shelter. Her awareness of the possibility of having just conceived a child contributes in turn to her anticipating the child in the man. Thus, early infantile desires of the healthy man and woman meet and, in cases of

complete harmony, individual psychological phenomena coincide with biological tendencies.

My report has barely scratched the surface; much of it was presented in far too schematic a form. A broader, in-depth examination would have assumed dimensions too great for an article in a journal.

Let us summarize. A man with emotional ties to his wife will voluntarily influence the physiological-reflexive sequences of his stages of coition, thus achieving concurrent climaxes and, indirectly, favorable conditions for conception as well.

The behavioral differences of the sexes before and after coition are also biologically meaningful although they are psychically determined. Having completed his procreative function, the male becomes passive, "he has fulfilled his biological duty" (analogy: the death of male insects, ants, bees, termites, after fertilization of the female). New duties and work now await the female; her activity has been aroused and is a necessity for pregnancy, the birth and care of the expected child.

In examinations of eugenic and biologic problems, one repeatedly comes across the strange and sometimes incomprehensible neglect of individual psychological factors. With all due zeal and care devoted to the welfare and perpetuation of mankind, man himself is often forgotten. The arguments for biological purposefulness in nature (which we do not deny) are often farfetched. Very often they sound convincing and beautiful, sometimes so beautiful one might think: "If only it were true!" But there is no cause for dismay, for nature does indeed function wisely, although differently from what most people imagine. Freud once expressed it thus: Nature presents her representatives with a lovely premium for their procreative activity—namely, the pleasure of coition. Her survival is secured. Man, however, thinks he knows better than nature; thus, he recommends a second ejaculation. It would be most desirable if the biologists and population specialists would devote themselves to the idea of the pleasure premium as a guarantee for propagation.

*Drive and Libido Concepts from Forel to Jung**

PREFACE

In recent years the theory of drives has undergone a number of transformations and interest in it has increased significantly. From the leading sexologists (Forel and Havelock Ellis among others) to Jung, with his more advanced concepts, we come upon the most diverse opinions and trends. Hence a synopsis seems to be called for. The following survey is designed to serve this purpose although it can only cover the most important drive theories, i.e., those best suited to demonstrate the development of the concept of drive. For understandable reasons, our report is mainly uncritical; criticism would have overburdened it due to the great variety of views and methods employed by the individual researchers. The arrangement of the subject matter corresponds to the ever-widening scope of the concept of sexuality and the transition from descriptive to interpretive drive psychology. The path to the latter was cleared by Freud's research and his discovery of the great significance of unconscious (repressed) material and infantile experiences for man's emotional life. The path from intellection to drive was followed via the patient's chain of associations, and thus Freud's psychology was destined to become mainly in-depth research in the field of drive psychology. For this reason I shall examine Freud's theory in greatest detail and present the genetic views of Jung, a former pupil of Freud, at the very end of this study.

FOREL, MOLL, HAVELOCK ELLIS

Forel¹ extends the drive theory beyond the limits of the descriptive standpoint less than all other researchers. His achievements in investigating instinct in intelligent insects (ants, bees, termites) are truly impressive, but it appears that his interest in this field obscured most of the possibilities of correctly viewing the conditions prevailing in human beings. The following will illustrate the peculiarity of his methods: "The fury of the sexual drive constitutes all of love in low creatures. As soon as this function has been fulfilled, love ceases. Only in higher animals can a permanent affinity be formed ... Mankind as well falls under the spell cast by the fervor of love, or better said by the fervor of sex. His whole outlook is colored by this ... The most common and even the most disgusting things become ... objects of intense desire ... This, briefly sketched, is the general view of the sexual drive ... However, we must analyze this drive more carefully. Natural drives are deep hereditary instincts reaching far back into the phylogenesis of our animal forebears..." He continues by stating that every drive is the motor aspect of nerve activity, supposedly the "inner something" impelling us to action. For a drive to be possible there must first be a sensation that causes it, as well as certain sensory stimuli that put the feelings in motion, and through this also put "the respective drive in motion."

"Therefore, it may be stated that drive mechanisms belong to the deep, phylogenetically inherited

automatic reflexes, which, as is known, are complicated and composed of temporally separated, successive, coordinated reflex actions, but nevertheless do not possess the actual plasticity of the so-called voluntary actions, which are dependent purely on conscious cerebral activity. These drive mechanisms cannot adjust to new, unforeseen circumstances and fail to function if the chain of events that caused them is broken. We must assume that instincts or drives are accompanied by a subconscious introspection (the subconscious) which, as such, can hardly achieve a connection with our higher consciousness (the usual consciousness of the waking state).”

That which we call sexual love in humans supposedly consists of the drives and emotions which have reached the cerebral cortex, namely, the contents of higher consciousness in a unified form. The emanations of these drives combine here with all other elements of the cerebral cortex, such as feelings, intellect, and will. Hence these are the secondary emanations of the animalistic sexual drive.

“Libido sexualis (sexual desire) is the manner in which the sexual drives of man express themselves.

“Since the male is the active party, his sexual desire for coitus is the greatest; normally it awakens in puberty but may nevertheless be stimulated by poor example at an earlier age and directed into unnatural channels.”

In a similar vein, he continues—with the necessary alterations—to treat the sexual drives in women. Finally, flirting is defined as a form of activity of the sexual drive without coition taking place.

Moll² differentiates between drives of contractation and detumescence; the former is more psychic in its nature and causes the sensation of being drawn to another, whereas detumescence signifies physiological relaxation.

Havelock Ellis accepts this classification but differentiates further between detumescent and tumescent drives. In his opinion, tumescence is physiological preparation for the sexual act, namely, erection of the penis, secretion of the Bartholin glands in women, increase of tension through various acts, in particular stimulation by observation or by kissing and touching the erogenous zones, and so forth. When the tension has reached its climax in coition, detumescence takes place, i.e., the relaxation of the male in the form of ejaculation and of the female by orgasm (but not invariably), causing convulsive spasms of the abdomen which may spread over the entire body. Here we find a significant approximation of Freud’s forepleasure and end pleasure, to be described later.

Moll³ pursues this in further detail:

One’s own observations immediately show that two completely different processes are involved in sexual drives. First, the process in the genitals, which is partially unconscious and partially brought to the conscious surface through the usual tactile or other similar sensations. Second, the loftier psychic process which draws the male to the female and vice versa. In reality both groups of processes are united in normal sexual relations. However, they are not only analytically separable but may also be observed clinically isolated from one another in specific cases. Some time ago I used this differentiation for the analysis of the sexual drive by describing the drive related to the periphery as the detumescence drive (from *detumescere*, meaning “to decongest”) and those processes related to physical and emotional attraction to another individual as the contractation drive (from *contractare*, meaning “to touch physically, to show emotional interest in”). To clarify this it is most advantageous to examine cases where these processes appear isolated from one another. There are mentally retarded individuals who practice

masturbation as a physical act because they are simply driven to it by sensations from the genitals, just as itching on the skin makes one want to scratch. They masturbate without thinking of another person, and they do not feel the need to have sexual contact with another human being. An analogy to this may be seen in the animal kingdom as well, in the masturbation of apes, bulls, and stallions ... The second component, the contraction drive, may also be observed from time to time in isolated form. There are boys who have the urge to touch, kiss, and think of women long before the visible beginnings of puberty, but who lack thoughts of masturbation or any other act involving the genitals. [I shall add: who lack any *conscious* thoughts ...] Such individuals are often quite surprised when one day these ideas are reflected in the genitals, be it simply in an erection or in erection and ejaculation while embracing a girl. In the sexually mature male, detumescence and contraction are consolidated, and this results in the compulsion to detumescence when touching a woman and finally to engage in intercourse ... The same holds true for women.

The sexual drive, and indeed both components of it, may be aroused either by physical or emotional stimuli. However, we must note that both components are so intimately fused in normal adults that they can only be separated analytically ...

On the connection between central processes and peripheral erotic sensations, Moll comments:

Let us first examine the question concerning the means by which pleasure and the simultaneous sensation of satisfaction are achieved ... The peripheral processes in the genitals are not always sufficient cause for these occurrences, as is often assumed. A homosexual who fantasizes a man during heterosexual intercourse, and thereby has an erection and subsequently ejaculates, does not experience pleasure or the feeling of satisfaction. In other words, although all peripheral processes occur normally, satisfaction is lacking because a sexual act adequate to the sexual drive is not present. However, the same homosexual finds erotic pleasure and satisfaction in the embrace of another man sympathetic to him.

Regarding erotic pleasure sensations in children, he continues:

It is extremely difficult to gain clear insight into this ... especially since erotic sensations as entirely subjective processes are so difficult to recognize from without. This much may be said: I feel convinced that sensations equal to later adult erotic sensations are aroused in childhood, and even in earliest infancy. However, we must be cautious in assuming this in specific cases. Certain rocking motions of nursing infants and other small children are often enough construed as proof of masturbational processes and of satisfaction obtained, but I feel that this is frequently incorrect. Such motions can be the expression of general well-being [I question this] without having the slightest connection with sexuality and specific erotic sensation. Of course, the latter does occur in small children and perhaps even in infants. When a child lies in its bed with misty wide eyes and manifests externally all the signs of sexual excitement as seen in adults, we may justifiably assume such erotic sensations.

Sexual excitation in children has since become an established fact. In every case of psychoanalytic treatment, conscious memories of erotic sensation were present, even in earliest childhood. It need not be mentioned that the reservations of those adhering to the non-analytic method of observation as to the existence or norm of sexual sensations during childhood are caused by limited externally perceivable indications. Furthermore, even in cases where questioning of a patient takes place in psychotherapy, a certain rapport with the patient is necessary to obtain such deep-seated admissions. Frequently, for inexplicable reasons, sex becomes the object of prudery even in doctor-patient relations. This is completely inappropriate and often even harmful, as it obscures important factors for comprehension of an ailment. But in psychoanalytic treatment itself, weeks of perpetual waiting for contact (transference) to be established are often required before the patient finally emerges from his reserve regarding sexual matters.

THE PSYCHOANALYTIC THEORY OF DRIVES

Definition of Sexuality

A report on the psychoanalytic theory of drive and libido is impossible without an introduction to the psychoanalytic concept of sexuality.

Since manifest actions of the sexual drive are the only directly observable elements of sexuality, we must be able to characterize these according to at least one feature common to all sexual acts. This may then enable us to place an action in the category of a sharply circumscribed complex involving a certain intellectual content.

Freud draws attention to the fact that the greatest difficulties in understanding complicated sexual processes and the danger of not being able (or not wanting) to comprehend certain sexual acts arise from confusion between “genital” and “sexual,” and also from the equating of sexuality with procreation. Sexuality is the broader concept; otherwise it could not for example include perversions.

Pre-Freudian sexology recognized procreation as the essential function of normal sexuality, subsuming under this concept everything that serves this function even indirectly. Sexual acts performed by individuals who rejected procreation or abhorred it were labeled “degenerate.” Recall the old dispute over inversion and the extreme views expressed on “degeneration” and “the chosen third sex.”

Freud expanded the concept of sexuality to include two further elements. One, normal infantile sexuality, was recognized first, although merely as an abnormality. The other, the neurotic symptom (neurosis as the converse of perversion), aroused great controversy in competent circles in regard to the ever-present, etiologically effective sexual element as postulated by psychoanalysis. After research by the Freudian school made it impossible to overlook the obvious fact of the primarily sexual etiology of neuroses, and (to the extent established until now) of many psychoses, influential circles began to admit that sexuality could be one of the many causes of neurosis, but nevertheless rejected Freud’s claim that the sexual factor could be repeatedly found in the etiology, whereas the other factors either were lacking or varied in the frequency or intensity of their appearance (see later remarks on this conflict).

It follows that we can distinguish four main groups of sexual behavior: normal sexuality (i.e., for the purpose of procreation), perversions, infantile sexuality, and the majority of neurotic symptoms. (According to Freud, a neurotic symptom is the result of repressed, unsatisfied libido and a substitute for a sexual act which the neurotic was forced to deny himself for some reason [I shall discuss this later].)

If we now return to our first question as to a common feature of all sexual behavior, we find that procreation (as a criterion) is of no help as it is inherent only in the normal sexuality of adults, and even here exceptions must be made, since no one could support the claim that two individuals about to engage in sexual intercourse are always completely preoccupied with the thought of begetting children. On the contrary, this attitude is extremely rare; for individuals to engage in coition with the conscious desire to procreate is an example of the sexual act in its purest form. Can this be a criterion

when it is known that the greater portion of humanity engages in the coarsest and most refined sexual practices for entirely different reasons? And what is the motive for this? There can be only one answer, i.e., sexual pleasure.⁴

In *Beyond the Pleasure Principle* Freud expanded this explanation of drive motivation in several directions. Proceeding from an examination of traumatic neuroses and the behavior of certain patients who during treatment repeatedly act out unpleasant situations from their lives, Freud arrives at the conclusion that the pleasure—un-pleasure principle does rule the drives, but that above and beyond this they are also based upon compulsive repetition. “The manifestations of compulsive repetition ... display a high degree of drive character, and when they oppose the pleasure principle, a high degree of demonic character.” Further: “... it is obvious that repetition and the renewed discovery of identity are in themselves a source of pleasure.” The sexual drives, he continues, are the actual life drives: “There is a kind of magic rhythm in the life of organisms; one drive group storms ahead to reach the final goal of life as soon as possible, the other turns about abruptly at a certain place along the way in order to cover the same path again from a specific point onward, thus lengthening the duration of the journey.”

Compulsive repetition binds the impulses which threaten to overwhelm the organism (for example, traumatic neurosis). This binding secures the control of the pleasure principle within which subsequent release pleasure is possible.

Freud draws attention to the fact that the word “pleasure” has two meanings:* “pleasure” as desire, i.e., directed toward something; and “pleasure” as a specific sensation during certain acts or thoughts, i.e., non-directed. The difficulties of an exact definition also arise (aside from individual peculiarities and the complicated nature of the pleasure—un-pleasure mechanism itself) from the fact that a “pleasure” (desire) can exist which is itself already pleasurable. It now becomes clear that the word “pleasure” (*Lust*) must be used with great care, and that pleasure, in our sense of the word, may be used to indicate only specific sexual sensations. It must be added that a great deal which our consciousness perceives as non-pleasure springs from pleasure via devious paths (neurotic anxiety: defense against forbidden pleasure by the more highly developed ego).

The desire toward achievement of non-directed pleasure, characterized by its own sensation complex, leads us to an action without which fulfillment of the desire⁵ is impossible. (Desire, action, and pleasure are causally interrelated.) This action, plus the pleasure created by it, is sexual and forms the only manifest part of sexuality. It follows that we must examine the sexual phenomenon from two aspects to gain further insight, namely the individual, subjective pleasure principle, and the biological, objective procreation tendency. In normal beings, both sexual components are united in coition. One might say both the individual and the germplasm are satisfied. The perverse individual, however, has placed his sexuality outside the realm of the procreative tendency. The capability with which he was endowed, to gain pleasure as a premium (Freud) for services rendered in the interests of the germplasm, can no longer be taken from him, despite his having withdrawn from fulfilling his task. In children, the organs of procreation are not yet mature, although the means of achieving pleasure are

already functioning. The absence of the procreation component is common to these latter categories. The neurotic is a sexual hyperaesthete, or a pervert with a negative symbol, namely, an individual who was forced to repress his sexual desire because it was too strong or not compatible with the reality principle (Freud; see below), but did not succeed in doing this, so that the repressed libido is released in symptoms.

If we review the relationship of these main groups to one another, we find that they differ mainly from a quantitative standpoint, in regard to libido activity and cathexis in the sexual fields.

In the following we shall no longer concern ourselves with neurotic symptoms.

Infantile sexuality and perversions both lack the procreation tendency. However, the causes for this differ; whereas in the former it is caused by the immaturity of the procreative apparatus (in the literal sense), in the latter it can be explained by the behavior of the other sexual component (the individual pleasure principle) existent in all three main groups, and especially by disturbances in the development of infantile sexuality. Perversions are infantilisms documenting themselves in the lingering acts of precoital pleasure mechanisms. They are the result of developmental disturbances (fixations of libido). The same holds true for neuroses, with the difference that they are caused by unsuccessful repression.⁶

I mentioned previously that the areas of normal sexuality and of perversion differ quantitatively from the area of children's sexuality, i.e., in cathexis intensity (libido cathexis). I must now add that the areas of sexuality in children are also more numerous. Many of these disappear in the course of development due to a mechanism of drive development (sublimation and reaction formation) to be described later. However, some of these areas can persist if the corresponding drive is preserved, and they strike us later as perversions (for instance, coprophilia when reaction formation has not taken place, and other perversions for which we find no model in normal forepleasure mechanisms). And then again there are perversions which cannot be explained by the preservation of a homologous area of sexuality with intensified libido, but must rather be traced to a highly complicated compromise in infantile partial drives (for example, homosexuality as the result of a critical deflection from the mother toward the father).

In general, the following principles hold true as postulated by psychoanalytic teachings: Infantile areas of sexuality coexist as equals, if one takes into account their use by corresponding partial drives. In normal sexuality, the field ruled by genital libido prevails, whereas the others partly undergo involution to auxiliary functions and partly "wither" due to sublimation of corresponding partial drives. In perversion, a field of activity predominates which under normal circumstances would have been reduced to one of the many forepleasure mechanisms and is either not directly connected to actual genital functioning or completely independent of it (sadism, fetishism). It need not be mentioned that satisfaction always occurs here in orgasm and ejaculation, the essential difference being that satisfaction is not achieved through genital activity. Freud qualifies this in regard to one group of perversions, which come under the heading of inversions of the sexual object (i.e., homosexuality and sodomy). Here, direct genital activity exists, but the perversions have arisen from a compromise of infantile partial drives which do not represent the direct continuation of infantile

sexual activity.

An outline of infantile sexuality. The infantile sexual phase extends from the time of the first sexual manifestations, shortly after birth, until puberty, that is, until that point at which the child's sexuality (with completely developed genitals and the ability to produce sperm and ova) is augmented by the procreation component and the elements of the individual pleasure components undergo their final alterations.

Within the infantile sexual phase, Freud differentiates several periods:

The first sexual period. Sucking, oral-erotic activity, is the infant's first sexual act, which at the beginning is combined with the alimentary drive but soon strives for independent satisfaction. There can be no doubt as to the sexual nature of sucking when one observes a child with "flushed cheeks gazing starry-eyed into the distance," sucking the nipple and immediately sinking exhausted into a deep sleep. Freud notes that these are orgasmic symptoms observable in adults also and that increased vasodilation, lessened receptivity to external stimuli, and falling into a deep sleep are always manifestations of sexual origin. In the adult the oral-erotic activity is retained in the search for a homologous sexual action, and we find it again in the form of kissing ("kiss connoisseurs"). Psychoanalysis has also proven that smokers or food nibblers were especially strong nursers.

The mucous membranes of the mouth constitute an area of sexual activity, an erogenous zone, as do all other areas of the body where skin changes into mucous membrane. But sucking activity does not limit itself to a pacifier or the mother's breast for long, and soon encompasses other parts of the body as well, such as fingers, toes, etc. A child thus slowly becomes aware of its own body and in the search for areas of new pleasure also discovers its genitals. Due to their (probably) phylogenetically established, strong predisposition for erogenous response, they are now the scene of a newly emerging sexual act, namely (infantile) masturbation. This infantile act is frequently observed, and includes actions of an extragenital nature. Its purely sexual nature is verifiable in the state of the infant during masturbation (i.e., flushed cheeks, convulsive movements, heavy breathing). Freud emphasizes that the intensity of this sexual act, as well as stimulation of the genital zone during cleansing, which must take place here especially often, may be counted among the most important factors in establishing the primacy of the genitals in later normal sexual development. This is the stage of autoerotism, encompassing several sexual acts which involve the infant's own body.

Autoerotism is further expanded by the child's devoting more attention to the functions of those individual parts of its body from which pleasure is derived. Accordingly, the mucous membranes of the anus assume the function of an erogenous zone. The passing of feces through the anus is pleasurable for the child, and to enjoy these sensations as intensely as possible, it refrains from defecating until this takes place as a reflex action. This is called anal eroticism and is usually coupled with urethral eroticism, the pleasure of urinating.

To continue our observations: What pleasure we see in the eyes of a child before it can speak when it pulls our hair, pinches our nose, or digs its fingers into our cheeks, and how much happier it becomes when we simulate pain! This is the pleasure derived from inflicting pain, the field of activity

of the sadistic partial drive. (It is well known that the explanations are not quite this simple and that the question of sado-masochism and its basis, skin and muscle eroticism, still remains unanswered. Here I must refer to the works of Sadger⁷ and Federn.⁸)

The child now wants to demonstrate its physical presence in the world, if I may formulate it thus. How can this be achieved better than by showing off those parts of its body which are most precious and the greatest source of pleasure, i.e., the genitals? It exhibits, but soon begins to desire that it be shown something in return and becomes a voyeur.

Thus, in the period from birth to the first love object selection at approximately age four, Freud distinguishes between oral sexual organization (activity on the mucous membranes of the mouth—sucking) and pregenital, sadistic-anal sexual organization. He does this because the activity involving the genitals remains almost completely in the background, while sadism, anal eroticism, and urethral eroticism come to the fore. Exhibitionism and voyeurism occur only during transition from the autoerotic stage to the first object selection and are much more intimately related to the genitals, as is object selection itself. All these activities may actually be established either as potential or as partially or completely manifest phenomena. One or the other may predominate, depending on the individual. This fact prompted Freud's assumption of a general polymorphous-perverse disposition in childhood.

The second sexual period. Many areas of sexual activity involved in the first sexual period disappear (under normal circumstances) with entry into the second, due to sublimation of the corresponding partial drives and to reaction formation. Anal and urethral eroticism, as well as the pleasure derived from playing with one's own excrement, vanish completely, oral eroticism persists in the form of kissing, and sadistic and masochistic activity recede greatly, without completely disappearing however. Voyeurism and exhibitionist tendencies, which were only faint during transition, are intensified in connection with the genitals, which now present themselves as the predominant means of sexual activity in this first genital (or second sexual) period. Likewise, skin and muscle eroticism, although already present in the first period, begin to assume greater importance. The latter, in particular, reaches its peak in the less restricted movements of the child from approximately age five until puberty and is then continued in normal, physically healthy individuals until menopause, although it constantly decreases.

The first⁹ love object selection takes place at approximately age three to five. The first object is one or several individuals caring for the child (mother, father, older siblings, nurse, etc.). This period is one of the most influential in the course of sexual development. Most complexes take root in this phase and, if they are very strongly developed, form a basis for an immediate fixation or for a later externally caused regression to this particular infantile stage.¹⁰

Object selection usually falls on the heterosexual parent; the son wishes to take the place of the father and marry his mother; the daughter wishes to assume the role of the mother and have children by her father. Of course, there are no concrete ideas of coition and the genital zone during this stage does not particularly overshadow the others, unless (as happens more frequently than one suspects) the child has heard, or even seen, parental coition and then wishes to "do the same thing" with his

mother.¹¹ This and everything connected with it Freud called the Oedipus complex and designated it the central complex of all neuroses. In this category we must also place the feminine attitude of the son to the father (identification with the mother) which is essential in understanding stuttering, inferiority, etc.

The Oedipus complex results in castration fear in boys due to slighting by the father, or frequently even to a direct threat of penis amputation. In girls, the result is envy at the sight of the boy's penis. The notion that the penis was cut off, or is simply very small and still to grow, plays an important part. Both are combined under the heading "castration complex." However, we must warn against taking the concept of castration too literally and interpreting it only as penis amputation. Actually every inferiority feeling,¹² in whatever area it falls, belongs in the category of a castration complex. Feelings of inferiority are nothing other than a direct continuation of the son's attitude toward the father (especially the austere father), rooted in feelings of dependence and to no small extent in the options and superiority of the latter, which finally climax in the idea: Father is allowed and is able to do more than I.

The castration complex often joins with sadism, forming the so-called sadistic concept of coition. When the child, seeking enlightenment, hears or even sees parental coition, and concludes from the groaning and other sounds that the father is hurting the mother, he subsequently construes this as castration. The castration complex, combined with the Oedipus complex and sado-masochism, can then become passive or active castration desire (as opposed to castration fear). Only during childhood and in the dreams and slips of adults can these and other similar manifestations of the castration complex be directly recognizable as such, inasmuch as they disclose thereby their direct rooting in the sexual constitution. More difficult to prove, and often verifiable only after months of analysis, is the fact that other adult psychic peculiarities also originate in the castration complex, for instance, the well-known adult inferiority feelings which at first sight appear to be entirely rooted in the ego constitution. Adler, who constructed his theory of the "desire for power" on these inferiority feelings, contends that, coupled with ambition, they form the core of neurosis. His contribution was very significant in that he demonstrated how feelings of inferiority, once present, constrain the individual to compensate, and also showed the importance of the resultant desire for power in the life and development of man. Adler's theory is actually just the further pursuit and elaboration of Freud's insights into the castration complex in the ego structure, although he denies its sexual origins; in other words, he denies the sexual intimidation of the child who is devoted to the pleasure principle, by its father in particular, and by its entire training. But every in-depth analysis is able to prove this to be true. Wherever the core of a neurosis is not the castration complex but some other infantile trauma (for example, neurotic illness due to repressed homosexuality), an explanation using Adler's theory of the desire for power will fail.

This phase of first object selection (at age three to five) is followed by a period of sexual latency. However, this should not be interpreted as complete sexual stagnation since the peaks of the constitutionally strongest fields of sexual activity emerge repeatedly even while the entire sexual level

has, so to speak, ebbed. Analyses of adults have shown that sexuality is “at work” in this stage as well, not in the conscious but in the unconscious. Between the ages of five and twelve, psychic dams and reaction formations are constructed against culturally unacceptable partial drives; disgust counters anal eroticism, shame counters exhibitionism, and, in general, every morally pertinent concept begins here. These reaction formations are aided and accelerated by training at home and in school, as well as by the general coercion exerted at the child’s first introduction into a social community (kindergarten, school, etc.). However, the idea that disgust, modesty, morals, etc., are a product of education and exclusively caused by it is completely erroneous. Education is but a catalyst accelerating the process of reaction formation and perhaps strengthening it. If nothing exists, nothing can be created, and it is the infantile partial drives which serve as the raw material from which culturally required elements are fabricated. Disgust and modesty, inherent psychic qualities, can be neither dispensed, transferred, nor taught. Education merely awakens the child’s drive to imitate. A poor wretch can never be shown the best way to enjoy life, even by the wisest suggestions, and unintelligence cannot be remedied by the most refined didactics. The prerequisite remains that raw material must be present.

Another function of the latency period is the sublimation of certain partial drives. This is described by Freud as the “diversion of a drive from sexual to loftier asexual goals.” The essence of such sublimation can be recognized most clearly in artistic and poetic qualities.

Furthermore, the incest barrier is erected during this stage, probably by sexual intimidation by the father.

When complete maturity of the procreational organs per se is achieved, sexuality, as mentioned earlier, is enriched by the procreation component. It would be superfluous to point out the well-known pubertal somatic changes in male and female. It is important to emphasize thoroughly, however, that there is no “awakening of the sexual drive in puberty,” as is stated in every physiological, biological, and even in many sexological textbooks. What occurs is rather a synthesis of all individual impulses (partial drives) into a unified whole, with particular emphasis upon the genital zone. The instatement of the “primacy of the genitals” is indeed one of the most important and significant processes of puberty. A vigorous libido thrust (perhaps caused by increased activity of the Leydig cells) draws all attention to genital sensations, and the tremendous, previously unknown pleasure of the first ejaculation secures libido fixation psychically to its normal sexual goal, namely ejaculation and sexual object selection—women in the case of men and vice versa. An unconscious revival of the Oedipus complex expressed in tender impulses (tender, in the sense of attenuated due to the incest barrier as opposed to the blatant, sensuous impulses of the child) then aids in choosing a normal heterosexual direction. A mother or father image is selected (second object selection). The childhood partial drives sink to the level of forepleasure mechanisms, thus enabling us to view every new courtship ending in intercourse as a brief recapitulation of sexual development from infancy to puberty. Detachment from the first love object is not always so simple and may not take place at all when parents lavish unnecessary tenderness on their children. This can completely inhibit the process of detachment so essential for an individual’s health.

There are two sides to every coin. Severity and a lack of parental love have proved damaging to a

child's ability to love; on the other hand, it is the parents' responsibility and duty to refrain from showering excessive love upon their children, thereby stimulating the revival of the Oedipus complex, which the unconscious and the child's training has somewhat ameliorated and which is now aligned with the demands of the second object selection. Among other factors, the authoritative inhibitions of society have a positive effect on the choice of a heterosexual course. Where these are not effective, inversion will be more frequent.

In the pubertal development of women, there is still another important task to be fulfilled, namely, the repression of clitoral sexuality and its transference to the mucous membranes of the vagina. The formerly active, masculine, aggressive libido current must now be directed into passive channels, although partial retention of clitoral sexuality is necessary. If female drives are to be correctly understood, we must emphasize that during puberty the woman merely replaces her active goals with passive ones, since passive drives per se do not exist.

The regular recurrence of masturbation during puberty takes on special significance. This is caused, and accompanied, by unconscious, incestuous desires which have now become active. Their only manifestation is a powerful guilt feeling, for which the layman makes "self-defilement" by masturbation accountable. In reality, the guilt feelings flow from unconscious incestuous desires. Likewise, the infantile castration complex plays a negative role, making pubertal masturbation a perilous reef to circumnavigate. Pornographic literature, and the lack of understanding and orientation of some doctors in sexual matters, also contribute. Psychoanalysis has been able to demonstrate that masturbation (unless of course excessive) is not injurious and that all supposedly harmful results (depression, etc.) spring from guilt consciousness. When the latent, frequently unconscious, content of masturbation fantasies are exposed, pathological manifestations disappear.

Drive and Libido

I shall now turn to the concept of drive and libido, as portrayed by the Freudian (i.e., psychoanalytic) school.

First we must differentiate between drives and other physiological stimuli.¹³

A stimulus implies something coming from without and affecting the nervous system. The reflex arc enables us to withdraw from the effect of a stimulus through muscular activity (to quote Freud literally, "muscular flight"), by dispatching the stimulus in the direction whence it came. In the same way, one could relate drives to external stimuli on the premise that the drive may be classified as a psychic stimulus. However, our efforts to equate the two are frustrated by consideration of the existence of other psychic stimuli much more akin to physiological stimuli than the aforementioned drive stimuli. In connection with this, Freud cites the example of a strong light striking the eye in contrast to dehydration of the mouth (due to hunger). He feels that the former is not a drive stimulus, but the latter is.

The differentiation between drive stimuli and other physical stimuli appears to be assured in the light of certain discrepancies between the two which render any analogy impossible. Whereas the

latter come from the external world, the former originate within the organic core. External stimuli may be discharged (i.e., released) through muscular flight, but this is impossible with drives. A principal difference lies in the manner of their appearance. An external stimulus may be compared to a single dynamic thrust. Even when it appears to be continually active, it may, upon closer examination, be broken down into individual thrusts which, in convergence, seem to be of a static nature. As opposed to this, drives are characterized by their urgent, constant force, which, at the most, can vary quantitatively. Thus we arrive at the more adequate expressions: “need,” pertaining to drive stimulus, and “satisfaction,” for the manner in which the drive is discharged.

To sum it up, a drive is characterized first by its internal origin, second by its inability to be released by muscular flight, and third by the constancy of its force.

This is the physiological point of view.

Observed from the biological standpoint of the law of expediency, the task of our nervous system appears greatly complicated by the introduction of drive stimuli. Whereas in certain physiological stimuli we recognize expediency in response (i.e., discharging of the stimuli through muscular flight), we find that in drive stimuli we not only fail to withdraw from the sources of stimulation but rather are attracted to them, as they represent the only means of gaining momentary satisfaction.

The expediency of drives lies in their functioning as propellants of progress, since they can occur only when the individual is in close contact with the external world. This contact can never be attained through physiological stimuli but is invariably established through drives, because the objects through which drives are satisfied lie in the external world and we feel constrained to seek them out.

Freud has also weighed the possibility of phylogenetic drive origin resulting from the precipitation of external stimuli. This hypothesis may well be completely congruent with Semon’s theory of engrams.¹⁴

Therefore the drive may be defined, from a biological standpoint, as “a concept bordering upon the psychic and the somatic, a psychic representation of stimuli originating within the body and penetrating the psyche, and a measure of the work demands imposed upon the psyche due to its relationship with the body.”

In drives we can differentiate between four characteristic elements which must be present if we are to use the term “drive” at all. These elements are: urgency, goal, object, and source.

1. *Urgency* is the measure of the work demands represented by the drive, and at the same time is its motor component.

2. The *goal* is satisfaction, the cessation of stimulation at the drive source.

Drives always achieve their goals via certain channels. It may happen, however, that a drive is inhibited or diverted, resulting in only partial satisfaction; we then employ the term “goal-inhibited drives.”

3. The *object* is that which provides satisfaction. This can be a component of the external world or a part of one’s own body.

A drive can have more than one object, and one object may serve several drives. (Adler refers to drive restriction.)

Objects are always interchangeable, although a permanent fixation of the drive on one object may also take place which, as we shall see later, plays an important part in the etiology of neurosis.

4. The *source* is defined by Freud as “that somatic process in an organ or part of the body causing stimulation of the psyche, as illustrated by a drive.”

A subdivision of drives according to object or aims is impossible due to their variability. Also not feasible is a subdivision according to their urgency, which, although quantitatively different, is inherent in every drive.

There remains only a division according to the source, and this leads us to two primordial drives that cannot be further divided, the sexual drive and that of self-preservation. The former serves to preserve the species, the latter to preserve the individual.

In psychoanalysis, this division was the result of recognition of the etiology of so-called transference neuroses (hysteria and compulsion neurosis), and it also appears to be supported from the biological standpoint (see above). In any case, there are two views here:

1. The individual is independent; sexuality is one of his activities.
2. The individual is an aspect of the immortal germ plasm.

Freud believes that the source of the sexual drive is in specific sexual, chemical¹⁵ substances circulating in our organism, accumulating in certain areas (glans penis, clitoris, mouth, anus) and causing these areas to become erogenous zones.

Freud’s sexual chemistry underlies not only the existence of drives but also their quantitative fluctuations. Through external stimuli, sexual (chemical) processes, and thus indirectly the propelling force of the libido, are intensified. However, these are questions which await further research.

We find here more than a mere description of the manifestations of the sexual drive. Freud is attempting to solve the riddle of the formation of drives. He raises libido to the status of energy stemming from the conversion of a second form of energy (see the chemical theory); this, in turn, is partially active as procreative energy—the energy of a new living being—and partially transformed into intellectual achievements (sublimation).

The Freudian libido concept may be summarized approximately in the following general definition: The sexual drive is a quantitatively fluctuating, impelling force. In adults it is the unification of manifold infantile impulses into a composite whole, a single urge with a single goal. Its energy, the libido, is entirely different, however, from the energy upon which other psychic phenomena are based, due to its special origin. The libido is also of a qualitatively different nature and its qualitative disposition is (probably) caused by special chemical reactions which set it apart from other psychic phenomena.

In children, libido is a purely narcissistic, so-called ego libido, and generated almost equally by all organs of the body. It is characterized by its general incorporation into the ego of whatever provides the child with pleasure, even if this lies in the external world (i.e., introversion).

From this primary, original, narcissistic libido, the object libido develops progressively, that is, cathexis of sexual objects with “guards” posted by the “commanding officer” ego libido. Only now

can the libido be examined. The individual directs sexual activities toward purely sexual objects with his will, and in fact endows asexual interests with libidinal supplements. Satisfaction of this object libido may be equated with partial extinction—the withdrawal of object libido (usually only for a short period), which now becomes ego libido once again. This withdrawal of object libido and libidinal supplement can, however, have a pathological effect, as seen in schizophrenia, catatonic stupor being its most extreme form.

Activity in the erogenous zones has an intensifying effect on any tension already present. This creates pleasurable sensations and the desire to achieve still greater pleasure (so-called “forepleasure”). End pleasure is satisfaction and relaxation, but this is only added when the genitals have become physiologically mature,¹⁶ while the forepleasure mechanism is already functioning in infantile sexuality.

Forepleasure contains the same dangers as do the partial drives in childhood. Here, too, fixation on a certain element of the fore-pleasure mechanism may occur, especially when the corresponding partial drive was heavily emphasized in childhood as well. This results in permanent lingering in preparatory acts.

In regard to further libido development in male and female, the following must be given careful attention:

In childhood, the libido’s mode of functioning, which is oriented to the gaining of pleasure, is identical in male and female, namely, both are active. Aside from other erogenous zones, pleasure is derived from the same morphological organ, i.e., the penis in boys and the rudimentary penis, the clitoris, in girls. Only in puberty does the female libido become different. If a woman is to become sexually normal, it is absolutely necessary that erogenous response be transferred from the clitoris to the mucous membranes of the vagina; clitoral sexuality must be repressed. Reaction formation usually takes place earlier in women than in men, and in general greater repression is necessary, because they must now direct themselves toward passivity, whereas before their libido was as active as the male’s.

While in men the emergence of libido in puberty flows through approximately the same channels as before, sexual inhibitions arise in women due to the necessary repression of clitoral sexuality. These serve as a particular stimulus for the aggression of male libido and contribute to the sexual overvaluation related to it. Anesthetic women have either unsatisfactorily repressed clitoral sexuality, or not repressed it at all. The causes for women’s greater inclination to hysteria is likewise to be sought in this necessary repression mechanism.

The tasks of puberty may be summarized as follows: 1. The unification of partial drives under genital primacy (in women, transference of sexuality from the clitoris to the vagina). 2. Object selection.

According to Freud, drives may experience four fates:

1. Transformation into their opposites. For example, sadism into masochism, voyeurism into exhibitionism (redirection from activity to passivity).

2. Reversal toward the individual himself. This constitutes a reversal of the object (as opposed to the reversal of the goal in 1). For instance, sadism (object = another person); masochism (object =

one's self).

3. Sublimation. For example, diversion of homosexual drives to the social community (Hans Blüher, *Die Rolle der Erotik in der männlichen Gesellschaft* [The Role of Eroticism in Male Society] [1917–19]), or into artistic productivity.

4. Repression. Between the ages of four and five, the beginning of the latency period, infantile partial drives are subjected to sublimation and repression, which are eminently important in aesthetic, ethical, and cultural respects. In part, they are intensified by the procreation tendency.

Sublimation is a function of drive, whereas successful repression refers to the object. The term “unsuccessful repression” is used when the drive itself is repressed, with or without the object. In this case sublimation is out of the question as repression of the drive requires previous successful repression of the object. In sublimation, the drive retains its direction after the original object has been repressed; in contrast to reaction formation (for example, disgust), which may be described as a drive directed against itself (anal eroticism).

The reaction formations of disgust, modesty, and morality result from coprophilia, anal and urethral eroticism, and exhibitionism, among other causes (Freud, *Character and Anal Eroticism*). Between the ages of five and ten the homosexual drive component must be repressed, just as clitoral sexuality is repressed during puberty. (But this still does not exhaust the number of objects serving the mechanisms of sublimation and repression.)

In phylogenesis as well as ontogenesis, we observe that sublimation increases with developmental progress of psychic functions. This takes place partially in the form of a more highly developed, refined eroticism (Forel: the psychic emanations of the sexual drive) and partially in the form of desexualized drive forces (Jung) and their libidinal supplements.

The entire psychoanalytic doctrine of neurosis hinges on the fourth point mentioned, repression (pathologically speaking, unsuccessful repression). Here I shall only point out what is significant for understanding what happens to the libido. I have already mentioned the repression of certain infantile drive components for the sake of normal sexual development. By this necessary repression a foundation is laid for psychic disturbances which erupt sooner or later if the partial drive was particularly emphasized, or when other hereditary and constitutional conditions favorable for neuroses are present.

Repression is defined in general terms as “that process in which an experience or thought is made unconscious, or when a conscious act is involved which is not allowed to enter the preconscious at all. This experience, thought, or act need not necessarily be traumatic in nature, but it must be capable of reaching the conscious level and it must belong to the realm of the conscious or the preconscious” (Freud, *Vorlesungen zur Einführung in die Psychoanalyse* [1917]/*Introductory Lectures on Psychoanalysis* [1919] and *Sammlung kleiner Schriften zur Neurosenlehre, 1893–1906* [1906]/*Collection of Short Articles on the Neurosis Theory, 1893–1906* [1924]).

A frequent and, from the practical standpoint, important result of drive repression is the development of anxiety. Anxiety is libido with a negative symbol (Freud: The fate of little Hans in

“Analysis of a Phobia in a Five-year-old Boy”). For example, a loved one is replaced, after repression, by a substitute idea—let us say, a dog for the father. Love of the father then changes into fear of the dog.

Two dangers threaten the libido along its developmental path: first, arrest, which results in fixation, and second, regression. When parts of libidinal functions do not pass successfully through certain preparatory phases, partial fixation results, that is, “a lingering of one part of the sexual function at an earlier developmental stage.” If a function encounters intense external obstruction at a higher developmental level, it returns to a stage of development in which there are appreciably fewer obstacles between it and its goal of satisfaction. The greater the obstacles and the previous fixations, the more easily and intensely this regression takes place and the more it encompasses. One can differentiate here between two different situations: first, a return of the libido to the objects cathected during earlier developmental stages, and second, a return of the entire sexual organization to an earlier stage.

Regression must not be confused with repression. The former is not a purely psychic process but is determined by organic factors as well. Regression plays the more important role. Repression, however, is a “psycho-topical dynamic” concept in which regressive aspects are not important. Repression is a subordinate concept to regression, and essentially topically determined.

Three elements are necessary for the formation of a neurosis:

1. *External denial* (as an exogenous factor), that is, the lack of some means to satisfy the libido. The symptom then appears as an ersatz for the denied satisfaction. However, not every denial of satisfaction results in neurotic illness. The sexual partial drives possess the peculiarity that when one is denied, another takes its place in an intensified degree, or sublimation results. The ability to sublimate varies from individual to individual, and sometimes the entire partial drive cannot be sublimated. In this way sublimation and replacement are means employed to prevent denial from resulting each time in a pathological phenomenon.

2. *Libido fixation* (as an endogenous factor). Incomplete libido development causes libido fixation, which is counter to real satisfaction and for this reason gives rise to neurotic illness. Fixation may be found in every neurosis, but the reverse is not true.

In the etiology of neurosis, both sexual constitution (fixations) and accidental or traumatic experiences (for example, denial) play a part. Together they form a constant factor—a complementary progression. Disposition by means of libido fixation alone again forms the constant factor of another complementary progression, namely constitution (phylogenetic experiences) and infantile experiences.

As a whole, neuroses are determined by

- a. phylogenetic experiences.
- b. infantile experiences.
- c. recent experiences.

All three must be present in the form of a complementary progression. If the first two factors predominate, a minor recent cause will suffice to produce a neurosis and vice versa.

3. *Psychic conflicts*. These become manifest in the struggle between desire impulses, and are provoked by denial. For a conflict to become pathogenic and lead to neurosis, inner denial must be added to external denial. There are two means of achieving libido satisfaction if denial occurs, namely, disguise and symptom formation. External denial removes the one possibility and internal denial excludes the other, so that the conflict is created by both forms of denial. The most significant conflicts take place between the ego and sexual drives inasmuch as the former inhibits the latter. Therefore, we may define psychic conflicts as a struggle between the ego and sexuality (ego in the psychoanalytic sense, as the conscious, socially adjusted mind).

Ego development runs parallel to libido development and mutual influence is exerted. If the libido is fixed at any given point, there are two possibilities: (1) the ego yields, resulting in perversion or infantilism; (2) the ego does not yield, resulting in conflict, libido repression, and neurosis.

The difference between ego drives and sexual drives may be summarized as follows:

Ego drives are characterized by (1) susceptibility to being acquired through ontogeny; (2) the change of objects according to time and place; (3) the fact that they are subject to the reality principle, i.e., they proceed toward postponed, modified, and decreased pleasure gains.

Sexual drives are characterized by (1) definite phylogenetic development (restriction takes place during ontogeny); (2) permanent objects, or autoeroticism; (3) unintelligibility, unsusceptibility to influence, and the fact that they are subject to the pleasure principle, i.e., they are directed toward achieving rapid, intense pleasure.

Primary Narcissism

Narcissism¹⁷ is generally defined as that perversion in which the individual does not direct his libido toward a sexual object outside himself but rather makes himself such an object, achieving an orgasm through sexual acts involving himself (masturbation in front of a mirror; viewing, touching, and stroking of his own body). Psychoanalytic research, however, has been able to demonstrate that narcissism is not only significant as a perversion but also fulfills a certain role in the sexual development of every individual, in intimate connection with the ego, with other perversions (homosexuality), and with certain psychoses (paranoia and dementia praecox).

Freud points out the difficulties in the study of narcissism, stating: "... and finally it seemed reasonable to assume that we could consider calling a much greater portion of the libido narcissistic, and that narcissism itself could lay claim to being a sector of regular human sexual development. The difficulties in psychoanalytic work with neurotics gave rise to this assumption when the narcissistic behavior in these individuals seemed to create one of the limitations in influencing them. In this sense, narcissism would not be a perversion but a libidinal complement to the egotism of the self-preservation drive, a part of which may justly be considered an attribute of every living creature."

The necessity of assuming a primary normal narcissism followed the observation of dementia praecox (Kraepelin, paraphrenia—Freud; schizophrenia—Bleuler). Such pathological cases manifest two fundamental character traits, namely megalomania and withdrawal of interest from the external

world. The latter, especially, caused the patients' inaccessibility and their inability to be influenced by psychoanalytic treatment.

The withdrawal of interest from the external world is said to be a result of relinquished object cathexis by the libido. What was previously object libido now becomes ego libido and suffers introversion. This is the term used by Jung to define the process in which psychoneurotics (hysterics and compulsion neurotics) withdraw the libido they have sent out toward objects and redirect it into fantasies, in contrast to schizophrenics, who do not cathect the retracted libido with fantasies. The latter results in megalomania, which has been created at the cost of liberated object libido. Megalomania, however, is a magnified pathological distortion of a condition experienced earlier, which was superimposed on primary normal narcissism. The megalomania brought about by withdrawal of object libido must be viewed as a secondary state which is superimposed upon the primary one.

Similar phenomena are said to be observable in the psychic lives of primitive peoples¹⁸ and in children. In the former they are manifested in an "overvaluation of the power of their desires," "belief in the magical powers of the word," and finally as "magic," which is perceived as a technique to be used against the world, "as a consequent application of these megalomaniacal prerequisites."

From these observations, the concept of an original ego cathexis is said to have arisen, from which libido is sent out to cathect objects although it can be withdrawn at any time. Libido (sexual energy) is only explorable as object libido. In ego cathexis, it merges with ego drives and is no longer distinguishable from them.

Ego and object libido are reciprocal in inverse proportion; impoverishment of the one effects enrichment of the other and vice versa. The greatest impoverishment of ego libido occurs when one falls in love and all libido flows toward the object. The opposite of this (impoverishment of object libido) determines the eschatological fantasies of paranoids.

If indeed an ego state does exist with primary libido cathexis, in which ego drives and sexual drives are indistinguishable from one another and temporarily not examinable, we might raise the question of why it is necessary to separate sexual energy (libido) from that of ego drives in the first place.

Freud admits the possibility that sexual energy (libido) could be a product of general psychic energy "in its deepest origins and most distant abstraction." However, the differentiation between ego drives and sexual drives arose from the examination of transference neuroses and has proved reliable. He adds that the above statement is not relevant because the original identity is so far removed from present problems and has "as little to do with analytic issues as the original interrelationship of all the races with the demand of the state that the relationship be established between testator and inheritor." In addition to this, the differentiation between sexual drives and ego drives is biologically supported in the respective masters they have to serve, namely protoplasm and the individual. The latter considers sexuality (from the standpoint of the "individual pleasure principle") as one of its intentions, whereas viewed from the standpoint of the "objective procreation tendency," the individual could be considered an appendage of primordial life itself. Jung¹⁹ assumed this original identity

between sexual drives and ego drives, and postulated that Freud had expanded libido theory to include paranoia and dementia praecox although it had proved inapplicable to these psychoses. Jung believes that introversion of libido always leads to neurosis but never to dementia praecox. He seeks to explain the psychotic loss of reality by a total withdrawal of interest. (According to Freud, it is caused by withdrawal of libidinal interest only. The ego is then cathected, and this process in turn affects the relationship of the ego to the external world.) Jung thus equates libido with interest, explaining this with his “genetic libido theory.”

Freud feels that, just as transference neurosis enabled sexual drives to be explored, ego drives can be examined through the study of psychosis. He cites three further means of exploring narcissism, namely by observation of organic illnesses, of hypochondria, and of human love life.

Anyone can observe that individuals who are organically ill withdraw their libido from objects, stop loving for the duration of the illness, and direct this liberated libido toward the diseased organ. Sleep produces a similar libido withdrawal augmented by the egoism of dreams. In both cases we see a change in libido distribution caused by changes in the ego.

The hypochondriac withdraws his interest and very clearly his libido and focuses them on the organ in which there are painful sensations, in contrast to organic illness, in which the sensations are based on real pathology. However, as Freud states, “The hypochondriac must remain justified; organic change may not be lacking here either.” All organs have a certain degree of erogenuity (i.e., the ability to transmit sexually exciting stimuli to the psyche) and every increase or decrease of this in a particular part of the body may very well be paralleled by a change in libido cathexis of the ego.

Every libido cathexis in the ego causes an increased tension and is experienced as unpleasurable. This answers the question of why the individual must transcend the narcissistic position and cathect objects—namely because it is just that unpleasurable tension caused by the libido stasis that produces the emission of libido. “Strong egotism protects the individual from illness; however, in the end he must begin to love in order not to become ill, and will necessarily become ill if, due to denial, he is unable to love.”

Our psychic apparatus is capable of processing stimulus factors and it is irrelevant whether this takes place with a real or imagined object. The difference emerges only later, in the form of libido stasis in introversion (unreal objects). Megalomania in paraphrenia is a similar processing of libido withdrawal into the ego. In anxiety neurosis dammed-up libido is transformed into neurotic anxiety; in hypochondria it is transformed into hypochondriacal anxiety. In the former, it is a matter of dammed-up object libido (on fantasy objects) and in the latter of dammed-up libido in the ego.

The study of narcissism is also made accessible by the observation of human love life. Here we may differentiate between two types of object selection, namely, the prototype and the narcissistic type. In the first instance, one loves according to the model provided by those individuals who were entrusted with nurturing in earliest childhood; in the second instance, one loves that which one is. This insight was gained through the study of narcissistic perversions and homosexuality. However, one never loves according to one of these patterns exclusively; both form a complementary progression

within the individual.

We may also differentiate between male and female object selection. Prototype object selection is typical for men. Blatant sexual overvaluation stems from infantile narcissism and corresponds to transference of this to the object. In women, however, an intensification of primary narcissism parallels the marked development of the sexual organs in puberty, rendering the formation of object libido equipped with sexual overvaluation an impossibility. If a woman becomes very beautiful, self-sufficiency sets in. It may serve as compensation for the prohibition of free object selection. But female narcissism also plays an important role in the courtship mechanism; this is similar to the charm of a child being constituted by its self-sufficiency and shortcomings, or the charm of many animals (cats and large beasts of prey) by their apparent lack of interest in us. The majority of women love because they are loved, and to the degree to which they are loved.

But women are also amenable to object love in two instances: they bestow complete object love on their children as a projection of a portion of themselves into the external world, or, since they themselves felt masculine before puberty and had to abandon this trait, they love the male ideal in men which is a continuation of their own forfeited boyish nature.

Since the characteristic of overvaluation is a pronounced narcissistic stigma, parental love is also nothing other than the parents' narcissism revived. Overvaluation of the positive traits of one's children is a universally recognized fact—children are attributed with and wished everything the parents were denied. "Sickness, death, forfeiture of pleasure, and the limitations placed on one's own will are not supposed to be valid for the children. The precepts of nature and society are to crumble before them; in reality, they are to become the center and core of creation once again."

Freud offers the following short overview for the paths object selection may take:

According to the narcissistic type, one loves

1. What one is (oneself).
2. What one was.
3. What one would like to be.²⁰
4. The person who was a part of oneself (the child).

According to the prototype, one loves

1. The nourishing woman.
2. The protecting man.

In normal adults, only traces of infantile narcissism may be seen, and since we cannot assume that all libido, as object libido, has been exhausted, the question remains as to the whereabouts of ego libido. We know that all libidinal drive impulses conflicting with ethical and cultural ideas are repressed due to the ego's conception of itself. An ego ideal is erected and the real ego measured against it, thus providing the requirements for repression. In individuals lacking such an ideal, drive impulses are not repressed. This ego ideal is now the object of self-love, which was focused on the pleasure ego in childhood. The libido's inability to forfeit previously experienced satisfaction, the lack of desire to surrender childhood narcissism, causes the creation of this ideal, which is merely a substitute for satisfaction.

But formation of the ego ideal must be differentiated from sublimation. The latter is a process in which object libido is redirected from a sexual to an asexual sphere. The former involves the object itself, which is psychically elevated.

Although formation of the ego ideal does encourage sublimation, it only serves as an impetus and never brings sublimation about by force. The difference in potential between this formation and the capacity to sublimate is one of the most important factors in the etiology of neurosis. In regard to repression, and therewith in regard to neurosis, they are even antagonistic. Ego-ideal formation increases the demands on the ego, thus facilitating repression, while sublimation is the only means of solving conflicts between sexuality and the ego without repression or the development of perversion.

The conscience is invested with the duty of watching over the narcissistic satisfaction derived from the ideal ego. Paranoid delusions of being observed are nothing other than the externally projected conscience now portrayed in a regressive form (as it was created). The ego ideal and its guardian, the conscience, were created by external stimulation under the critical influences of parents, educators, public opinion, etc., so that now the individual's own conscience appears as a continuation of the external conscience. Paranoid resistance to "censorship" may be explained by the fact that a large amount of homosexual libido was used to construct an ego ideal. Now that the individual wishes to free himself from this influence, the homosexual libido withdraws. From paranoid complaints, we may surmise that the conscience coincides with self-observation, upon which it is constructed.

In other realms as well, for instance in dreams, the critical censor can be discerned. Freud believes that censorship in dreams is the work of the ego ideal and the conscience. He arrived at this conclusion from H. Silberer's description of the "functional phenomenon." Silberer had demonstrated that there is self-observation during dreams in the state between waking and sleeping where one can directly observe thoughts being put into visual images. However, this is not a portrayal of a thought content but a momentary state of the dreamer woven into the dream content and clothed in visual images.

Self-esteem is an expression of the magnitude of the ego and is intensified by everything one has achieved and possesses. It is heavily dependent upon narcissistic libido. Not being loved humbles, but being loved (the goal of narcissistic object selection) heightens self-esteem. Loving, i.e., libido object cathexis (expressed in terms of the libido formula), has a diminishing effect due to dependency upon the love object. Similar observations can be made in transference neurosis in which cathexis of fantasized objects causes self-esteem to sink, as opposed to a rise in self-confidence in paraphrenics. Satisfaction of object libido contributes to the formation and preservation of self-confidence.

Now that the function of the ego ideal has been clarified, the third possibility of narcissistic object selection may be explained, namely, one loves what one would like to be. When narcissistic satisfaction encounters real obstacles, the sexual ideal (the object raised to an ideal by libido overflow) assumes its place for substitutional satisfaction. One then loves those positive qualities in the object which one does not possess oneself, or which one has lost.

Since the ego ideal comprises social elements (class ideals, national ideals) as well as individual elements, it is important in mass psychology. Guilt consciousness—or social anxiety—is homosexual

libido transformed into anxiety. Previously this was bound to the narcissistic as well as to the social elements of the ideal ego and was set free through non-satisfaction of the same. Originally guilt was “fear of the parents’ punishment or, more correctly, fear of loss of their love. The parents’ place is later assumed by an undetermined group of contemporaries.” Thus paranoia is frequently caused by mortification of the ego due to lack of satisfaction in the realm of the ego ideal.

JUNG’S “GENETIC THEORY”

I have already mentioned that, according to Freud, libido is an energy that is particularly capable of displacement inasmuch as asexual drive impulses are able to assimilate certain amounts of sexual drive force. Freud calls this “libido supplement.” It enables objects or functions, themselves asexual, to assume a sexual nature; however, this is not always the case.

Freud, in *Three Contributions to the Theory of Sex*, states: “I must mention in advance that these psychoneuroses, hysteria and compulsion neurosis, are based in my experience upon sexual drive forces. I do not wish to imply that sexual drive energy contributes to the forces sustaining these pathological phenomena, but rather to assert in express terms that this component is the only constant, and also the most important energy content in neuroses. Thus, the sexual life of these individuals expresses itself either exclusively, predominantly, or only partially in these symptoms.” Freud explains the loss of reality in schizophrenia exclusively by the withdrawal of sexual interest, but he feels that the introversion of libido leads to ego cathexis, which may cause loss of reality.

Jung overlooked this possibility and felt that the reality function is sustained not only by libido supplement but also by other sexual drive forces or erotic interests, since in most cases of dementia praecox and paranoia a gap in reality occurs which is not to be explained by the withdrawal of libido supplement alone.

Hence the division of the reality function into libido supplement and another sexual drive is not applicable in this context, because libido regression regularly leads to hysteria or compulsion neurosis, although never to dementia praecox. In transference neurosis, cathexis is withdrawn, introverted, and returned to earlier patterns through regression, whereas the asexual drive forces maintain their relation to reality.

In dementia praecox, however, reality lacks not only that portion of libido which is superfluous in specific sexual repression as we know it, but also much more than can be ascribed to sexuality in the strictest sense. So large a portion of the reality function is lacking that other drive forces must be lacking as well, the sexual character of which are to be strongly challenged, since no one would agree that reality is a function of sexuality.

Jung contrasts the descriptive libido definition given in Freud’s *Three Contributions to the Theory of Sex* with his own genetic definition, and raises the question of whether the reality function—composed today to a very slight degree of libido supplement and primarily of other asexual drive forces—is not phylogenetic in most of its sexual expressions.

As a solution to this issue, Jung points to the propagation drive. From exacting developmental

historical research, one can see that most of our contemporary reality functions are nothing other than splinters of the general propagation drive.

In the ascendant animal kingdoms, transformations in the principles of propagation are provable. The mass of procreative products and the fortuitousness of fertilization were restricted in order to assure fertilization and effective incubation. The energy in egg and sperm production is transformed into mechanisms to attract a mate and protect the species. "Hence we see the first artful drives in the animal kingdom limited, in the interests of propagation, to the mating season. The originally sexual character of these biological institutions is lost with their organic fixation and functional autonomy."

From this standpoint, libido cannot be differentiated (in principle) from the hunger drive, because in nature (particularly in prehistoric animals) this difference does not exist.

Whereas Freud explained ego drives as serving to preserve the individual and sexual drives as serving to preserve the species, Jung's views may be formulated as follows: Preservation of the species is made possible by a drive of the individual, although this is unthinkable without another drive for the preservation of the individual. These are inseparable and subsumed under the heading of the propagation drive. In this way libido is expanded to a philosophical concept, the concept of a will, a continual life drive "which strives to achieve propagation of the entire species by the preservation of the individual."

Desire (libido) is manifested in the most varied applications and forms. In childhood it appears entirely in the form of the alimentary drive, while the separation and formation of sexuality occur later, at which time desire appears as the propagation drive per se. Only now is the term "libido" justified, whereas at first it was the undifferentiated primitive libido representing growth energy. The division into two drives is especially clear in butterflies, where the nourishment stage (caterpillar) is separated from the sexual stage (butterfly) by the pupa stage.

From the sexual primitive libido (the production of millions of egg cells and spermatozoa from one small creature) fractions develop that restrict fertility. A special differentiated libido develops which appears desexualized and stripped of its original function of egg and sperm production, to which it cannot return. Thus the primitive libido was absorbed by secondary and tertiary functions in the course of phylogenesis. However, if part of libido energy has been organized for building a nest and is thus unavailable for any other purpose, then "there is also no reason to separate all other desire, for example, the desire to eat, from the desire to build a nest."

According to this viewpoint, the drive force of the reality function (Freud's reality principle) is not now but *was once* a sexual function. The process of primitive libido absorption progresses in the form of "sexual supplements." The assignment of sexual libido from the reservoir of remaining primitive libido to auxiliary functions always takes place. If this happens without detriment to the individual, it is termed sublimation; failure causes repression.

From Freud's descriptive standpoint one sees a multitude of drives and the sexual drive as a partial phenomenon. From Jung's genetic standpoint one sees a relative union in the form of a primitive libido as the propagation drive from which drives branch off and are thereafter capable of absorbing libidinal supplements from it.

Only from this standpoint is the libido concept applicable to paranoia. Thus, if it is said that an ill person withdraws his libido from the reality function, this means not only the withdrawal of libido supplements but also withdrawal of all other desexualized drives which sustain the reality function.

Therefore it is obvious that Jung's libido theory not only enlarges the concept as compared to Freud's but also actually contradicts it at certain points.

Except in cases of psychoneurosis, great difficulties are encountered in applying Jung's libido concept to human sexual life. To avoid these difficulties in part, one would have to subdivide his libido concept once more into libido in the broad sense (equivalent to the sum of all desexualized drives) and libido in the strict sense (active exclusively in the sexual sphere). However, such a subdivision would only create greater confusion and would not provide further insight into the nature of libido. Or to avoid all complication, could one create a new term for libido in the restricted sense? In this case, I would prefer to maintain Freud's division into self-preservation drives and sexual drives. To operate with a concept of libido as an all-embracing propagation drive in the purely sexual field is unthinkable, because one would continually have to consider and eliminate all effective asexual elements, a condition which would further burden the already difficult problem.

Nevertheless, Jung's views are of great biological interest theoretically, even if for the moment they appear to have only philosophical significance. I find the possibility of speaking in terms of a psychosexual germ cell very tempting, though in many respects (scientifically) dangerous. Still, the possibility must not be overlooked. Further study of sublimation on the one hand, and the organic basis of libido on the other, could shed light on this problem.

*Concerning Specific Forms of Masturbation**

When analyzing the elements of a dream we are, as a rule, not satisfied with the patient's own statement that dream element X stands for experience Y. We strive rather to discern the particular reason for Y having chosen to express itself in terms of X. Through a clarification of the specifics of this choice, we hope for a deeper understanding of those details from which we can then reconstruct the formation and meaning of a symptom. In my opinion, this most circumspect examination of specific determinants must be accepted as one of the many ground rules of analytic work itself. From this standpoint, I shall proceed, in the following brief comments, to an area of drive expressions to which psychoanalysis has attributed overall importance.

The nature of masturbation has been clarified, and the origins of typical unconscious fantasies with their resulting guilt feelings have, for the most part, been brought to light.¹ However, I should like to fill in a small omission in the understanding of masturbation by observing the specific forms it can assume. The difficulties encountered in the treatment of impotence have taught me to pay special attention to the manner in which the patient masturbates. I have discovered that many an unconscious drive may express itself and find release in a manifest but seemingly insignificant detail in the manner of masturbation. This escapes discussion during analysis until its mention is brought into sharp focus, and above all until the patient is advised to refrain—not from masturbating—but from this or that detail in the manner of its practice.²

From a wealth of cases I shall mention only two, both of which have been thoroughly analyzed.

Case 1. Twenty-eight-year-old patient, waiter by profession, long-term total impotence. Analysis runs very smoothly for eight months. No masturbation during puberty. First masturbation during the war at age twenty-two. The analysis falters one day during a discussion of anal-erotic complexes and leg-fetishistic fantasies. Uncommonly long period of resistance follows during which masturbation is taken up once again.

Form: The penis is pushed backward between the legs and tickled from behind with one hand while the legs are pressed together.

The analyst has the patient recall the minutest details of the masturbation and narrate them several times. It occurs to the patient that during masturbation the pleasurable sensations are localized mainly on the inside of his thighs rather than in his glans, where there is sometimes no pleasurable feeling at all. Subsequent ideas: The pleasure of rubbing a woman's vagina with his leg. "Why do I have such strength in my legs and not in my penis?"; "I squeeze my penis." The underlying reason for this behavior lies in the repetition of behavior which is of the greatest importance for his impotence: patient suffered from enuresis nocturna until the age of six, at which time his father had "cured" him (injuriously) by means of thrashings. "I press my thighs together in fear, as I did then, to hold back the urine."

The analysis of this form of masturbation lasted several months. We shall omit a report on the

course of the analysis at this point, but the results disclosed the following:

1. A repetition of the situation involving the pressing together of the thighs for urine retention.

2. The thrashings were perceived as castration threats from which the penis was protected.

3. Erogenous response had been transferred from the glans to the thighs. The thighs served as a defense and at the same time assumed the erogenous function. By way of projection, the legs and chest (this by a different determination) became the predominant means of attracting women.

4. A defense against the thought of the mother copulating: "I don't want the woman to have intercourse with anyone else; a woman presses her thighs together when she doesn't want it."

5. The analysis of "tickling from behind" opened the door wide, first to a vast region of passive-feminine tendencies and later to the area of autoeroticism as well as anal-erotic and self-fertilization fantasies (the penis as a piece of feces).

6. There was an unconscious fear of masturbation by hand—be it his own or someone else's. During puberty the patient had surprised the maid and her lover just prior to coition and grasped the man by his erect penis. Thereby sadistic tendencies had been awakened and resulting guilt feelings had placed a taboo on the hand (complete inability to have an erection was essentially one single immense taboo). (*Horror manus* is common in cases of severe impotence and the analysis may be considered to be at least a temporary therapeutic success when the patient begins to masturbate again, doing so candidly, manually, and without guilt feelings. The further task of the analyst is then to guide the patient—who often enough has experienced his first powerful erections during masturbation—to readiness for coition.³)

By the means described above I have, within a relatively short space of time, come upon very important material which would certainly have taken longer to obtain by any other process. Success was not lacking: strong, prolonged erections occurred as soon as the unconscious determinants, especially that of the hand taboo, were analyzed and erogenous responses of the penis had become free once again.

Case 2. Thirty-two-year-old patient, psychosexual hermaphrodite with male and female capability, suffered long-term disturbances of potency with women. Narcissistic personality; mania for self-analysis. Resistance to treatment manifested itself in adroit conjectures aided by intelligence. Patient has some knowledge of psychoanalysis, greatly to his own detriment. He knows everything, explains everything immediately and spontaneously, contributes numerous ideas but remains emotionally untouched. Excessive masturbator from age eight to the present. Analyst resorts to advising restraint from masturbation. The patient, who has a strong desire to be cured, reacts with several weeks of resistance in the form of defiance and silence, but follows the advice.

Masturbation during the day and evening is replaced by nocturnal masturbation, usually following a dream. Supposedly, there is nothing the patient can do to control this. It becomes clear to both patient and analyst that the masturbation is diverting all of the energy meant to emerge during treatment and that the patient is unwilling to give up his fantasies. At this point, it would be dangerous to prohibit masturbation; on the other hand, the analysis is making no progress despite the combined intensive efforts of both parties.

The patient is told to describe the manner in which he masturbates. At first he can remember nothing at all. Gradually, individual details begin to surface. The patient masturbates lying in bed bent far over backward, or with his penis extended forward, keeping one foot out of bed. Just prior to ejaculation he reaches for the chamber pot, supposedly not to soil his bed. He masturbates with three fingers only, or rather with the tips of three fingers, by placing the index and middle fingers on the dorsum of the penis and the thumb underneath. It is noteworthy that the patient sleeps in the same room as his mother to date.⁴ He was born illegitimate. His leaning over backward reminds the patient that as a child he once saw a picture of the sacrifice of Isaac, who was lying, tied and bent over backward, his father standing above him with drawn knife. I should remark that the patient had mentioned this picture much earlier in treatment, without any reaction, whereas now its emotional content emerges very plainly. His narcissistic isolation, which had blocked the path to emotional reaction until this point, was due mainly to a desperate attempt to suppress his powerful unconscious fear of castration. His self-secure, arrogant personality was a cover for deep-seated feelings of inferiority and an unconscious masochistic desire to surrender himself (while his manifest behavior could better be termed sadistic). This form of masturbation coincided with his masochistic submission to castration by his father, whom he both loved and hated intensely. As a child he yearned for the presence of his father and this is the root of a good deal of his homosexual inclination. Another detail contrasts with this: By keeping one foot out of the bed he is fleeing castration, as it were. The stroking of the penis with three fingers and their characteristic positioning, as well as the use of the chamber pot, led to further insight: "During masturbation I assume the role of mother and child in one."⁵ In this connection an old desire became plainly conscious: that his mother take out his penis and hold it so that he could urinate. At this point I shall not pursue these connections further, but simply mention that this analysis of the form of masturbation led to considerable progress by opening the door to material related to infantile enuresis.

Thus, in case 2, the patient was advised to refrain from masturbating temporarily, and furthermore, close attention was given to exact reporting of the details of manipulation.

In case 1, the procedure was reversed in consideration of the total repression of genital eroticism (whereas in the second case genital autoeroticism was overstressed). It was not recommended outright that the patient masturbate. Instead, the comments he made regarding the horrors of masturbation and the damage it can do, etc., were refuted. As if in casual conversation, it was remarked that most men masturbate, even the healthiest, and that masturbation, when practiced for a certain period of time, is perfectly normal; it relieves the strain of repression. Incestuous fantasies had been amply brought to light much earlier, and some time later the patient began to masturbate as described.

Guidance of masturbational practices during treatment is an essential and active therapeutic tool in the hands of the analyst. In some cases it may involve danger, and much more experience in its use should be acquired.

It may be assumed, and has already been proven repeatedly, that the most essential emotional drives are accumulated, expressed, and released in masturbation, which serves as the focal point for

infantile and pubertal sexuality. In many cases one must strive to apply this knowledge to the technical aspects of analysis. In doing so, one finds confirmation of the hypothesis that masturbational fantasies are best approached through the analysis of the form of masturbation at the specific time, as well as through forms of masturbation practiced earlier. Correct transference and all the other criteria of a smoothly proceeding analysis are, of course, also necessary. I should like to express the hope that the emphasis I have placed upon the importance of the form of masturbation will not be interpreted to mean that I view this consideration as a cure-all. All that is being implied is that, by this means, one can achieve insight into questions pertaining to genital eroticism easily and quickly. This is especially true in cases of impotence. We know that masturbation is normally prominent for a varying length of time around puberty. Attention given to the form of masturbation can render some assistance in judging whether or not processes which may cause trouble later on are hidden behind masturbation. It can by no means tell all.

A boy in generally good mental health masturbates in a manner which clearly reflects his role. I have become acquainted with the following principal forms:

1. Masturbation against the sheet or an improvised vulva (shirts, pillow, etc.), lying on the stomach, by means of active movement of the pelvis and without manual assistance. In this case the masculine adjustment seems to be assured and the fantasy directed toward the opposite sex (even if unconsciously incestuous). Alloeroticism is the motivating force here.

2. In manual masturbation, lying on the side or in a bathtub, the autoerotic element is much stronger. In my experience, this form of masturbation is by far the most frequently employed.

3. When the individual masturbates lying on his back with all activity localized in his hands the prognosis is not very favorable. My experience has shown that this mode of masturbation is primarily practiced by males with feminine attitudes.

4. Forms of masturbation similar to those described earlier must be viewed as pathological. A few examples: A boy masturbating in his parents' bedroom during parental intercourse, whereby he attempts to have his orgasm coincide with that of the father. Two analyses (erythrophobia and a case of neurotic anxiety) served to show me the danger of this kind of behavior. Masturbation which involves placing the penis between the wall and the bed—or between the mattresses; pinching of the penis, as well as masturbation with a cloth wrapped around the penis. Both of these forms can be traced to self-punishment tendencies; the latter is rationalized with "so that it won't hurt." Masturbation in front of a mirror (narcissistic); while reading rape scenes (this is very frequent); on the toilet; in public parks, even though well hidden behind bushes; mutual masturbation with friends; etc., etc. All these indicate pathological processes in the unconscious.

It was possible to expose one special form of masturbation as an active homosexual act which had been transferred to the patient's own body as a result of repression. The patient (a compulsive neurotic) usually masturbated in the bathtub by leaning forward slightly and, in doing so, rubbing his erect penis, which he had previously soaped, along his thighs. (The opposite of this is masturbation in the form mentioned in case 1: passive-feminine.)

In girls, masturbation lying on the back, involving the clitoris (prior to puberty) and the vulva

(after puberty), must be considered normal. Of the pathological forms of expression I might mention the following: masturbation by tugging at the clitoris (desire for a penis) or lying on the stomach with the hands pressed to the breast;⁶ masturbation involving the anus (very frequent in men also). It is open to question just how we are to evaluate female masturbation by pressing together of the thighs. Usually it is considered normal, but I feel, after having once analyzed a woman enuretic, that in such cases considerable disturbance may be present.

*Two Narcissistic Types**

I

The content of Alexander's description and delineation of the "neurotic character" with its diffuse symptoms, and the neurosis with its localized symptoms, receives my full endorsement. Here I should like to examine one point raised in his article. He states: "It is difficult to answer the dynamic question as to whether pressure exerted by the factor causing the neurosis—libido stasis—is strong enough to find release through new channels, in new symptoms, or whether the defense mechanism of the entire organism—repression—is powerful enough to prevent the achievement of genuine satisfaction altogether." In this form the question does not strike the core of the problem. It is no coincidence that Alexander, in his analysis of the neurotic character, was led so deeply into the circumstances surrounding castration complexes—especially when we consider that a castration complex involving the entire personality is found in all cases of neurotic character. Behind this complex, as a rule, we find an astonishingly strong narcissistic constellation (on which Alexander laid too little stress), and this presents itself, in the final analysis, as the result of an attitudinal overemphasis of the most important erogenous zones—anal, oral, and urethral. We must assume that this kind of overemphasis not only significantly strengthens the ego libido but also creates a heightened irritability of the entire personality, which can cause disturbances at the slightest provocation. Consistent follow-up over the last few years of experiences pertaining to the depth and range of the castration complex prompts us to assign to this concept the full breadth implied by its elements—namely, to perceive it as the expression of the injured integrity of a part or all of the personality (in the unconscious the penis stands for the entire ego).

It is immaterial here whether the castration complex originates in the narrower sense of injured integrity of the genital per se (perhaps by a threat of penis amputation, punishment for incest, etc.) and expands from this point to encompass the entire personality, or whether it begins at the sexual periphery and then focuses inward on the genital. Alexander notes correctly that the castration complex has its associative basis initially in the trauma of being removed from the nipple or of losing feces, since the child perceives its feces, and the nipple as well, as part of its own body. Obviously narcissistic irritability can be aroused by the most heterogeneous of impulses (injury of object or ego libido, physical injury, or illness).

The actual site of the injury is hardly worth considering compared with the final localization which must take place where corresponding cathexis prevails. When a hysterical woman converts her repressed object-libidinal wishes into hysterical vomiting, denoting a well-defined symptom separated from the rest of her personality, this clear delineation may be accredited to the fact that primarily object libido was involved. The more ego libido is involved in a disturbance, the more diffuse and extensive the symptoms. Separation from the rest of the personality is impossible, since ego libido implies the sum of all libidinal impulses toward the ego. For all practical purposes, no clear separation

of the two can be maintained; one can speak only in terms of a predominance of object- or ego-libido disturbance.¹ Actually there is no neurosis, no matter how clearly defined, without traces of a disturbance of the entire personality. Feelings of inferiority, an accompanying symptom of all neuroses—the “narcissistic scar” (Marcinowsky)—are the ever-present expression of this disturbance.

Thus, in my opinion, it is not a lack of the preponderance of either libido stasis—or repression—that is the dynamic differentiating factor between the neurosis and the neurotic character, but rather the predominance of disturbance in ego libido (neurotic character) or object libido (neurosis). For this reason I cannot agree with Alexander that the neurotic character is a halfway point between neurosis and health. Neurotic character is a more severe condition than neurosis, despite the lack of various means of satisfaction in the latter. Every analyst knows that, therapeutically, the prognosis is generally much more favorable in a neurosis than in a neurotic character. The conversion during treatment of a neurotic character into a less diffused neurosis, which Alexander described so excellently, must be recorded as a therapeutic success, the more severe illness having been converted into a milder form.

Although Alexander did not mention it, this conversion takes place, in my experience, when transference to the physician becomes effective and the narcissistic isolation of the personality is overwhelmed by an object-libidinal attitude. (In patients of this kind, one must not be lured away from the important narcissistic background by frequent blatant manifestations of object libido. The object-libidinal struggles are usually attempts to balance disturbances of the ego libido.) The struggle between object and ego libido, which is played out before our eyes, once again emphasizes the importance of the censoring process of conscience, causing all kinds of denials and, secondarily, causing the localization of the symptoms.

II

A few further technical and descriptive comments concerning two frequent types of narcissistic inaccessibility during treatment:

Transference is quicker and easier, but above all more intense, in the case of symptomatic neurosis than in the neurotic character. It is not merely greater insight into the nature of the illness and the desire for recovery which promote transference in the former, or the narcissistic constellation alone which impedes its progress in the latter. The neurotic character perceives analysis (which involves the rendering of associations and the relinquishing of tangible means of satisfaction) as castration itself, because of his castration complex. Sooner or later he will construct a negative transference in which the analyst is a natural enemy to him, in much greater measure than he is to the neurotic.

Freud once mentioned that narcissism can limit susceptibility to influence in the neurotic as well. This brings to mind two narcissistic types in particular, which on the whole may be counted among Alexander’s neurotic characters.² As a rule, narcissistic armor appears sooner or later in these cases and it requires all the analyst’s skill to penetrate it.

The first type is so well known to the analyst that a description of it may be omitted. Patients of

this kind, with manifest feelings of inferiority, transfer very favorably in the beginning and, with correct, gentle treatment and acceptance, appear to be happy to have found someone willing to appreciate and pay close attention to their complaints. Initially they even disclose quite a bit of unconscious material, but one may find after months of treatment that they are still clinging to their original symptoms and neurotic aberrations. Finally one realizes how brilliantly they can simulate participation while remaining emotionally untouched. One discovers that conscious belief in their own extraordinary value is concealed behind their complaints of feeling inferior, incapable, or unintelligent, etc. Secretly they consider themselves better, cleverer, more moral than anyone else. In a masochistic fashion they play the role of martyr in an evil world, without ever suspecting that their martyrdom is the expression of a tremendous guilt complex. Their narcissistic satisfaction is, however, not limited to the acting out of guilt complexes; it also involves a fantasized ideal ego whose characteristics often betray the fact that its roots are sunk directly into an unaltered infantile pleasure ego. Every time the ideal ego urges the fulfillment of its impossible demands, the feeling of inferiority increases to a point where reality must be devalued to avoid further self-loathing, i.e., the grapes become too sour and the final formula which remains in the unconscious runs: "I am really so worthy because I have such high ideals." The emphasis has been shifted to the possession of an ego ideal. It is obvious that the narcissism is not willing to forgo the source of its pleasure, and the feelings of inferiority erect, so to speak, a protective wall around the narcissistic core. Freud already noted that repressed exhibitionist tendencies may also be concealed behind complaints of inferiority.

The object of analysis is to tear down the ego ideal as the pleasure source and direct the freed libido toward genuine satisfaction. In extremely stubborn cases, where belief in the ego ideal is continuously guarded by complaints of inferiority, a different analytic technique is required: Contrary to the initial approach of quieting the patient, of assuring him that he is not inferior after all and that he has accomplished something, he must be told that he is correct in complaining and be made aware that he is basically quite convinced of the excellence of his own personality but that this conviction is incorrect. Not only does this analytic shock cause the complaints to cease, but all the self-love is exposed and can now become the object of analysis. It must be emphasized that this measure is a last resort and that its prerequisite is a transference capable of bearing the load.

This first narcissistic type, with manifest feelings of inferiority and latent narcissism, may be contrasted to the second type with, as analysis shows, manifest and compensative narcissism and latent feelings of inferiority.³ This type is more sparsely represented than the first, less transparent, and offers a poorer prognosis for treatment. Here we have the obtrusive, conspicuously self-secure individual, always thrusting himself forward in an attempt to gain the center of attention, thinking he knows it all, and showing not the slightest trace of any critical perspective of himself. Transference in treatment is minimal since what actually keeps him in analysis is his mania to boast about his experiences, intellect, and wit, and to find an obliging listener in the analyst. All transference is based on identification; he wants to solve everything himself and knows everything better than the analyst.⁴ Whereas exhibitionist tendencies are repressed in the first type and reappear only as neurotic modesty and complexity, in this type they are fully manifest; the large and powerful penis is exhibited—

symbolically—time and time again. Finally one concludes that the patient is not only showing his penis to the analyst and the external world but that his untiring exhibitionism is the result of the frantic suppression of an unconscious castration complex in his own eyes. He has not erected an ego ideal but has instead compensated by overestimating his real ego. It is a constant bargaining over the validity of his worth, an eternal struggle between urgent feelings of inferiority and this compensative tendency, that never allows the patient to find peace or to push through to real achievement.

In contrast to the representatives of manifest inferiority complexes, where the narcissistic armor appears late in treatment, cases of latent inferiority display this armor from the very beginning. Here, too, active intervention is necessary if analysis is to progress at all. One can allow the patient to ramble on and by showing the utmost reserve eventually make him sound absurd, but this is time-consuming. In one such case I was successful in effecting a change for the better by suddenly altering the situation.

In the first type the object of treatment was to make the latent narcissism manifest; in this case it was the latent feeling of inferiority which had to be exposed. Thus, once while the patient was beautifully practicing “mental masturbation,” as he later termed it, I had him get up from the couch and take a seat directly opposite me.⁵ The effect was amazing. The patient, who usually lay there distinguished and straight as a stick, without ever moving, conversing in an even, complacent tone, immediately faltered, flushed, and literally began to squirm in his perplexity; he couldn’t even muster the courage to look me in the eye. Suddenly he pleaded, “Doctor, please let me go back to my castle” (the couch). Naturally, I did not permit this, but instead used the opportunity to direct his attention gently to his perplexity and to show him that in reality he felt very inferior, etc. Over the course of the next few weeks the full significance of his castration fear (the cause of his impotence) emerged in detail and with emotional involvement.

Concerning the development of these two narcissistic types, I state the following: Both pass through an infantile state of strong incestuous attachment resulting in castration fear and feelings of inferiority. In both cases the autoerotic basis is predominantly anal and urethral (ambition—jealousy). The oral component is neither typical nor constant, but nevertheless frequently overemphasized. In most cases, enuresis nocturna during childhood can be established. At a decisive moment in the patient’s life the incestuous desires are strongly repressed, resulting, in the first type (as far as could be verified), in a lasting passive-feminine attitude toward the father and an idealization of women. In the second type, there is alienation from the mother and an inclination toward men, in the active sense (manifest or latent). The incestuous period is shorter and more intense in the second type. Later in the development of the second type, a lasting underestimation of women remains, in contrast to the first type, and this second type generally inclines to narcissistic object selection, i.e., manifest homosexuality (many military officers and members of uniformed student fraternities fall into this category). Contrary to the manifest masochistic disposition of the first type, the latter often shows sadistic traits.

The following listing may serve to clarify the differences and similarities of the two types.

<i>First Type</i>	<i>Second Type</i>
Manifest feelings of inferiority	Latent feelings of inferiority (castration complex)
Latent narcissism	Manifest compensative narcissism
Anal-urethral disposition	Anal-urethral disposition
Strong, lasting incestuous attachment	Short incestuous attachment with subsequent alienation
Overidealization of women	Undervaluation of women
Passive-feminine	Active homosexual (latent or manifest)
Latent sadism, manifest masochism	Overt sadism
Exhibitionist tendencies repressed;	modesty Unrepressed exhibitionism, transferred from the genital to sexual and other feats
Satisfaction through ego ideal	Satisfaction through overvaluation of real ego
Positive transference in treatment	Minimal transference
Prognosis favorable	Prognosis questionable

We see that the two types are polarized in regard to the dynamics of the unconscious and the conduct of partial drives. They share in common an anal-urethral disposition, intense incestuous desire in childhood, and a severe castration complex.

Due to the lack of analytic experience with a representative sample of cases, I dare not offer a contribution to the problem of differentiation between identical dispositions, or the specifics of neurosis selection and character formation in respect to these two types. However, I cannot allow this opportunity to pass without reporting a few relevant observations. It must remain the task of further research to determine the extent to which we have the right to generalize.

It is striking how frequently examples of manifest feelings of inferiority are seen, quite unexpectedly, in upper-class families with a large number of children, strictly raised. In contrast to this, cases of the second type are often found to have a fairly lax upbringing. Either they were raised without siblings, as “spoiled only children,” or they stem from lower-class working parents and, through favorable circumstances, achieved an elevated position which has subsequently “turned their heads.” Originating from a lower-class family contributes heavily to latent inferiority feelings and their compensative tendencies. Endogenous conditions also seem to contribute in part to achievement of an elevated position. Following denial of incestuous desire, the representatives of both types regress to earlier stages, usually to the level of a compulsive inclination, i.e., to anal and sadistic levels. Children who have had a strict upbringing, however, find the path of regression blocked. They retain the mother fixation and revive an earlier stage (for example, the sadistic) through its masochistic opposite and are aided in this by the guilt consciousness their upbringing demands. The repressed anal impulses are revived in a wide variety of neurotic symptoms and are based on passive-feminine attitudes toward the father.

A representative of the second type afforded me fairly deep insight into the circumstances surrounding his regression. His mother was a waitress in a rural district and the patient had grown up without a father, as an illegitimate only child. Having repressed his incestuous desire, he found ample opportunity to engage in anal and sadistic activities while leading the life of a street urchin. Since the corresponding partial drives were not repressed, he managed to sublimate them to some degree.

Alienation from the mother was facilitated by yearning for the unknown father. The real ego emerged (he became a typesetter) from the sublimated parts of his anal eroticism and suppressed his castration complex as well as his feelings of inferiority through excessive self-valuation, due to the contrast with his lowly social position during childhood. We may assume that severity reinforced by beatings is less significant in regard to the constitution of a castration complex and feelings of inferiority than is the manner in which the beatings are related to the former relationship with parents and siblings and to open or closed channels of regression. I have known both manifest narcissistic as well as inferiority types who were frequently beaten.

In representatives of the first type, the possibility of overvaluation of the real ego is eliminated by the lack of opposition to a previous lower social position. These individuals are forced to erect an ego ideal, the intensity of which nourishes their manifest inferiority feelings.

I am aware of the fact that my delineation of the differentiating factors is obscure and unelaborated. I am unable to comment further, but I do feel that obscure beginnings are more valuable than lucid but false findings. The results of my examination of differentiating factors between the two types show: obstruction (manifest inferiority) or non-obstruction (compensative narcissism) of regression channels to the anal and sadistic phase, following repression of incestuous desire. If the anality and the sadistic-aggressive tendencies eluded intense repression, the child remains in this stage longer, but will, under favorable circumstances, later dispose of these drive impulses more freely. Under the pressure of the castration complex, however, unlimited disposal is impeded and this results in desperate suppression of inferiority feelings, which are later expressed in one symptom or another.

*Concerning the Energy of Drives**

I

Psychoanalysis arrives at a metapsychological grasp of psychic life processes by viewing them from three perspectives. These three points of view (listed below) serve to implement a scientific classification of both pathological and normal constellations and their development.

1. Topical: This enables coordination of ideas, thoughts, or impulses of unconscious (repressed) material with the preconscious (i.e., ego-adjusted material which may be called to the conscious surface at any time) and with the conscious (i.e., the psychic contents of current consciousness).¹

2. Economic: This determines the variations in the quantity of excitation, the pleasure-unpleasure constellation.

3. Dynamic: This provides insight into the qualitative and quantitative fluctuations of unconscious impulses, reveals repressed and repressing demands, and, aided by the economic standpoint, reconstructs the genesis of the current drive constellation from childhood history.²

Such a metapsychological formulation of various impressions, empirically gained and then theoretically cast, is the external façade of a psychology which is essentially a drive psychology (Freud's depth psychology). It may be distinguished from descriptive psychology, which stems from psychic phenomenology. The latter may be termed "how" psychology and the former "why" psychology. For example, in regard to the position taken on the question of imagination and perception in paranoid hallucinations, depth psychology does not linger on the "how" but attempts to discover "why" the hallucinations occur and concludes that they represent a projection of tabooed drive impulses in the ego.³

II

In the depth-psychological line of questioning and in the method of free association which developed from it, we find the reason for psychoanalysis' having arrived⁴ at a formulated drive concept from which descriptive psychology has always remained barred. Freud's definition of drive⁵ ("The drive is a borderline concept between the psychic and the somatic") demonstrates that, in addition to the psychological, considerations of biological and physiological aspects are indispensable for clarification. One of the greatest drawbacks of Adler's⁶ drive theory is that, contrary to psychoanalytic teachings, it fails at every point to recognize connections to the biological and physiological. The concept of infantile sexuality which intimidated and confused even highly intelligent minds for so long (and often still does) was finally confirmed by physiological research, although Lipschütz⁷ does add that psycho-sexual phenomena cannot be explained as a result of endocrine secretions alone. The sexuality of children and adult sexual perversion may be viewed as fragments of infantile sexuality which, in the course of further development, have been augmented by new elements in the form of the

influence of sexual glands. The development of the Leydig cells takes place in two thrusts: The first is in the fetus prior to birth and the second is during puberty. "What has usually been termed puberty until now is very probably only a second, more powerful phase of puberty, which begins around the middle of the second decade of life." Likewise follicular and interstitial cell formation was found to take place in women between the second and fifth months of gestation.⁸

We may therefore be justified in taking renewed hope that the old psychoanalytic theory of erogenous zones,⁹ which has been proven significant for the well-being of the individual¹⁰ by psychological methods, will one day stand firmly on a physiological foundation. For the moment, however, we may only share Freud's belief that there is a connection between pubertal glands and erogenous zones.¹¹ The assumption that the erogenous zones are supply areas for the pubertal glands is not farfetched. Also, the idea that special sexual substances circulate in the body was put forth by Freud as a tentative hypothesis in view of the similarity between psychoneurosis (with its predominantly sexual etiology) and intoxication neurosis.¹² There is still considerable dispute in authoritative psychiatric circles as to whether the etiology of dementia praecox is toxic or psychic. A recently published, remarkable monograph by Hollós and Ferenczi¹³ demonstrates that the question of organic or psychic is in itself incorrect. Ferenczi draws attention to the manner in which the self-observing ego faculty reacts to the organically caused personality deterioration in the mental disturbances of general paresis. The manic-paranoid phase stems from this source (compensation for the deterioration through megalomania), as well as the depressive phase (recognition that the integrity of the ego has been injured). It has been demonstrated that alcoholic psychosis must become the object of psychological as well as of physiological or cerebropathological research.¹⁴

III

The concept of psychophysical parallelism¹⁵ is becoming increasingly difficult to defend; reflections on the interrelation of soma and psyche, such as Bergson's¹⁶ in his discussion of aphasic disturbances, are becoming more significant.¹⁷ I feel obliged, nevertheless, not to abandon the parallelistic theory altogether; it forms a good working hypothesis despite the fact that it must always be borne in mind that one operates here in the same way one would with the atomic theory in physics. Euclid's basic geometric laws served as a fertile basis for all our modern technical achievements; nothing seemed more solid, better verified, or more unshakable than they. However, Einstein's critical intellect succeeded in refuting them. One might extend the analogy further: parallel lines actually do cross—in infinity.

We shall proceed from Semon's viewpoint that every sensation is paralleled by a process of physiological stimulus in the corresponding organ and that the sensation is thus the psychic aspect¹⁸ of the physiological stimulus. Processes involving chemical and physiological stimuli in the erogenous zones are one aspect of simultaneously appearing, pleasurable sensations.¹⁹ Their intensity is dependent upon the intensity and duration of the stimulus from without or from within if, as we shall assume, sexual substances have accumulated in a certain area. This accumulation may manifest itself

as the pleasurable tension which at the same time is experienced as unpleasurable and urges toward release of the excitation. Freud²⁰ posed a question in regard to the simultaneous occurrence of pleasure and unpleasure: “This characteristic tension in sexual excitation raises a question difficult to answer, but one which is also very important in the understanding of sexual processes. Despite all differences of opinion in psychological circles I maintain that a feeling of tension must contain a feeling of unpleasure. I find it crucial that this sort of feeling brings about the urge to change the psychic situation and acts as a driving force completely foreign to the nature of the pleasure experienced. However, if one considers sexual excitation unpleasurable, one stumbles on the fact that the same excitation is undoubtedly pleasurable. Wherever there is tension due to sexual processes, there is pleasure. Even in the preparatory changes in the genitals there is a type of satisfaction. How then is the unpleasurable tension related to pleasure?...”

Let us assume, for instance, that the satisfaction of hunger serves merely to counteract something negative without yielding any positive results, and is only a removal of tension. (Except, of course, in the case of “hunger” for delicacies. Epicureanism is related to oral eroticism, thus satisfaction may include a certain pleasure.) All tension originating in the ego is unpleasurable. If I am traveling on business through an ugly area, for instance, on an important mission that affects me personally very little, the resulting tension will be directed toward fulfilling my task as quickly as possible and will be strictly unpleasant. The situation would be different if a loved one were waiting for me at my destination; the tension would then perhaps be greater (in expectation of a reunion) but also partially pleasurable. The journey would then have positive aspects for me. We admit that all tension originating in the ego is uncomfortable to the extent sexual components are not involved. In describing sexual tension exactly, however, we must mention that here pleasure and unpleasure alternate. In our imagination we experience for the moment the pleasure which will later become a reality. Pleasure gained in this manner, although very slight, is responsible for the pleasurable nature of the tension; the following phase will be all the more enjoyable the more intense the preceding fantasy was. Non-sexual tension almost uniformly involves unpleasure, but in sexual tension pleasure and unpleasure alternate, the amplitude of the fluctuation being dependent upon the intensity of fantasized or expected pleasure. On closer examination I can, in fact, agree with Freud’s concept of the unconditional unpleasure in sexual tension, for tension itself—when it is unpleasurable—is merely a result of unsatisfied libido. Intermittent pleasurable elements caused by mnemonic ecphoria lead to an interruption of the tension, which subsequently increases proportionately. However, the nuances between pleasure and unpleasure are so vague, and the various phases intermesh so finely, that one feels justified in speaking of “pleasurable tension.” I must now add, in correction, that it is not the nature of tension that changes, but rather the fantasized pleasure which in turn causes heightened unpleasurable tension. Forepleasure tension naturally contains the same elements, but in much greater measure. In this case a further element is added, namely, the real pleasure gain in the preparatory acts. If we select an erection as a prime example, we may assume that the tension of the skin covering the penis, resulting from local hyperemia, has an effect similar to the external stimulation of the sensitive nerve endings, thus providing a direct pleasure gain.

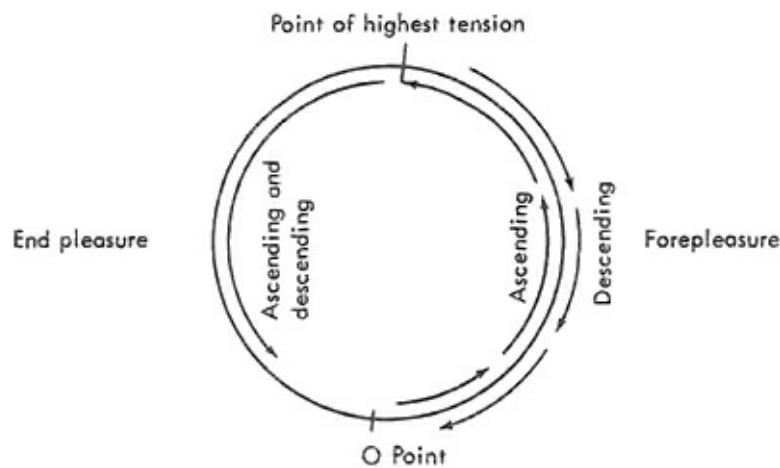
However we may not view the experience of pleasure as a passive submission to a sensation. Recent psychological concepts (act psychology)²¹ diverge altogether from purely sensualistic theories of feeling. They see indications of a biased individual attitude in every psychic experience; “it is incorporated into the experience.” Bergson²² has termed perception “virtual action” and has also provided the most correct phenomenological description of pleasure sensations.²³ “What is great pleasure other than a preferred desire? And where do our preferences lie if not in a certain disposition of our organs, which causes our body—in the case of a choice between two pleasurable sensations in the psyche—to incline more toward one than toward the other? If one analyzes this inclination, one finds innumerable movements, *as if the organism were striving toward the pleasure offered. The attraction of pleasure is nothing other than the beginning of this movement,*²⁴ and the intensity of enjoyment originates in the organism’s momentum as it becomes engulfed and rejects and repels all other sensations.” The contraction of the bulbocavernosus and ischiocavernosus muscles is responsible for orgasmic pleasure.²⁵ The reasons for contractions of musculature in the penis and lower pelvic cavity, causing such highly specific orgasmic pleasure sensations, will have to be provided by physiological disciplines. We are primarily interested not only in the different localization but also in the different function of the fore- and end pleasure. The former ecphorizes greater readiness for motor activity, paralleled by progressive concentration of libido on the genital musculature. No matter which partial drive serves the forepleasure mechanism, and regardless of the normality or perversion of sexual activity—whether narcissist, pederast, or exhibitionist—end pleasure always remains focused on the genitals.

Hence the “motor” criterion cannot be the most significant one in differentiating between peripheral-tactile forepleasure and orgasmic-motor end pleasure. Equally intense motor tendencies are involved in both. The only decisive quality is the concentration of libido at the genitals in the orgasm. When the latter subsides libido again diffuses to the other erogenous zones. It is like the foaming of the ocean’s waves thrown against the rocky coast, which then repels them in wide planes. It is understandable that prevention of the subsidence of this excitation and its diffusion into the erogenous zones, because of coitus interruptus, creates the unpleasurable tension which finally leads to neurasthenic and anxiety-neurotic symptoms.

We view this motor incorporation into the pleasure sensations to be one of their integrated constituent parts and cannot conceive of the passive-receptive elements without it. Simultaneously, we feel that this is the very prototype of the “drive,” i.e., the drive in its most primitive form which is extinguished, so to speak, in itself. In pleasure sensations, a self-generating and simultaneously self-nullifying force—sexual pleasure—desires itself and is extinguished when its desire ceases, namely, when satisfaction has taken place. Unpleasure and resultant tension are not only caused by the prevention of pleasure gains but even more by the hindrance of the nullification of pleasure (which can take place only in the genitals), according to whether one considers the sensory or the motor elements. The organism strives to maintain the most stimulus-free condition possible²⁶ and to keep the energy on the surface constant. Every increase of surface potential must have an unpleasant effect if a

decrease (i.e., the transformation of motor energy into potential energy) is prevented. The pleasurable aspects are due to the fact that every increase is accompanied by a partial decrease; only a decrease of surface potential actually provides pleasure. As paradoxical as it may sound, it is not the self-generative but the self-destructive elements of pleasure sensations which cause the actual pleasure. It is as if the carriers of the surface potentials take five steps forward and three backward in forepleasure. It is characteristic in sexual pleasure that partial reduction acts as a stimulus for the building up or increase of tension. However, this is valid only in forepleasure. In end pleasure, tension differences become increasingly great; the increase and reduction pass through larger ascending and descending phases, until finally the descending component reaches the desired zero point and the ascending component cancels itself because both originated at the zero point.

When the descending phase equals the ascending in intensity, the ascending and descending phases suddenly reverse at the point of greatest tension, forward or backward respectively, toward zero. Whereas in forepleasure the directions were opposites, in end pleasure they now correspond. The difference in intensity of the ascending and descending phases (increase and self-destructive tendencies) constitutes the drive-dominated nature of sexual pleasure.²⁷



IV

What causes renewed progression—in other words, what rekindles the desire for new achievement once it has extinguished itself? It would be easy to answer the question by using the mysterious concept of “drive.” However, in my analysis of pleasure sensations I was unable to avoid the impression that the prototype of drives may be seen in the motor elements of sexual pleasure. I hope I will not be accused of trying to solve the riddle of the drive in this way! I would never have dared to begin this exposition with such intentions. In science there is no basic answer to fundamental questions (and the drive problem is indeed one of these) but only a shifting in the line of questioning, or rather engendering of new problems through the solution of the old. *The question of the nature of drives is transferred to that of the nature of sexual pleasure*, if my explanations have been accepted. I have merely described the nature of the pleasure sensation in more exact terms. A causal explanation cannot and may not be our objective, due to the present state of our knowledge. The question would without fail lead us into the most profound depths of biology.

However, my analysis of the pleasure sensation does enable me to derive a more exact understanding of the drive concept. It encompasses the ascending (constructive) and descending (destructive) aspects of the assimilation of the individual into the pleasure experience. However, it is also part of the drive concept that the impelling urgency is experienced without pleasure sensations. (“To have a desire for desire.”) If the pleasure sensation is the essence of the drive, it becomes its origin and source only via the mnemonic function. The drive viewed thus is the motor expression of the memory of pleasure already experienced. I wish to remind the reader that I am merely restating more concisely what Freud²⁸ mentioned incidentally in another context:

“A drive can never become the object of the conscious mind, but only the idea representing it. But it can only be represented in the unconscious by an idea as well. If drives did not attach themselves to ideas, or did not appear as affects, we would have no knowledge of them. If however we do speak of unconscious, or repressed, drive impulses, this is mere terminological negligence. By this we mean nothing other than a drive impulse, the representation of which is unconscious; anything else would be out of the question.”

It is obvious what this conceptual representation may be—an idea of an object, or rather of an organ, closely associated with the memory of experienced pleasure. This association alone gives an idea import, whether in the sense of attraction (pleasure) or defense (unpleasure).

In a discussion of autoerotic infantile sexual behavior, Freud remarks: “Further, it is obvious that the actions of the sucking child are determined by the search for previously experienced, and now remembered, pleasure ... It is also easy to guess on which occasions the child first experienced this pleasure which it now strives to renew. The first and most vital activity of the child, nursing on the mother’s breast (or breast substitutes), must already have acquainted it with this pleasure. We might say the child’s lips behaved like an erogenous zone and stimulation through the flow of warm milk was surely the cause of the pleasure sensation...”

Concerning the infantile sexual goal, he says: “The sexual goal of the infantile drive consists of achieving satisfaction through stimulation of voluntarily selected erogenous zones. Satisfaction must have been previously experienced to leave behind a need for repetition.”

On revival of infantile masturbation at approximately age three he states: “However, all particularities of this second phase of infantile sexual activity leave very deep unconscious traces in the memory of the individual and determine further character development if he remains healthy, or the symptomatics of his neurosis if he becomes ill after puberty.”

The direction of the drive is determined by its point of departure, namely, the pleasure intensely experienced in a certain organ. The fixation of a drive indicates strong emphasis upon constitutionally erogenous zones, to the extent fixation of autoerotic drive elements is involved. Behind fixations of object-libidinal drive elements, we regularly discover autoerotic fixation; hence, for example, many a mother fixation is caused by extreme erogeneity of the oral zone and is therewith secondarily determined by fixation on the mother’s breast. Every object dissolves, in the course of analysis, into single organs which provided pleasure; likewise, the narcissistic inclination of the entire personality

breaks down into fixations on autoerotically important organs (anus, mouth, penis, etc.). Hence, we may view infantile object selection as the first synthetic-abstract achievement. The idea of the mother's organs is repressed and combined into the superimposed concept of a mother. With the completion of this synthetic act, the barrier between sensual (organs) and tender (mother) impulses is erected.

In psychoanalysis one speaks of libido fixation. According to the psychoanalytic definition, libido is the intensity attached to a drive, or the measure of its strength. We differentiate between ego and object libido according to whether the drives are focused upon narcissistic-autoerotic goals (the organs of one's own body) or on the external world (prototype of the final goals: the organs of the mother, sister, nurse, father, brother, etc.). Libido, as an intensity factor of drives, is thus the complement of the concept of potential pleasure energy which must still be postulated. The intensity of a pleasurable sensation experienced in an organ is decisive for the intensity (libido) of the corresponding partial drives. In turn, the intensity of the pleasurable excitation is dependent upon the organ's physiological disposition to arousal. Hence "drives" indeed result from hormonal processes but only indirectly; the causal link which connects the two is pleasure as a direct result.

Let us return, after this digression, to answering the question of what factors are responsible for reviving (in other words, reactivating) desire after it has extinguished itself. Following successful coitus, all sexual energy in potential form (to remain with our metaphor) has reached zero surface potential. But what causes the renewed tension, i.e., the rise of the surface potential? By noting, in correction, that there is nothing forcing us to attribute potential and kinetic (drive) energy to pleasure sensations, we rid ourselves of any accusations of dragging physical concepts into psychology. Let us remember that the body, or rather the sensory-motor system, is the executive organ of the psyche. Just as the blacksmith must wait inactively until the nearly extinguished forge begins to glow once again by use of the bellows, so the reservoir of pleasure engrams must wait until the sensory-motor system, exhausted in the orgasm, recovers and is capable of achievement once again. Engrams are also ecphorized, and thus sexual tension is increased by the continual influx of stimuli from the psyche (fantasy) and the body (touch, sight), and not least of all by changes within the body itself (hormone production, sperm accumulation in the tubuli, discharge of the menses, etc.). Every internal or external stimulus has an ecphorizing effect.

Just as the sexual pleasure in every individual pleasure sensation generates and simultaneously destroys itself, thus serving as the source of the pleasure-drive-pleasure cycle (as internal and external stimuli reactivate the engram reservoir of pleasure sensations, i.e., the drives), in the same way the innate portion of the sexual drive can be nothing other than the mnemonic pleasure engram reservoir, experienced in body and psyche by our early ancestors and activated by child care.²⁹ The fact that libido does not develop in early castrati but remains in late castrati proves our views on the ecphorizing effect of childhood pleasure on the mnemonic portion of the sexual drive.

Let us attempt to summarize:

1. Endocrine secretion and organ erogeneity are not the direct bases of the sexual drive but rather assume this function indirectly through the peculiarity that when stimuli occur the erogenous zones become aroused, and this is perceived as a pleasurable sensation.

2. These are the constituent elements of a psychic organization we call the sexual drive, due to its particular characteristic of having to be re-experienced.

3. The drive theory also comprises the concepts of organs and objects which are associated with the idea of pleasure.

4. *Functionally the sexual drive is the motor aspect of all pleasure experienced in phylo- and ontogenesis; psychologically it is an expression of the memory of experienced pleasure.*

5. Libido sexualis is a measure of intensity and is dependent upon the intensity of pleasure sensations from which the motor transformation has proceeded.

6. Hence the problem and the line of questioning is transferred from drives to the psychological and functional peculiarity of sexual pleasure, namely, that it must be re-experienced. Within the realm of this new problem falls the question of the how and why of specific sexual substances.

I am aware of the disadvantages which arise from such concentrated treatment of this important issue. I did not intend to pursue related questions and complications, but wanted only to present, in essence, a compendium of the drive with consideration of its basic rhythm. Hence, I was forced to omit the higher, arrhythmic drive manifestations. This was all the more easily done, as psychoanalytic literature, especially Freud's basic works (*Instincts and Their Vicissitudes*, *Beyond the Pleasure Principle*, etc.), has treated the higher-drive derivatives in great detail. My exposition is intended to be simply a thorough pursuance of the psychoanalytic drive concept in its constituent elements, with consideration of the latest physiological findings and more recent developments in descriptive psychology.

*On Genitality**

From the Standpoint of Psychoanalytic Prognosis and Therapy

The theory of psychoanalytic therapy is most intimately connected to practical experience and is thoroughly dependent upon insight into the earliest phases of libido development. Even today it is by no means complete, and intense efforts must be made to achieve clarity concerning the mechanisms of analytic cure. The following exposition may be viewed as a small contribution to the solution of a subsidiary problem. I shall discuss the role which genitality plays in the prognosis and treatment of transference neurosis, and I believe that in doing so I am bringing an issue worth noting to the fore. It is quite striking that among the twenty-eight male and fourteen female neurotics I have treated, there was not one who did not manifest symptoms of impotence, frigidity, or sexual abstinence. A survey of several other analysts revealed similar findings.

I

Freud supplied essential reference points for a comprehensive grasp of the theory of analytic therapy mechanisms. Let me recapitulate briefly. We are acquainted with: (1) mitigation of tension in treatment through acting out or remembering a repressed affect or idea (one of the most effective therapeutic processes); (2) transference, that mighty enzyme that aids in the solution of inner conflicts, although not a healing factor itself; (3) the role of “conviction,” which motivates the patient, through inner accommodation, to condemn desires, attitudes, and drives which have become conscious.

These are processes which interpenetrate with varying intensity, according to the case, and finally help the patient to take the step from the pleasure principle to the reality principle which he was unable to take in childhood.

We immediately encounter further problems of analytic therapy when we consider that all these processes (acting out, transference, etc.) are merely *modi operandi* on basically biological-psychological material present in the patient, which the analyst can neither add to nor subtract from. This material is represented by what we call drives. Analysis simply implies a reorganization of the drives, or actually a “synthesis” (Freud),¹ accomplished by loosening fixations at one point and helping a weak tendency to achieve its full development at another. Consequently, in-depth analysis of a severe neurosis basically involves a *biological* process in which we must reckon with biologically caused factors within the patient.

In addition to the statement that the above-mentioned processes of cure are merely operative in the drive material, I must mention two other facts little studied until now: (1) that *improvement, even in serious neuroses, may occur when these processes have not been completed*; (2) that *symptoms can*

stubbornly resist treatment, despite extensive disclosure of the contents of the unconscious, despite the presence of conviction and condemnation, and also despite transference.

The problem of a neurosis resistant to analytic treatment demands the analyst's most earnest concern in theoretical as well as practical respects. I consider the opinion that everything about refractory neuroses has simply not yet been discovered as not generally applicable in light of the fact that symptoms can recede without complete exposure. The healing process may be divided into two parts: (1) recalling the repressed material to consciousness; (2) the conflict of the newly conscious drives, attitudes, and desires now fought on common ground. In point 1 the analyst can achieve a great deal and "certainly also ruin a great deal" (Freud); in point 2 he must come to terms with what he finds.²

We are well acquainted with the difficulties in the analysis of masochistic-feminine patients (Freud)³ and narcissistic patients (Freud, Abraham),⁴ and the relatively poor prognosis for the treatment of perversion (Freud). However, these are not dogma, and masochistic-feminine, narcissistic, and perverted patients can improve considerably and even recover completely.

In the following, when I deal with the significance of genitality for the therapy of neurosis, I shall not consider the known processes in the psycho-biological drive material mentioned above but rather attempt to find the conditions of recovery within this material itself. It is advantageous to mention beforehand that for section III (which is concerned with neuroses that are refractory) I studied nine case histories of male neurotics who underwent depth analysis, that is, who experienced at least a clarification of the oedipal period and remained resistant permanently or for a long while. Among them were two compulsives, three hysterics (with compulsive traits), two erythrophobics, a stutterer, and a psychosexual hermaphrodite. All suffered coincidentally from potency disturbances to a greater or lesser degree. Three of the cases may at the same time be termed neurotic characters. Seven had long since been released from treatment and were occasionally asked to return for check-ups. The complicated genital situation of women could unfortunately not be studied precisely, because the number of pertinent cases was too small to assure valid results. In this respect my delineations will show a gap, although this could easily be remedied by further study.

II

First, the question of how extensive improvement or remission of symptoms is possible without complete exposure of the unconscious.

Case 1. A young college graduate in treatment for eleven months because of inability to work due to wandering thoughts, migraine headaches, vertigo, compulsive brooding, and fear of impotence. After eight months of treatment the oedipal attitudes were resolved to the extent that he engaged in intercourse successfully for the first time. The next day the inability to work and migraines disappeared (these had already improved two months before), although various lesser symptoms persisted. After twelve more weeks of treatment, filled with the struggle to wean him from the analyst (the patient reacted to any hint that treatment would soon be over with a relapse), he was released

from treatment and took a job as a bookkeeper, which he has held successfully for two and a half years. He is now potent, his inability to concentrate has disappeared, but relatively severe confusion during conversations regarding emotional matters still remains. The patient experienced a long period of masturbation in childhood. After repression, he regressed to the anal stage, which revealed itself in the form of compulsive brooding about the birth process. Later compulsive brooding and doubts were manifestly related to metaphysical problems. After the repression of genital eroticism was eliminated and the incestuous desires made conscious, intercourse was successful; the anal-regressive phase was discussed only incompletely and the oral-libido position almost not at all.

This was a case of incomplete analysis, with the result that the most socially disturbing symptoms disappeared altogether but that neurasthenic traits persisted partially. The effect of liberated genital libido was prompt.

Case 2. A thirty-two-year-old psychosexual hermaphrodite who was impotent with women, had suffered from excessive compulsive masturbation from age eight onward. The patient had been in analysis for twelve months. At the beginning prognosis was questionable due to his excessive narcissism. Only through active intervention⁵ could he be made to expose his unconscious masturbation fantasies and thereby give up his excessive masturbation.

Following this, intercourse with women was successful in every respect; however, incautiously I expressed my satisfaction, and as a result the patient went directly to a prostitute after treatment and was completely impotent once again. His narcissism had begrudged me my success. After the summer vacation he reported having twice visited a public swimming pool frequented by homosexuals; he had attempted intercourse but did not achieve satisfaction. He told me, as if to excuse himself, that he had wanted to see whether he was still capable of homosexual acts. This interesting development of wanting to make a conscious decision, which had been implemented by treatment, encouraged me to suggest waiting before continuing analysis. After three months his condition was the same as it had been before analysis. After six months I asked him to return. This time he literally inundated me with gratitude and reported that several months before he had begun an entirely satisfying relationship with a girl, that his potency was excellent, that homosexual ideas and fantasies were virtually nonexistent, and that he wanted to marry the girl. Five months later his condition continued to be good.

In this case as well, I was certain that essential factors had remained unrevealed,⁶ among others, the point in his life at which he had turned from his mother, his anal fantasies, and his position between father and mother, etc. Only his infantile masturbation period (ca. age five), including incestuous fantasies, had been thoroughly discussed. Until the time of analysis he had never met his father, as he was an illegitimate child (longing for the father: homosexuality.). During treatment he decided to visit the father, who was living in the same province, and became reconciled with him during a lengthy heart-to-heart talk.

This case is now practically free of symptoms, although theoretically unclarified in its essential points. The causal therapeutic intervention solved only one essential factor, namely the compulsive masturbation with its genital fantasies.⁷

The early beginning of his compulsive genital masturbation proves that this patient had also

experienced a phase of genital libidinal attachment to his mother.

Case 3. A twenty-six-year-old man in treatment for four months due to impotence and lack of feeling toward women. The patient was apathetic and sluggish. Virtually no transference occurred in analysis. There were many indications that he was intensely anal and feminine and, when at home, substituted for his deceased mother, attending to the household, etc. He was given an explanation of this, as well as of his concealed genital masturbation. In the beginning, he stated he had never masturbated genitally, information which, if true, affords a poor prognosis in impotence. I then discovered that he manipulated his genitals almost continually, even to the point of a sensation similar to an orgasm. He was on the verge of disclosing infantile material when he developed severe resistance, took a vacation, and after four weeks informed me of his “recovery,” which, as far as I know, was permanent.

Here there was also a strong mother fixation through identification. The patient manifested many traits of latent homosexuality and definitely belonged to those more severe cases characterized by a passive-feminine constellation. Nevertheless “recovery”⁸ was very swift.

Many such cases can be reported but I shall allow these three to suffice. What was the situation in regard to their genitality?

The first had repressed his genitality, although he did masturbate briefly during puberty. The second masturbated excessively and repressed his incestuous fantasies. The third had masturbated genitally from childhood, although in a disguised form.

The favorable solution of these cases, despite insufficient analysis, speaks for the possibility of loosening, within the unconscious, the residual, originally fixed libido positions without conscious processing. It is as if the portion of anchored libido liberated in analysis had established itself in reality and paralyzed the indirect satisfaction of still-repressed libido by means of the attainment of real satisfaction. It is essential only that liberated libido be strong enough and the remaining repressed libido weak enough to enable this paralyzation to take place. No partial drive is as well suited for attachment to the external world as genitality. If the remaining libido is too strong (more on this later) or if the course of analysis causes, for example, a release of anal positions before genital ones, then freedom from symptoms⁹ is an unlikely result when analysis is incomplete because only genital libido is even partially tolerated in the repression-filled atmosphere of reality. Such cases result in the well-known retention of one or more symptoms, despite their clarification (as mentioned by Freud in a discussion).

The results depend substantially upon the course automatically taken by analysis. Patients who tenaciously grasp the analysis of a symptom, due to a peculiarity unappreciated until now, and occupy themselves mainly with handling one definite libido element, achieve symptomatic relief,¹⁰ if this element is genital, through unconscious loosening of the neurosis structure and by paralyzation. This impedes exhaustive analytic insight into the structure of the neurosis. There are others who flee from issue to issue, from libido element to libido element, driven by resistance, and who supply only fractional solutions to this symptom or that. However, in time they afford better insight and achieve

improvement or complete analytic recovery.¹¹

Experience inevitably confirms that liberation of genital libido is also highly important in analytic treatment of neurotic women. Even though the analyst must contend with a world full of prejudice, lack of insight, and dishonesty in regard to female sexuality, he must nevertheless maintain the standpoint he has gained through experience, namely, that, in principle, the same mechanisms are active in women as in men, although transformed in keeping with the other sex. Repression of the desire to masturbate is, on the average, significantly stronger in women due to the displacement of genital eroticism from the vagina to the clitoris which is usually present, as well as to complicated masculinity desires. The resolving of incestuous fantasies and elimination of guilt feelings frequently lead to masturbation, which always has a liberating effect. (The patient must arrive at masturbation by herself.) In married women the road to genital satisfaction via masturbation is unnecessary if the husband is potent. In men also, especially in the treatment of severe impotence, one encounters conventional barriers which are not to be underestimated if masturbation is to be replaced by heterosexual attachment and sexual intercourse. But in comparison to the corresponding difficulties in women, particularly in girls raised in repressive milieux, they are hardly noteworthy. One compulsive female patient who had abstained from intercourse, due not only to moral convention, but also to compulsive rejection of men, would not masturbate, even after complete analysis leading to extensive symptom remission. Sometime later she recovered entirely when she married and experienced genital satisfaction. Another girl from a more liberal sexual background, who had supposedly sought treatment of her enuresis (in reality she had come because she had remained emotionally attached to a man who would have nothing to do with her although they had once had intercourse), recovered from this and other neurotic attitudes as well when, shortly thereafter, she began a completely satisfying relationship with someone else. And still another who had been frigid in several relationships recovered, after analysis, from her inferiority complex and from several compulsive symptoms as well. In these cases analysis had brought about merely the solution of an incestuous father fixation. Of course it would not be correct to postulate that a satisfying sexual experience had cured these people. They first had to be made capable of these experiences through analytic liberation from their neurotic reaction patterns. One often hears of neurologists recommending that young female hysterics marry. In minor actual-neurotic disturbances and minor anxiety conditions, marriage may sometimes help, but under no circumstances where repression, particularly of genital libido, is present. In such cases marriage can only be disastrous. The same holds true for the advice about starting a relationship that neurologists often give abstinent male neurotics. Whoever gives such advice overlooks (due to a lack of knowledge) the fact that, for example, erythrophobics have no access to their genitality because it is repressed and transferred to the face.

Concerning masturbation begun, or continued, during analysis, it must be mentioned that the danger of fixation on this mode of satisfaction is present only when masturbation dominates libido discharge and is accompanied by guilt, which is often extremely difficult to eliminate. On the other hand, I know of no case in which masturbation practiced during analysis complicated the approach to genital union with a partner after the fantasies and guilt had been resolved.

Case 4. This case of a forty-five-year-old climacteric virgin suffering from severe anxiety from earliest childhood, as well as from a severe hysterical respiratory tic from age twenty-two, illuminates the significance of genital libido in influencing even neuroses of long duration. The patient remained a virgin due to inhibition and satisfied herself for a time through genital masturbation characterized by the insertion of little tubes into the vagina each time one of her relatives married. Whenever she forbade herself to do this, the tic would become more severe for some time. It was a symptom of repressed masturbation and fellatio desires (Ferenczi). The former came under discussion. Unfortunately the patient was unable to be analyzed properly because of deafness, which she hysterically misused and exaggerated as well. Several cathartic hypnotic sessions at the beginning of treatment and months of discussion nevertheless shed some light upon the neurosis. As soon as she remembered her desire to masturbate and the attempts she had made to do so, and had come to terms with them, the tic almost completely disappeared. She then practiced masturbation from time to time, which usually brought her relief, although not always, as she suffered from immense guilt feelings toward her mother, who had forbidden her to masturbate at age five. The guilt feelings, of course, could have been eliminated only by analysis. In any case, the partially regained genital freedom did cause some lasting improvement, although almost negligible compared to the improvement of the other symptoms (compulsion and anxiety states).

In periodic depressives it is common for more or less severe potency disturbances to occur in men and vaginal anesthesia in women during the depressive phase, only to disappear once again when the depression subsides. We may view the fluctuation of genital readiness as an expression of the affective oscillation of the entire personality.

In cases where relatively intact, unrepressed genital impulses are in the service of a neurotic-perversed tendency, one has to struggle with the immense advantages acquired by the perversion when it seizes possession of genital libido.

Case 5. A thirty-seven-year-old compulsive brooder and doubter, suffering from mild ejaculatio praecox, had married six months prior to the beginning of analysis and had remained impotent since his very first attempt at intercourse with his wife (although he had always been able to have intercourse with prostitutes assisted by various perverted practices). Analysis yielded the following: From childhood there had been damaging rivalry with a brother some years his junior. At age twenty-five the patient broke three engagements because he did not wish to give up his means of satisfaction with prostitutes. Active in the background was a strong attachment to his mother which was not entirely unconscious. While away in a foreign country, the patient heard of the marriage of his younger brother. He then no longer enjoyed being in a foreign country, returned home, and married the first girl introduced to him several weeks later. In this case analysis could not boast of success, although the patient did manage finally to have intercourse with his wife. Inwardly he longed for the satisfaction he obtained from perversions and intercourse with prostitutes. Analysis did not progress, since the only motive which could have furthered my work, namely, the desire to stay with his wife, was too weak in every respect and the perverted tendencies too strong. Had he been ten years younger

he might have yielded to the pressure of analysis. He left his wife shortly after discontinuing treatment. The question remains unanswered as to whether the decision of a doubter, an ambivalent neurotic incapable of making up his mind, to end his torturous life with a woman is not to be viewed as a sign of success. His wife, who had been healthy until this time, almost fell prey to his illness inasmuch as indications of early hysteria became manifest.

III

Most of the cases mentioned until now involved both minor and severe affects which combined with an infantile neurotic disposition later in life. In all cases, genital-libidinal impulses were more or less strongly pronounced and partially unrepressed, although incestuously connected and active in genital masturbation (for instance, case 2). For the most part, particularly in the women, genital libido had been strongly repressed and subjected to hysterical or compulsive transpositions and substitutions. Whereas the main therapeutic objective lay in the resolution of incestuous fixation in the cases with unrepressed genital libido, the others involved reversing the transposition and regression processes. However, one could always rely upon genitality, which, awakened from its "Rip van Winkle sleep," could assume its normal function once again.

The following two cases represent "old" neuroses in Abraham's sense, in which analysis could not from the start rely on the presence of even a repressed genitality capable of functioning. Contrasting these types will illuminate the fact that, in the prognosis of old neuroses existing from earliest childhood, the following questions can be crucial:

1. Did similar damage occur before or after the childhood-genital phase?
2. Was this damage able to arrest the development of genital-libidinal forces altogether, or only substantially impede it?

In other words, what kind of damage occurred? Both cases involve damage prior to the genital phase.

In many cases where the present illness has existed for only a few years, one encounters, in the course of analysis, neurotic disturbances that already existed in childhood, i.e., the present neurosis is based on an earlier one (Freud). But still these cases show a remission interval of undetermined length, during which libidinal balance was restored. The spectrum comprises a continuous progression from post-pubertal neuroses, with early cursory neurotic symptoms, to the severest cases of neurosis dating from early childhood without a remission interval. The latter are naturally the most difficult to influence, and prognosis in regard to complete recovery is almost always questionable. One encounters here a rigid drive constellation based upon infantile fixations with drastic disturbances of genital drive tendencies. In addition to this, the entire personality is permeated with distortion due to the long duration of the illness and the attachment to neurotic attitudes. Those parts of the personality to which we address ourselves as helpers in analysis prove very weak and insignificant.

In other analyses I perceive our task to be the use of flexible, unrepressed drive impulses against those which are repressed, rigid, and fixed (Freud). Further, we can observe how genital libido

liberated from repression aids recovery tendencies (cases 1 through 3) and how other rigid drive impulses become more flexible and reconcilable in the transference struggle or in recent conflicts, finally either yielding to the main genital impulses or achieving sublimation through other means. The prerequisite for this favorable solution is a certain measure of activity, which is a principal characteristic of genital eroticism but cannot be more clearly defined. Further experience shows that a tumultuous solution, a clamorous struggle of the antagonistic forces now in the same arena (Freud), is more painful but leads to a more thorough solution than tranquil, silent recognition. This calmness, which often has the appearance of indifference, may be an expression of resistance, i.e., “This is all very fine, but it does not affect me.”¹²

Case 6. A twenty-eight-year-old farmer’s son has been in treatment for three years due to complete impotence and has remained completely resistant to treatment with the exception of almost insignificant improvement, such as slight erection ability in masturbation and decrease of timidity with women. He belongs to those cases which allow very deep insight into their libido development but seem to cling endlessly to their symptoms. Analysis went back to the end of age two and always progressed at a steady rate, interrupted only occasionally by the usual resistance to new disclosures. Two significant dreams at age three were exposed. He had been suffering from enuresis nocturna and was once beaten unconscious by his very austere father, whom he consciously loved as much as he unconsciously hated. From that day onward the enuresis stopped, although later (ca. age six) it transformed itself into a compulsive symptom, namely, urination every time he entered a certain cellar. (I shall not examine the clinical aspects of this case.) At approximately the same time (outside information indicates he was then exactly three years and two months old), the patient’s stepmother (his own mother had died shortly after his birth) delivered a child and the patient witnessed this through a glass door from the adjoining room. The horrible sight of the huge bloody cavity had, via identification, led to his own imaginary lack of a penis. This castration trauma became symbolic because of its connection with punishment for a genital, or actually urethral-erotic crime (i.e., bedwetting), a short time before. A year or two later, when the patient was told his father’s wife was not his mother, he turned away from her completely (jealousy of the other stepsiblings contributed) and resurrected his own mother in fantasy—that is, his conscious desire from then on was to die and be united with his mother once again.

The gravity of the reported experiences alone would suffice to explain the severity of the neurosis, but not its resistance to treatment. In this case the patient’s age, or rather the stage of libido development in which the traumas were experienced, seems to be a decisive factor. Analysis showed that, at the time of the first two traumas, the patient was in the libido-development stage where the important step from identification with the love object (here the stepmother) to genital object selection must be taken. When the traumas took place, genital eroticism was in the germination stage and the patient’s libido position was that of narcissistic identification (Freud). His narcissism never climaxed in the attainment of the genital phase and remained permanently damaged. Further genital development was arrested by the trauma of being beaten. The birth scene resulted in fixation of the libido in the identification stage. Hence his relationship to his father was set in a passive-feminine

pattern. His later manner of masturbation typified this: He caused ejaculation by extreme tension of gluteal and leg musculature. He had practiced this muscle tensing in childhood also, in order not to feel so acutely the pain of his father's blows. However, there was also incestuous attachment to the stepmother and younger sister dating from the period prior to age three, but this was oral-urethral and not genital in nature. Analysis of incestuous relationships alone is not adequate to solve genital insufficiency when these relationships are not genital in nature.

In regard to prognosis, I could only hope that in further analysis he would take the step to genital eroticism prevented earlier or that the analysis would expose the indispensable minimum of genital libido necessary for recovery. Until now these hopes have remained unfulfilled.

In other cases where genital organization is established in childhood, we see that strong genitality, no matter how intense the subsequent repression to which it is subjected, is easily capable of resisting guilt. If, in analysis, we liberate genital libido from repression, we find it of great assistance against guilt feelings; it is their greatest opponent. Furthermore, it contributes to the struggle against passive tendencies, that measure of activity¹³ indispensable for recovery. In case 6, guilt feelings were able to take effect uninfluenced and undisturbed by genital-narcissistic impulses.¹⁴

The most profound cause of the patient's affect paralysis, which manifested itself in everyday life as well as in his transference, and of his feebleness in the conflict, was a lack of genital eroticism and activity.¹⁵ I was unable to find a drive force to assist me in my efforts to annul the guilt feelings and infantile means of satisfaction which were extensively revealed. Transference also, although uniformly positive, was characterized by emotional paralysis.

Case 7. A twenty-eight-year-old man in analysis for sixteen months due to impotence, nocturnal emissions, headaches, anxiety, inferiority feelings, and obstipation. The obstipation existed from earliest childhood. Almost all members of the family are neurotic and suffer from chronic constipation. (From ages four to ten the patient experienced hysterical fear.) A quite uncommon anal fixation in the pregenital period determined his later destiny. His emissions were remnants of a short urethral period at approximately age four. Now urine came instead of semen, flowing out irregularly. (See Abraham on the significance of ejaculatio praecox.) Very late in analysis a short but intense period of genital masturbation, voyeurism, and exhibitionism at age five was revealed. Only then did the symptoms begin to recede, the intestinal function became completely regular, and the patient had intercourse successfully several times.

In case 6 there is a fixation in the pregenital organization as a result of traumatic inhibition. Case 7, however, involves fixation due to "pleasure hypertrophy" (of anal libido) in the same stage. The cause of pleasure hypertrophy appears to be constitutionally emphasized erogenous zones.¹⁶ Nevertheless, genital development did occur to an extent difficult to ascertain, although genitality was later overcome, so to speak, by pregenital organization. The difference between fixation due to inhibition and fixation due to pleasure hypertrophy is significant in prognosis. Although weak because it was riddled with anal-sadistic traits, genitality in the latter was important in childhood and was able to be freed from its supplements, against which it was subsequently effectively employed. As was

demonstrated, this crutch is of no use in neurosis after fixation resulting from inhibition, as the patient had reached only the rudimentary beginnings of the genital phase or had never reached it at all. Furthermore, fixation due to pleasure hypertrophy involves a surplus of libidinal impulses, whereas fixation owing to inhibition involves a lack of these impulses, because intimidation also spreads to pregenital organization, resulting in emotional paralysis. In psychoanalysis one can usually use a surplus of libidinal impulses to better advantage than weak, sparse drive impulses. However, I do not underestimate the difficulties caused by pregenital pleasure hypertrophy in perversion.

I believe we can isolate one important element. The prognosis for long-standing neuroses is more favorable if less-disturbed genital development was able to flourish in childhood. Whether repression of genital libido occurs early or late has no significance for a prognosis. What is important is that it exists at all. When liberated from repression, it becomes a powerful tool in the hands of the analyst. It produces activity, inhibits the effect of guilt feelings, counteracts all passive impulses, and is best suited to render even the strongest of other drive demands powerless.

The difficulties encountered in the analysis of erythrophobics illustrate the position of genital libido in this illness. In contrast to that in typical compulsion neurosis, it is characterized by particularly strong genital narcissism, which has been transferred to the face through repression of exhibitionist tendencies (blushing = erection).¹⁷ Hypergenitality is not simply a reaction to the castration complex but is much more intrinsic. The genital period in childhood was experienced as especially pleasurable, and damage in the sense of the castration complex struck the climax of infantile genital masturbation and exhibitionism like a bolt of lightning. The typical hypochondriacal complaints in erythrophobics, as well as the strong narcissistic homosexual traits seen in neuroses, are also found in paranoid illnesses. For instance, the fear of being observed, or of betraying masturbation through outward appearance, and the like, is entirely paranoid. Deluded by narcissism, most of these neurotics really believe people are watching them, laughing about them, etc. Insight into the illness is also rarely profound in these (unconsciously) genital-narcissistic, homosexual patients.

A narcissistic but damaged hypergenitality causes therapeutic difficulties just as does hypogenitality (case 6).

IV

In order not to complicate my delineations, I have omitted some other neurotic positions unfavorable for a good prognosis, such as deep guilt feelings due to unconscious masochism (Freud, *The Ego and the Id*, “‘A Child Is Being Beaten’”). The relationship between genital, or rather narcissistic-genital, libido on the one hand and masochism and guilt feelings on the other is one of the most important unsolved practical problems of psychoanalysis. I intended only to demonstrate the importance of genitality as a therapeutic aid and to present the prognostic prospects it offers the analyst. In the beginning, patients' comments on their genitality are not easily evaluated if analysis has not yet yielded clearer data. A patient's report of a long period of genital masturbation can be deceptive and is not a valid indication of strong genitality. If one probes deeper, one often hears subsequently that the

practice of masturbation did not involve rhythmic movement of the pelvis or rhythmic friction with the hand, but rather pressing the genitals so that semen flows out (urethral), or that ejaculation was brought about by rhythmic contraction of the intestinal muscles¹⁸ (anal) or by squeezing the penis between the thighs, etc. On the other hand, acts equivalent to genital masturbation (Ferenczi), such as tugging at various parts of the body, the habit of handling every part and playing with it, continual unconscious touching of the penis through the trouser pockets (case 3), etc., may indicate strong but repressed genitality. The effects of an intense castration complex may also be numbered among the signs of injured genitality. One can evaluate genitality from fantasies even better than from the patients' complaints. In case 6 the man was materially interested in marriage but could hardly be brought to cease his complaints of incapability to have intercourse; he had never fantasized vaginal coition but rather biting off a woman's breast or drilling through her as the act of intercourse.

The complicated connections, transformations, and substitutions of pregenital organization, and the relationship of the various libidinal components to corresponding erogenous zones, are destined to become central questions of psychoanalytic pathology. A preliminary comment in this regard is relevant to my topic. I have access to material, cases 6 and 7, among others, which forces me to assume the existence of a process opposed to the genitalization of non-genital areas (Ferenczi), i.e., cathexis of the genitals with non-genital libido. In analytic literature there are numerous points of departure for theoretical concepts of this nature, for example: Sadger on the penis of the homosexual as breast; Abraham on the inundation of the penis with urethral-erotic libido in ejaculatio praecox; Federn on the penis and sadism; and Ferenczi's unpublished theory of genitality.¹⁹

In patients who have not reached the genital period at all, or only the onset of it, such an inundation of the genitals with libido from another source almost regularly occurs. In the fantasy it is not utilized genitally. At the beginning of analysis genital primacy may be simulated.²⁰ Prognosis here will depend, as in other instances, on whether erotization of the genitals occurred before or after the genital period; that is, whether strictly genital pleasure had already been experienced or not.²¹

There is one question, paradoxical as it may sound, that is not easy to answer: What is genital eroticism? Ferenczi's attempt to view the genital function as the result of a process of amphimixis seems heuristically valuable. I am unable to share the view of friction as a compromise between anal and urethral libido; genitality certainly has its own psychically represented core, which is added to amphimixis. What we call genitality is probably something highly complex to which all the pregenital libido positions contribute. However, if we consider genitality apart from urethral-anal-erotic (Ferenczi) and sadistic (Federn) contributions, there will still be a remainder unsuited to any pregenital organization, namely, erection, active entrance into an opening,²² longing for the womb, and rhythmic ejaculation. Only from the absence of these functions are we able to recognize them as the principal genital characteristics.

Genital, rhythmic semen ejaculation is repressed by the urethral-erotic passing of urine; active genital desire to penetrate the womb is repressed by passive-anal fantasies of intercourse. Genital erection is impeded if the penis symbolizes a deadly weapon, and following repression, erection becomes taboo. In this manner the guests of the genital zone, the pregenital supplements, repress

genitality, their host.

Since two of the principal characteristics mentioned, namely, erection and rhythmic ejaculation, first appear in puberty, only the active longing for openings offers a sound criterion for establishing the presence of infantile genitality. Strong attachment to the mother is not cogent proof that the genital period was experienced, as this attachment can be permanently anal, oral, or other. In addition, genital masturbation and exhibitionism, if present in childhood, indicate strong genitality.

V

If we survey the relationship of genitality to the structure and development of neurotic illness, a rough summarization will yield the following possibilities:

1. In childhood the genital object-libidinal period was successfully passed through, the fate of the oedipal relationship temporarily leaving behind only a disposition to neurosis. In later years, for example, in puberty, the incest desire was revived. For some reason the disposition to neurosis was reactivated and either the genital impulses were repressed entirely once again or only their incestuous objects were repressed.

In this case analysis has accomplished its most essential task when it exposes the incestuous object and directs genital libido to the external world by way of transference.

2. Fixation took place in the genital-oedipal phase on the level of genital-narcissistic organization. This appears to be the case in most severe neuroses. Genital libido is already repressed here, whereupon

a. Genital libido is displaced (hysterical genitalization of erogenous zones [Ferenczi]), or

b. Following repression of genitality, pregenital positions are revived, such as the anal-sadistic (compulsion neurosis revived by regression [Freud]).

It usually depends upon the strength of pregenital organization whether only a fixation in the genital-oedipal phase then takes place, with displacement of genitality (i.e., genitalization of other organs), or whether pregenital positions are revived due to regression. (This causes analytic work to become more difficult, especially in case b, as a struggle with pregenital libido then ensues. Prognosis, however, is always favorable.)

3. Fixation occurred in the pregenital stage due to strong emphasis on pregenital erogenous zones, although some libido was nevertheless focused on the genital zone (for example, case 7). This results in partial fixation. In such cases the prognosis may be questionable, as analysis now has the task not only of removing all repression, which in itself leads to recovery in the first and second possibilities, but also must bring about the full development of genital eroticism as well. Only if this occurs may we hope that pregenital libido will yield to the fortified genital libido. The fortification of genitality is often dependent upon the measure of pregenital libido focused on the genitals. Furthermore, it is important for prognosis whether pregenital activity in childhood was accompanied by strong or weak guilt feelings, which in turn is dependent upon whether object-libidinal cathexis existed during the

pregenital period and to what extent.

4. The genital period was never reached²³ (case 6), or rather, never activated. Neither genital masturbation, exhibitionism, or incestuous desire was experienced. All object-libidinal cathexis and possibly even infantile masturbation are pregenital in nature. Prognosis is poor because, despite the removal of repression, pregenital tendencies which are useless in reality (with the exception of partial sublimation) are not opposed by any drive force capable of negating them, thus enabling the individual to form a sexual attachment in reality.

*Psychogenic Tic as a Masturbation Equivalent**

A.F. was an embroidery worker, forty-seven years old. Previous diagnosis by the Wagner-Jauregg neurological clinic: psychogenic diaphragmatic tic. Her symptoms were sudden convulsive exhalation accompanied by violent spasms of the entire body, especially the neck and head, and a cramping of the shoulders. At times there were only slight clearing of the throat and a sudden forward and upward jerking of the head. Aside from these agonizing symptoms, the patient suffered from extreme depression, compulsive brooding, insomnia, inability to work, and a succession of secondary symptoms, such as a drawing sensation in the limbs, headaches, shooting pains down her back, and other psychosomatic sensations. There were no neurological findings other than a diffuse hypersensitivity and hyperalgesia.

CASE HISTORY

The patient was raised in a middle-class family, the youngest of three sisters. The others were ten and eleven years older than she. There were no male siblings. Her mother, who ruled the household, loved her youngest child very much, spoiled her, but also raised her very strictly. Above all, her entire independence was undermined, and every self-initiated undertaking was represented as a dangerous venture. There were often scenes where the mother and the oldest sister joined forces against her. This led to shouting, and occasionally she had been struck. As a rule, reconciliation followed, the patient avowing her remorse.

Both her sisters married while the patient was still very young. Thereafter, the mother became even stricter with her. When, as a young girl, she reported that a man had spoken to her on the street, she was told that this was the most dreadful offense. Finally, she no longer dared tell her mother anything at all, but she also dared not lead her own life behind the mother's back. She rather agreed with her mother's views; for example, her mail had been censored for years even after she reached adulthood, and when resentment arose because of this treatment, she considered herself an ungrateful sinner. Her relationship with her older sister—who was also strict—was similar to the one with her mother.

When the patient was twenty the oldest sister contracted meningitis. The doctor considered her case hopeless, and when her husband heard this, he took his own life. The sister recovered, but she lost her sight as an aftereffect of the illness. The whole affair shocked our patient, and (as she herself once mentioned) she somehow perceived her sister's blindness to be the result of the husband's death.

At age twenty-two the patient contracted pleurisy. The tormenting cough lasted long after her recovery. Her father, who was ill at the same time, shared her room. An extremely nervous person himself, he found her coughing unbearable. He often screamed at her, especially at night, to be considerate and to try to suppress the cough. Every attempt she made to do so had just the opposite effect. One day her mother gave her a substantial dose of morphine to ease her cough, upon which it

became convulsive and assumed the form of “whooping” (as the patient called her tic). It still retains this form. The whooping would start whenever she was among people, but never when she was alone.

Three years later, her mother, who had cared for her so devotedly, died of a heart ailment. Severe increase in the whooping followed. At this point, on her doctor’s advice, the patient had herself committed to Rosenhügel,¹ where another doctor took over her case. After several sessions her condition improved slightly. Shortly thereafter she suffered two traumatic experiences in quick succession which served to perpetuate the condition.

The first involved her father. When the patient was four years old her father had become emotionally disturbed due to heavy financial losses. He had apparently recovered and over the course of the following years he had managed to remain reasonably stable, but then he suffered a relapse. According to the patient’s description of his state, it may have been melancholia. She considered it perfectly normal that she should live with him and nurse him, as her mother’s natural successor. The doctors advised against this, saying her father would receive equally good care in an institution and that, as a young woman, she could not be expected to devote all her time to a sick old man. She allowed herself to be persuaded and her father entered an institution (Steinhof). The patient suffered terrible pangs of conscience, feeling she had acted heartlessly. The whooping grew worse, and insomnia and headaches began.

The second event was initially favorable to the patient’s condition. She became engaged to a family friend whom she had known from childhood. Previously he had never impressed her very much, but now that she felt so entirely alone she showered him with all her love. But here too great disappointment was in store. Her fiancé also became ill, and under very peculiar circumstances. Supposedly the patient was completely naïve about sex. She had thought marriage would be merely a “friendly, harmonious union.” Her fiancé, not knowing this, had wanted to confide something about himself to spare her later disappointment. Today the patient believes he wanted to confess his impotence, although she is not sure. She could not understand what it was all about. He tried in vain to explain himself, growing more and more amazed: “You mean you know nothing about all this?” She was frightfully ashamed. They were always somewhat more excited in conversations of this sort and “in general he was always very nervous.” Meanwhile, he had been “seduced” by the housekeeper and finally, after a “breakdown,” had himself committed to Rosenhügel. Then letters began to arrive from his doctor saying it would be better for her ailing fiancé if she freed him and did not press the issue of marriage. She replied that she did not wish to be an obstacle to his recovery and broke the engagement. This was a great blow, and from then on she felt her whole life had been shattered. Shortly thereafter she attempted suicide by drinking a large bottle of potassium bromide. To her great shame, however, she was discovered and her stomach was pumped.

After that she saw her ex-fiancé several times and, although she was excited on these occasions, she now feels indifferent toward him. From that time on, however, she has been filled with a constant, intense yearning, without knowing for what. In any case, not for her fiancé.

A year after her attempted suicide, her father died. She blamed herself for his death. (Had she only taken care of him after her mother’s death he would still be alive today.) At this time a hearing defect

she had had from childhood became worse.

Since her father's death—when she was thirty-eight—the patient has been living alone on what she earns as an embroidery worker. Occasionally she meets with her older sister, although she does not get along with her and cannot endure her presence for very long.

Over the years other symptoms have developed in addition to those mentioned above. For several years she has had hysterical fears akin to claustrophobia. She is afraid of being alone on the street for any length of time, afraid of being trapped in a large gathering of people, but above all she fears a large number of people in a streetcar, a train, or a closed room. Furthermore, she is afraid of riding trains in general because she will be stared at due to her whooping. Just thinking of these things increases her whooping. She fears being run over to the extent that she dares not cross a busy street. In general, she also fears being alone and complains of an indefinable “yearning,” especially in the evening, which makes her very melancholy. She complains vehemently that she cannot bear anything resembling an obligation and that this impedes progress in her work. For instance, she becomes extremely restless and everything within her revolts if she is given a deadline to finish a piece of work. Thus she also asked whether she had to keep her therapy appointments punctually. Actually, however, she never came late, but rather too early.

The whooping grows worse when she feels watched. She especially fears her brother-in-law, who cannot stand it. The tic itself, however, is not as unpleasant as the thought that someone might observe her and think her insane. Earlier she had had the same experience with her cough as she now has with the whooping: she had felt observed and scorned for her coughing. The sequence was as follows: coughing—shame about coughing before her father—shame of coughing on a train in other people's presence—suppression of the cough—fear that the coughing might start up again in the train—appearance of the tic at home and in trains—fear of the tic—appearance of the tic in other situations—worsening of the tic following each of life's disappointments. Strangely enough, the patient emphasizes repeatedly that the tic is her very own “special something” and that absolutely no one else has it and that consequently the doctors do not really understand her. She finds it very peculiar that she “can't exist without some ailment.” She has often noticed that when the whooping stops spontaneously some other symptom immediately revives or a new one appears. On the other hand, when the whooping becomes very severe, she has no other discomfort.

So much for the information gained in a few superficial conversations.

We are confronted with a psychopathic personality with compulsive and anxiety symptoms. Both parents contributed to her illness. One sister was “nervous.”

TREATMENT

The patient sought help at the psychoanalytic clinic after a relapse in March 1922. For a period of six weeks she underwent daily psychoanalytic treatment there, until this was interrupted by her physician's leaving Vienna. On September 4, I took over the case, although for suggestive treatment only, well aware that in so severe a case this could at best produce momentary relief from the acute

depression. Facilities for analysis were not available, but one could not let the patient wait. It was not reasonable to expect even fairly satisfactory results from purely suggestive therapy, even employing hypnosis, with a patient who had previously been treated by every conceivable method without success. The only possibility was to attempt a cathartic inquiry in the manner of Breuer and Freud, but this too failed due to the impossibility of putting the patient into a deep sleep. Neither prolonged nor fractional hypnosis brought her beyond a state of somewhat deeper cataleptic somnolence. When it occurred to me that she reacted to every sleep suggestion with severe whooping, as if in protest, I began to understand this peculiar behavior in a patient who was otherwise, as will be shown later, quite open to suggestion. It became obvious that she was repeating a scene from the time of her pleurisy. Then too her father had demanded that she sleep, and then too she had reacted with violent coughing. Her rebellion against any obligation may also have played a part. Nothing could be done. Since it was of the foremost importance to find the most significant focal point of her libido, that is, the active repression which precipitated her last relapse, I decided to try Kohlstamm's "palimnestic method." This involves ordering the patient to dream of a specific situation—or simply just to dream. If the plea to the unconscious is successful, the patient may, for example, dream the interpretation of one of his symptoms. Although admittedly not much could be expected, it was tempting nevertheless to see how far one could penetrate the unconscious without actually removing resistance in the way that psychoanalytic technique demands.

Thus, as far as the psychoanalytic interpretations of the following dreams are concerned, they have no real claim to validity since they are not grounded in psychoanalytic technique. They are based on previous experience with analyzed patients and the corroboration of the patient herself. It must also be noted that the patient had absolutely no knowledge of psychoanalysis and had received no explanations during her previous six weeks of treatment.

October 19. Patient relates in a casual manner all events leading to the onset of the tic. Long before the pleurisy, and afterward as well, she had suffered from twitches in various parts of the body. One tic, for instance, consisted of a continuous wagging of the head from left to right. This symptom had appeared at age thirty-five during a burial in a cemetery. It was as if she were compelled to say "no" over and over. Patient received the first order under light hypnosis: "Tonight you will dream clearly and understandably of what you meant by wagging your head at the burial."

October 20. The patient reported that she did indeed dream, but unfortunately nothing in regard to the wagging. I asked her to relate the dream nevertheless. "It was all very confusing. I was afraid; there was rioting in the streets, commotion, animals were being caught with lassos, windows were being broken." Without the patient's own comments, very little could be done with this; on the other hand, I did not want to disturb the experiment by interrupting. During the course of conversation the patient mentioned her ex-fiancé, stating that he had once been rather forward. She had restrained him vehemently and implored him not to go beyond a certain point. When had this happened? Prior to her departure to B—for the funeral. That explained a few things. In a censored but nonetheless typical form she had dreamed of her defloration; hence her fear, windows were being broken. The "no" tic was the expression of her defense. It is noteworthy that the patient, without having been asked to

associate, had made her own way via several associations from the dream to its latent content and to the significance of the tic. Second order: “Tonight you will dream of your fiancé’s approach.”

October 23. No dreams. The whooping had been especially severe in the evening before falling asleep. Third order: The whooping would be severe only between 11 and 12 a.m. The rest of the day she would have peace. That night she was to dream of her father and the pleurisy.

October 24. No dreams. Complains of pain in her left side since this morning—it was “like then.” She was advised to have an internal physical examination and to stay in bed for a few days.

November 4. Physical examination shows no findings other than congestion of the apex of the right lung. No noticeable changes in the pleura. Nonetheless she had run a temperature as high as 38° C. (100.4° F.). The pain persisted. I could find no explanation of the problem other than that she had followed my order to dream of pleurisy to such an extent that she had reproduced the symptoms via conversion. My assumption was correct; the fever and pain disappeared promptly with the use of suggestion. It became clear that she had especially strong resistance to having any light shed on her experiences during the pleurisy. She complained the whooping was now very severe before falling asleep and that it kept her awake until early morning.

There had to be some special reason for the whooping during hypnosis and prior to falling asleep at night. Psychoanalytic experience tells us that every symptom is the censored means of satisfying a forbidden, repressed drive—as well as being an expression of defense from the standpoint of the repressive faculty. Therefore, I first had to ascertain what kind of satisfaction the patient derived from this main symptom. It was quite obviously also an expression of general defiance. Hence the patient received the fourth order, to dream of the connection between her father and the whooping before falling asleep.

November 6. The dream: “I am sitting in a café with Dr. R. and my father. I have not been married long. Dr. R. is giving me arithmetic problems I am not able to solve.” Because of her resistance my order was not followed: The problem I gave her was too difficult, she could not solve it (i.e., did not want to). She then recounted that her father had always coughed violently and groaned before going to sleep and that she could hardly stand it. “I often thought this was sinful of me. One shouldn’t make fun of anything; one might come down with it oneself.” When she saw someone in the streetcar with a tic, she immediately felt impelled to imitate it; she could not control herself. I remarked that she was probably imitating her father by her whooping, perhaps as punishment for laughing at him while she was still in good health. For the moment the patient did not react to this explanation.

November 10. Patient dreamed again. One dream in particular had been tormenting her for years. Her mother owned a bird which the patient loved dearly but which the father hated. “I often dream of that bird sitting in its cage, and I feel very guilty for having neglected it or let it go hungry.” She dreamed of the bird, however, only since it had died. In dreams a bird is a common phallic symbol. We recall her guilt feelings about not having nursed her father. I had touched upon this theme in our previous session. In the interest of the experiment, the patient was given no explanation of the symbolism, etc. She then volunteered that seven years prior to the whooping she had suffered for

several months from spells of yawning before falling asleep. These spells usually took place after stimulating conversations. Once something very strange happened. Until the age of thirteen she had slept in her parents' bedroom. Then her sister married and she moved into another room. One night the patient had gotten up in her sleep, taken her pillow under her arm, and entered her parents' bedroom, groping for their bed. Her mother called to her and she awoke. Fifth order: She was to dream why she went into her parents' bedroom that night and what meaning was attached to carrying the pillow. (I made the mistake of giving her too complicated an order in an area where extreme repression was to be expected.)

November 13. No difficulty falling asleep, but she was nauseous and had a headache shortly after awakening. She had dreamed of pains in her heart and of yawning. The patient is nauseous only when she cannot overcome her fatigue. She had been nauseous for the first time when very frightened by her first menstrual bleeding at age twelve. Constant dysmenorrhea; last menstruation in September 1922. During the time of the "no" tic she missed two menstrual periods.

My object was to ascertain how the spells of yawning were related to the insomnia and the menstruation to the nausea. By analogy one could assume that her somnambulant actions, especially carrying the pillow under her arm, were caused by unconscious ideas of having a child. The hysterical reproduction of stomach pain and nausea, as well as the close associative proximity of the menstrual bleeding, seemed to confirm this. The somnambulism had belonged to the period of yawning spells. Sixth order: "You will dream why you could not fall asleep at the time."

November 14. Patient had the following dream. "It was very unclear. I was in a dark room and very frightened. Someone knocked. I heard noises and threw open the door. I had cramplike twitches ... A young man was visiting my sister and they were sitting in the next room playing the piano. I was jealous and wanted to play my own piano. I found some music but they took it away from me." Severe yawning and whooping before falling asleep. This time the patient did not hesitate to interpret the dream. Regarding the noises, she volunteered that she couldn't have heard anything because her mother had been too old at the time. (The mother was forty-six years old when the patient was born.) The clarity of the second part of the dream encouraged me to ask her outright whether she had ever masturbated. She asked what that was. After an explanation she said she had never known that a person could achieve satisfaction alone. She admitted the possibility that she may have tried, because once, at age eight, her mother had slapped her hand for playing with her genitals. It occurred to me that the whooping regularly grew worse when she thought she had done something the mother had warned against, like drinking cold water, getting overheated, and so forth. I asked her whether she had ever masturbated since. No, positively not, although she did sometimes place her hand on various parts of her body to quiet the whooping when it was especially severe, often on her genitals. In complete frankness she admitted she had inserted a glass tube into her vagina prior to her relapse in March. Why had she done that? Her niece had just been married, and for some reason she could not explain, the patient had been very excited. Afterward she had become quite upset, was afraid she might have injured herself, and had had herself examined.

This much was certain: The engaged couple alone in the next room had excited her at the time; she

had become jealous, and that evening had struggled with the temptation to masturbate. On that occasion also she had not been able to fall asleep. The spells of yawning were in themselves a symptom of her repressed desire to masturbate, and the whooping before falling asleep later assumed the same function. In the dream her desire to masturbate had expressed itself in the familiar form of "playing one's own piano." The first part of the dream may have been a memory from the time she had shared her parents' bedroom. Thus the whooping was a substitute for the satisfaction of masturbation and bore all the features of her mother's prohibitions, which came back to her whenever she did something that reminded her of them. Her opposition to all forms of obligation now also became transparent. Each prohibition echoed the sexual taboo; every form of obligation resulted in unconscious protest against forced sexual abstinence; and finally the whooping served as a means to express her defiance. She had supposedly always defied her mother's severity anyway, and the whooping, as a repression symptom, also encompassed identification with the prohibiting person, the mother. This identification had originally caused the repression, which was maintained until the present.

I was now able to answer her unrelenting question: "Why must I always do either the opposite of what I want to do or something else altogether?" This doing "something else altogether" was compulsive. If she decided to walk down one street, she felt absolutely compelled to walk down another; or if she resolved to do a certain task the next day, she would inevitably do a different one. Finally, it had reached the point that she would plan to do the opposite of what she actually intended. Her unconscious, however, could not be tricked. At such times she had no trouble doing what she had pretended to plan. The psychological dynamic motivation of these compulsive symptoms was generated by the tension between her desire to masturbate and the masturbation taboo. Her comment about having to do something other than what she wants to do could be interpreted as "I want to masturbate but I have to do what Mother tells me, which means abstaining." Identification with the prohibiting person remained dominant.

Now my object was to ascertain the degree to which the patient's mother and her bans were involved in the symptomatology.

Seventh order: "You will dream of your mother's forbidding you to masturbate and the manner in which you masturbated."

November 17. The dream: "It was as if Mother had accused me of something horrible. I was insulted that she had treated me like a stepchild. There I sat on a kitchen stool feeling very sad. My hands were maimed but Mother didn't notice it. I was in the house of a girl friend who had just married. I was lying in her bed, dressed (there were two beds), and was disgusted at the thought of lying in a bed someone else had used." The patient had fallen asleep easily that evening but had awakened after some time and masturbated. "It was such a strange feeling, like a twitching all over my body." While relating this she slipped and said "whooping" instead of "masturbating." Afterward she fell asleep easily. Today, for the first time in years, the whooping had not occurred at all for several hours; even in the streetcar it had been very moderate. This sudden cessation of the whooping

following masturbation and orgasm unmasked the symptom as a substitute for masturbatory satisfaction. However, it was not to be expected that the patient would come to terms easily with this new, or better said, consciously new experience. Analysis has demonstrated that decades of old repressions cannot be eliminated that easily. Then, too, only the drives had been freed of repression, not the fantasies and guilt feelings, as the last dream had shown so clearly. The patient had sat with maimed hands; hence, punishment for masturbation had also been realized in the dream.

In any event, therapeutic success was dependent upon how the patient would put the liberated drives to work. One could assume that satisfaction through masturbation without guilt would take her well beyond menopause. The therapeutic prospects are more favorable in younger neurotics, who still have the opportunity as well as the capability to deal with the drives liberated in analysis, partly through real gratification and partly through sublimation. In this case, however, there was no possibility of gratification with an object, as she neither wanted to nor could she marry, and there were very few possibilities for sublimation at her age after so long an illness. These were the factors which indicated that psychoanalytic treatment was not called for. As Abraham mentioned in his report, the age of the patient and, even more, the length of the illness constitute very important considerations in a prognosis. The success of psychoanalytic treatment, which would have involved at least two years, was very dubious in this case.

Because of the importance of discovering the patient's unconscious reaction to her masturbation, I formulated the eighth order thus: "You will dream of the relationship between your masturbation and your maimed hands."

November 20. On the seventeenth she had been very elated. The whooping had ceased, but she had not been able to sleep and had masturbated. "I feel as if I was getting my period." On November 18 and 19 she had also been sleepless, wanted to masturbate, tried to resist the desire, but was successful only the second night. The whooping was very severe again and she felt guilty about masturbating. She dared not, nor did she want ever to, masturbate again. She asked whether she would be able to break the habit. The struggle to repress the drives anew had already begun. I asked about her dreams. "I dreamed I was lying on a couch. My mother and sister came into the room. I sat up and looked at them in amazement. Then Mother told a dirty joke. I vomited a piece of feces, which I threw away with my hand. They said I had to clean it up. Then I saw myself in a bloodstained, torn shirt, as if I were having my period, and Mother said, 'There, that's just fine.'" The patient felt her mother's telling a dirty joke was the most peculiar part of the dream; in reality this would have been impossible. Her mother had also said, "There, that's just fine," and had meant the masturbation. In other words, "What you are doing is not bad but good." Her mother had also done something forbidden: "She told a dirty joke, therefore I may masturbate." Hence the conflict between the desire to masturbate and the masturbation taboo was resolved by fulfillment of the desire and removal of the guilt feelings attached to it. Her sister had actually told a dirty joke (prior to the patient's masturbation with the glass tube in March) about a woman who introduces her husband to an acquaintance and presents a candle as her brother-in-law. The only comment the patient made regarding the feces was that as a child she had often had to clean away the cat's feces and had felt

insulted at having to do so. The bloodstained shirt indicates the danger of masturbation. Bleeding—menstruation—injury (“torn”).

November 23. The patient complains that she does not feel well at all, she feels even worse than before, she now has both the whooping *and* the masturbation. Yesterday she masturbated once, today twice. She had pain and burning in her genitals and was afraid she had injured herself. Last night something strange happened. She awoke and saw her left hand hanging over the edge of the bed, “as if it were dead.” I asked her which hand she uses to masturbate. It was the left. Patient very uncommunicative today—no dreams.

November 24. No whooping yesterday afternoon or this morning. No insomnia last night, but nocturnal masturbation. Twice thereafter the left hand had appeared to be “dead,” “withered,” and “noticeably thinner.” The experience had been uncanny and accompanied by pain and stiffness in the left foot. She asked whether the pain and burning in her vagina could be related to her mother’s frequent complaints of the same ailment (she had suffered a prolapse of the uterus and had had a ring inserted which caused her pain). Under hypnosis the patient was told to experience the same sensations in her hand that she felt at night. Her hand became pale and thin and slowly sank downward from her chest. In this passing conversion symptom, her infantile fears of punishment for masturbation were realized. The pain and burning were also to be construed as realization of punishment in the genitals. The patient herself corroborated these obvious assumptions several days later.

Her dreams ceased, or were so censored that they were impossible to interpret. It is also probable that specific infantile experiences which could not be grasped except in actual analysis were coming to the surface. At the same time transference was becoming too intense, complicating her condition, since the step-by-step solutions usually necessary in analysis were not possible. Menstruation with profuse bleeding occurred and lasted for eight days, whereas it usually lasted only two. The patient related this to masturbation. I persuaded her to have a gynecological examination. The next day she reported that she had seen her gynecologist but had received only urotropine for her cystitis. And the bleeding? She had forgotten to tell the doctor about it. I mentioned that this had been the main purpose of her visit to him. She didn’t understand how she could have forgotten, but it was no longer necessary anyway, as the bleeding had suddenly stopped the night before. The doctor’s diagnosis read: “Normal genitalia with cystitis, which could account for the pain.” The pain and the feeling of rawness also ceased after several days. The patient no longer masturbated and whooping was very moderate.

Once again she had succeeded in repressing the impulse to masturbate because of the pressure of guilt feelings and castration anxiety. Unconscious ideas had “materialized” (Ferenczi) in the symptom of the withered hand, the rawness, and the bleeding. I could not ascertain why the bleeding had subsided prior to the medical examination.

The palimnestic method employed up until this time no longer produced results.

I should still have liked very much to discover the reasons for the “erotization” (Ferenczi) of the throat and especially the larynx. The cough, which still persisted as a tic symptom, may have been a

contributing but not the decisive factor. The factor of “somatic cooperation” (Freud) was still to be evaluated, i.e., the patient’s repeated attacks of angina from early childhood. Thus the throat may have been predisposed as a focal point of sexual excitation (upward displacement, Freud). Even more important was the patient’s remark late in treatment that whenever she was particularly excited about something, and also during masturbation, she had a strange sensation which ran “from my throat to my genitals.” This sensation demonstrates very clearly that there is a “connection” between the “erogenous zones”—the mouth and throat (the oral region)—and the genitals. This relationship is seen in all hysterical conversion symptoms of an oral nature, such as bronchial asthma, hysterical vomiting, globus hystericus, mutism, etc. When genital eroticism is repressed, if it is not allowed to find expression, as in this case, it is then shifted to other erogenous zones and causes corresponding hysterical symptoms. The bodily region involved thus acquires genital significance (Freud). The resulting genitalization of the throat (Ferenczi) was portrayed in the patient’s descriptions of her sensations—she felt as if someone were tickling her throat with a feather or pushing a quill up and down in it. Typical dreams contained the idea that someone, usually a man, was pushing a stick, a feather, a knife (all phallic symbols) up and down in her throat. Without a doubt these were repressed and secondarily activated fellatio wishes, which are typical in regression from genital to oral organization. In this case, however, regression was not complete and genital cathexis remained active to a great degree despite repression (see her reports of half-unconscious attempts to masturbate, for example, merely “placing the hand on the genitals”).

This case demonstrates a hysterical-conversion-type tic. Ferenczi² describes it as a compulsive symptom and in doing so draws on the work of Meige and Feindel.³ The origin of compulsive hysterical tics is a problem in itself. Ferenczi⁴ was the first to recognize them as masturbation equivalents.

After three weeks of actual psychoanalytic treatment, analysis had to be discontinued as the patient’s hearing ailment had temporarily become so severe that communication was impossible. In the meantime, however, her conflicts about masturbating had moderated somewhat and she had termed it “the best way to fight insomnia.” Thus, in our following conversations, most of the emphasis was laid upon removing as much of the masturbation-connected guilt as possible. Other than that, one could only wait.

EPICRISIS

Two years have passed and the patient’s condition has shown slow but constant improvement. She has no special difficulties with menopause. The tic has gradually subsided and during the past year appeared only when the patient is extremely excited, subsequently diminishing once again. It is noteworthy that during the first stages of improvement, depression and compulsive brooding occurred in place of the tic, but disappeared again as soon as the tic intensified. This substitution is entirely understandable in the light of the Freudian libido theory and of psychoanalytic interpretation of symptom dynamics. Unreleased impulses seek escape in a symptom and, if one channel is blocked,

will search for another. Proof of this can be found in all psychotherapeutic treatment of symptoms: If a regnant symptom is eliminated through suggestion, another will take its place, either immediately or somewhat later, according to the strength of the rapport with the physician.

The patient's struggle with guilt feelings about masturbation was a long and difficult one. Self-accusation and the most varied forms of self-torment occurred periodically. In the course of time, however, she came to terms with the guilt. Her repressed impulses have not actually been eliminated, from the standpoint of analysis, but they do have means of release (i.e., masturbation) should they achieve pathological intensity. Formerly, for example, at the slightest argument or quarrel, the patient would act out her excitation for days in fits of crying and incessant whooping. Since the path has been cleared of obstacles (i.e., the guilt feelings reduced), excitation of this sort passes quickly. It is noteworthy that the most diverse conflicts and the slightest degree of sexual excitation immediately activated these feelings and aggravated the symptoms.

The patient's insomnia has ceased entirely and she has completely regained her capacity to work. Hysterical conversion symptoms did not reappear. Her previous phobia of crossing the street in winter, her fear of being alone in a dark room, and the like, have vanished to the extent that she is now able to do whatever tasks are required without being substantially hindered by anxiety. Here too progress can be seen quite clearly, as the anxiety states experienced last winter were not nearly as severe as those of the winter before. Recently the patient has renounced her isolated life style and is considering looking for a male companion.

This case is instructive in many respects:

1. The original question, that is, to what extent can one uncover repressed material (remove resistance) without employing psychoanalytic methods, has received a definitive answer. At a certain point in our palimnestic exploration, the dream experiments failed and the patient's dreams became atypical and obscure. This may be explained by an increase in "censorship" (Freud) as well as by the fact that material pertaining to specific experiences began to emerge, material which can be successfully interpreted only by means of systematic analysis. No doubt the intense transference to the analyst functioned as resistance. The remedy for this, i.e., dissolution of the transference (which is indispensable in psychoanalysis if progress is to be assured), could not be carried out. There is an essential difference between psychoanalysis and all other forms of psychotherapy. In the former, emotional rapport with the physician, transference itself, becomes the object of analysis, and a very essential object it is. One finds that without psychoanalysis, resistance can be removed, or rather circumvented, only to a very slight degree. This becomes obvious in every cathartic-hypnotic treatment, where one gets the impression that the patient under hypnosis surrenders only the material which he would, with sufficient rapport, be willing to relate in a state of waking consciousness. Without psychoanalysis, sooner or later one reaches a deadlock.

2. The case may be viewed as an experimental demonstration of several basic psychoanalytic hypotheses, for instance, that infantile masturbation is accompanied by severe castration anxiety, which localizes either in the hand or the genitals. We recall the experiment with the withered hand, as well as the profuse menstrual bleeding following masturbation during menopause, and the patient's

fear of having injured herself. Beneath the surface the mother's masturbation ban is unremittingly in effect. This literally accounts for the whooping, which was irrefutably proven to be a masturbation substitute (Ferenczi); masturbation is likewise expressed by the symbolic meaning of playing the piano ("to play my own piano"). To demonstrate the interesting relationship between the tic symptom and identification with the coughing father or with the strict, ever admonishing, and prohibiting mother would take us too far afield. Additionally instructive is the patient's response to the order to dream of her excitement during pleurisy in which she reproduced the pleurisy itself, and even the fever, by means of hysterical conversion.

3. Regarding therapeutic success, the results of treatment were far removed from the ideal analytic recovery. Infantile fears and guilt feelings (the patient had already suffered acute anxiety states during childhood) were not completely eradicated but rather disarmed by the physician's authoritative assurance that masturbation is not harmful and is a very general human practice. Hence the fears were allayed by the excitation having found a means of release, as mentioned above. The case demonstrates nevertheless that even long-standing, severe neuroses, in existence for decades, can be responsive to influence if suggestion is analytically employed and the analyst is patient enough to make at least one effective incursion into the dynamic structure of the neurosis. This particular patient, who had received treatment involving every method of suggestion for twenty years to no avail, reacted positively for the first time when the crucial point of her development (sexual abstinence) was used as a point of departure for treatment. Hence she was able to weather the critical period of menopause with relatively little discomfort. We may assume that the psychotherapist has access to many means of relieving discomfort in all cases of climacteric neurosis and depression and that much may be accomplished in such cases, provided each case is individually considered, with careful attention given to analytic theory, and above all provided the patient's sexuality is not disregarded. The sexual constitution of neurotics is a focal point for their most difficult problems, which must always be viewed individually. These are usually not difficult to solve in a thorough analysis. I must emphasize, however, that a psychotherapeutic attempt to remedy sexual disturbances requires thorough psychoanalytic training as well as experience if one is to avoid the danger of calling forth spirits one cannot command. For the moment it must suffice to mention that the isolated instances we have observed of lasting change for the worse through psychoanalysis were the fault of the physician and not of the method itself.

*Further Remarks on the Therapeutic Significance of Genital Libido**

In a short essay, "On Genitality,"[†] I arrived at the conclusion, by means of a comparative examination of infantile genital organization in clinical material, that, all else remaining equal, the freer of pregenital supplements the formation of genital object love has been, the more favorable the prognosis of a transference neurosis is likely to be. Although a number of objections occurred to me at the time, I felt constrained to hold fast to the theory and to postpone a detailed elaboration of the problems until the opportunity offered itself to clarify one or two questionable points on new material.

The postulate above was based on the observation of empirical facts; theoretical substantiation was attempted only to a very slight degree. Furthermore, the object was not only to clarify the concept of the normal psychogenital function, but also, and this was far more difficult, to establish criteria for the intensity of infantile genital primacy and to learn to distinguish this from other libidinal organizations. In this pursuit I relied upon current analytic views on libido-developmental stages, particularly those of Freud and Abraham. However, it became apparent that without the assumption of highly intricate combinations of various libidinal organizations, nothing could be accomplished because the concept of a "pure" genital primacy is relative and it would contradict analytic experience to assume that an abandoned libidinal position has no influence on later libidinal positions. The assumption of combinations, or "amalgamations," of libidinal structures was additionally based upon Ferenczi's hypothesis of an "amphimixis" of drives, and on Freud's assumption of the "compounding" and "decompounding" of libidinal and destructive drive forces. The deeper one attempts to penetrate the problem of "combinations of pregenital and genital organizations," the more complicated the situation becomes. Therefore it is advantageous to postpone the issue until later and, for the moment, to content ourselves with formulating a set of prognostic questions relevant to every analysis:

1. Is genital libido repressed or is it not; rather, to what extent is it hampered by guilt feelings from manifesting itself freely?
2. Has it been replaced by pregenital libido, and if so, to what degree and through which pregenital tendencies?
3. Assuming that the libido structure is predominantly pregenital, is this due to previously achieved infantile genital organization having been abandoned through regression? Or was pregenital fixation caused by arrested development?

By delineating a large area of inquiry, to which a later detailed examination will be devoted, I now arrive at the actual theme of this dissertation, namely, "orgastic potency" and other matters concerning the curative function of genital libido.

ORGASTIC POTENCY

Here we immediately encounter a serious objection: Is there no neurosis when there is an efficiently functioning genital libido?

I shall begin the discussion by pointing out that all forms of impotence (ejaculatio praecox, ejaculatio retardata, complete or partial erection incapability, etc.), frigidity, total or partial vaginal anesthesia are symptoms of psychogenital disturbance. To what degree are these symptoms present in neurosis? A statistical survey of recent case histories offers us clear-cut information. The statistics were gathered from the histories of all individuals who sought treatment at the Vienna Psychoanalytic Outpatient Clinic in the period 1923 to the spring of 1924, and also included all of my private, previously analyzed cases. The original plan of an exact statistical classification according to age, neurosis, and form of genital disturbance had to be abandoned; it would not have fulfilled psychoanalytic statistical demands because the statements of analytically untreated patients in regard to their psychogenitality are thoroughly unreliable—as might be expected—and therefore usually impracticable for statistical use. Characteristically, most of the female patients interviewed did not understand when questioned about what they experienced during intercourse, assuming that they did not avoid the question entirely. For example, I began treatment of one female patient who had professed at admission to the clinic that she was not frigid. I discovered later that she was not only entirely anesthetic but suffered from vaginismus as well. Another female patient said she did “feel something,” meaning the sensation when the penis entered; other than that she was vaginally anesthetic. One male patient who sought analysis because of anxiety stated that he was completely potent. In analysis I discovered that he lived in serious actual conflict with his wife, had intercourse with her on the average of once every six weeks “as a duty,” and did not “enjoy it at all.” As deeper strata were revealed in analysis, impotence set in immediately. (I shall return later to such special cases.) Another patient stated he had intercourse regularly, but as I discovered during analysis, intercourse consisted of friction on the vulva and ejaculatio praecox. These examples will suffice to explain why an exact statistical report was not undertaken. Nevertheless, the following rough figures will illuminate the situation sufficiently:

Private patients. Among twenty-six women and girls there was not one who, at the time of treatment or earlier, was capable of a vaginal orgasm. Sixteen were neurotically abstinent at the time and several had masturbated clitorally for a long or short period of time after puberty. Of the rest—mainly married women—all were either partially or totally vaginal-anesthetic; three were clitorally excitable to the point of orgasmic sensation. Among thirty male patients, twenty-eight manifested one of the familiar forms of impotence. One was heterosexually potent, but he had entered analysis only out of curiosity and soon stayed away. In the other case mentioned earlier, impotence emerged during analysis. In addition to this, the cases mentioned manifested almost all forms of neurotic disturbance. In general, the severity of neurotic disturbance is directly proportionate to the psychogenital disturbance.

Clinic Outpatients. Of the 204 males and 150 females, 64 made no references to the sexual function in their case histories. Of the remaining 115 women, none had commented on orgasmic sensations. Eleven of the remaining 175 men professed potency. These figures speak for themselves. It is noteworthy that neurotic abstinence is predominant among youthful female hysterics. Reports of

unhappy marriage are surprisingly frequent in climacteric neuroses. In the anamnesis of male patients, spontaneous reports of impotence are far more frequent than reports of frigidity in women. Also, neurotic abstinence is generally rarer in males than in females.

Genital dysfunction in more extensive neurotic disturbances appears to be a foregone conclusion on the basis of libido theory. However, it is important and interesting that the clinically so-called monosymptomatic neurosis, which I examined with special care in this regard, also frequently manifest fairly extensive disturbances of genital libido. To cite a few examples: A twenty-eight-year-old kleptomaniac suffering from erection incapability was otherwise completely healthy and able to work. The onset of impotence coincided with his first theft. A thirty-six-year-old woman with bronchial asthma, completely anesthetic vaginally, could experience satisfaction only through cunnilingus on the clitoris. Analysis demonstrated the intimate connection of this specific means of satisfaction to the orally founded symptom. A thirty-eight-year-old man suffering from a severe psychogenic spasm of the jaw from age seven had also been completely impotent for a long time, with the exception of one successful sexual act. Many women who sought treatment at the clinic because of migraine headaches or insomnia were frigid as well; many candidly admitted being unsatisfied.

To the extent that the material was available, I discovered similar conditions in psychotics and epileptics. In youthful female schizophrenics, neurotic abstinence is almost the rule. It would, however, be audacious to draw extensive conclusions in the field of psychosis at this time. Male schizophrenics are frequently completely potent, or even hyperpotent, which is a problem in itself.

Surprising as these findings may be at first glance, they are self-evident if we consider Freud's first, and as yet unrefuted, formulation of the etiology of neurosis: No neurosis without a sexual conflict. In this he interpreted "sexual" in the broad sense and "genital" in the narrow. Based on my survey, and also on the psychoanalytic theory of neurosis, we may reformulate the above statement even more explicitly: Virtually no neurosis without disturbance of the genital function. Roughly summarized, psychoanalytic theory states that hysteria is usually an illness of the genital-libido stage, and that compulsion neurosis is distinguished by regression from the genital to the anal-sadistic stage, which means that sadism (or masochism) and anality are the dominant libido tendencies in this illness. Cyclothymia, chronic depression, which usually represents masked compulsion neurosis, and the pathological states of neurasthenia and hypochondria, little studied until now, regularly manifest severe regressions from the genital stage. According to analyses I have conducted, and observations made in the outpatient clinic, the majority of the clinically termed psychopathies (we would call them character neuroses) almost always manifest completely chaotic libido economy, and only in the rarest cases genital primacy.

Since, despite these findings, the objection has been raised by several authoritative sources that there are neuroses with an undisturbed genital function, at least in men, I shall pause at the question of how any substantial neurosis is conceivable with an intact genital function. One could settle the question quickly by pointing out that these cases represent such a small minority that they may be viewed as mere exceptions which prove the rule and should be treated separately. However, I immediately reject this as unsatisfactory. It is more readily conceivable that the libidinal conflict,

whatever its nature, is active but isolated somewhere in the unconscious, whence it creates a symptom, while a sufficiently strong portion of libidinal impulse focuses on the genitals and functions normally. And indeed analytic experience demonstrates that this may be the case in male compulsion neurotics (female compulsives usually reject sexuality altogether, due to their excessive masculine tendencies, and are always frigid in intercourse). Male hysterics are always impotent. To comprehend this entire situation, we must broaden our scope.

To start, I shall lay aside the preformed bias of defining impotence as merely a greater or lesser inability to become erect (*impotentia errigendi*), or as premature ejaculation or no ejaculation at all (*ejaculatio praecox*, *impotentia ejaculandi*). The functions of erection and ejaculation are somatic in nature and, excluding coarse stimulation (such as erection occurring in hanging or due to urine pressure), respond only to psychic stimulation involving complicated, stimulatory, peripheral (tactile), and central processes which must be uniformly directed. The entire undivided personality must participate. In every form of impotence, the stimulation process is disturbed, or rather inhibited, through repressed ideas (castration anxiety, the idea of the vagina as an anus [hence, disgust], homosexuality, etc.). The form impotence takes depends on *when* inhibition takes place. In neurotic, abstinent individuals who always become impotent when they attempt intercourse, inhibition is permanent, partially conscious (fear of impotence), and partially unconscious. Especially in abstinent compulsives, the unconscious psychic inhibition is obscured through various ideologies (asceticism, religiously motivated self-restraint, and many more). In other individuals, the inhibition occurs shortly before introduction of the penis, or occasionally only during intercourse. The erection then subsides or premature ejaculation takes place.

The inhibiting unconscious and conscious thoughts are either counter-genital ideas, for example, fear of genital castration by the father or the mother, or the inhibition results from competition with other impulses that are simultaneously in effect, such as lingering in forepleasure practices, homosexual fantasies, etc. In the former instance, the psychogenital tendency toward genital union with the partner is present in full intensity but is curbed by castration anxiety; in the latter, psychogenitality is weak from the start or in competition with other (for instance, homosexual) tendencies. In the first, libidinal impulses may be present in a unified form; in the second, the libido is fragmented.

I shall now present a specific case in which the competing non-genital fantasy fuses with a part of the genital libido. A man has intercourse with a woman while entertaining active homosexual fantasies. He is potent, from the standpoint of ejaculation, but the orgasm is weak and satisfaction is not achieved. Ejaculation and orgasm are only loosely connected. *The relaxation normally following the orgasm, which may be traced, according to libido theory, to a reduction of the libidinal tension level, is contingent upon the orgasm and not upon the ejaculation.* The patient, who is potent but suffers from anxiety, struggles with homosexual desires while fulfilling his “marital duties” and this disturbs his orgasm. When these fantasies emerge in analysis, complete impotence promptly sets in. Previously he had “not enjoyed” intercourse, as it was merely a duty; now homosexuality, which has

become conscious, inhibits the erectile function as the conflicts are not yet solved. In addition, the patient is one of those narcissists who are unwilling to admit their impotence to themselves and who develop such strong compensation that intercourse is successful in regard to erection and ejaculation, but not orgasmically. The same holds true in the occasional apparent recoveries from impotence where the individual is fully potent during the act and capable of intercourse due to transference but does not experience a relaxing orgasmic sensation since the libido is still fragmented. When this transference success is destroyed, impotence regularly reappears. The patient did not seek a woman for the purpose of deep union or because he desired her, but rather because he wanted to do the analyst a favor or, at a deeper level, to act out his homosexual transference-love on a woman. In the treatment of impotence one frequently finds that orgasmic potency is long in coming, even though erectile and ejaculatory potency have been established. Libido stasis manifested in actual-neurotic states disappears only when orgasmic potency has been established. This in turn restates the fact that only the orgasm, and not the ejaculation of semen, has a libido-discharging effect.

While it is correct that male compulsion neurotics may manifest erectile and ejaculatory potency, it is orgasmic potency which is essential. We can prove that it is lacking in every male and female neurotic. The result of this lack is that the actual-neurotic factor of libido stasis is present in any neurotic illness worth noting. In female patients it is strictly a question of orgasmic potency. Therefore it is no wonder that among the cases mentioned earlier eleven men reported they were "potent," whereas neurotic women rarely report orgasmic sensations, and when they do, the report is misleading.

Thus the analyst must be extremely skeptical of reports concerning non-analytic cures of impotence. Admittedly, minor isolated disturbances of psychogenitality may be permanently eliminated by various means of encouragement, but the establishment of psycho-genital primacy, an indispensable prerequisite for orgasmic potency, demands analytic regulation of libido economy. We know how deeply seated libidinal disturbances can be and do not consider it a cure when, for example, an impotent patient is advised to pinch his penis at the root and insert it in this artificially erect state; "then it will work." Even when erection and ejaculation follow, the patient is still unsatisfied and his libido stasis continues.¹

Among other variants, female potency differs from that of the male in one essential point: Women can experience pleasurable genital sensations during intercourse without achieving an orgasm. This situation renders it exceedingly difficult to evaluate female genitality through non-analytic exploration. But analysts too may overlook the fact that the orgasm is lacking if they content themselves with the report that "pleasure is experienced" or that the patient enjoys intercourse. Even at a time when I was already carefully observing these issues, I was once deceived. The case involved a married female hysteric whom I began to treat for a relapse following her analysis with another physician. According to the report from the previous analyst, the patient was not frigid. The fact that she sometimes rejected her husband but otherwise experienced pleasurable "sensations" and enjoyed intercourse contradicted my hypothesis. For me the interesting aspect of the case was the question of how the genital function could be intact and coexist with a neurotic disturbance of libido. One day she reported that she always quarreled with her husband after intercourse. He complained he was unable to

sleep because she read for hours after coition. I immediately knew she was unsatisfied, since the best criterion for satisfaction having occurred is a strong desire to sleep. Upon closer inquiry I discovered that the patient had never experienced orgasmic sensations; her pleasurable feelings were produced through contraction of the muscles of the perineum. This in turn revealed itself as a significant vaginismus symptom based on the fantasy of amputating the male member and keeping it for herself. (Orgasmic potency in women with active castration desires is, in my analytic experience, absolutely out of the question.) Following this emergence of masculinity fantasies, orgasmic potency gradually developed. After her first complete orgasmic experience, she said she had never known this feeling, which proved her previous anesthesia. This case taught me to examine the ways and means of genital activity even more critically and to assume the existence of psycho-genital dysfunction—despite contrary reports by the patients—rather than psychogenital integrity. Usually I find my assumption holds true.

From a case of male anal-compulsive brooding, I also obtained the necessary justification to expand the concept of potency to encompass orgasmic potency and still comply with all the demands of libido theory and actual practice (to be discussed later). A nineteen-year-old man complains of inability to concentrate. Potency is supposedly normal. He states he has intercourse very often, three or four times a week, but is not able to remain with one girl; he views “the girls” as toilets, as opposed to his beloved, idealized sister. He always practices “coitus interruptus.” Intercourse is never “fun” and only constitutes the end of a “flirtation.” The purpose of being with girls is to discover everything about them; this is related to an immense desire for knowledge dating from infancy. In addition, he wants to have as long a list as possible of girls he has “had.” He says he has to have intercourse but finds it bothersome. This case also manifests erectile and ejaculative potency, although it would be superficial to term the patient’s psychogenitality “normal,” as his desire is underscored by compulsive sadism and narcissism: striving to exploit the girls, using them as a toilet, “leaving them stranded,” which gratifies him considerably, and finally “having” as many as possible. There is no trace of exhaustion or any feeling of satisfaction following coition. We may assume that all so-called Don Juan types who pride themselves on possessing a great many women or on proving their potency by consummating the greatest possible number of acts in one night are attempting to compensate for an inordinate fear of impotence, among other motives—for example, seeking the mother (Rank). Such men manifest limited potency; one such patient even reported that prior to his illness he not only experienced no orgasm after the second attempt but that the act was actually painful. He was in a phase of neurotic hyperpotency which preceded his later pathological impotence.

In psychoanalysis it was known very early (Freud, *Three Essays on the Theory of Sexuality*) that fore- and end pleasure are two phases of the same process, which normally concludes with the latter, its main goal. Neurotics and perverts, however, are inclined to linger in the forepleasure acts and either postpone end pleasure as long as possible or forgo it altogether. The struggle to overwhelm and subdue the partner is an important component of the forepleasure mechanism. It is well known that if this goal is isolated and becomes the sole objective, the result may be a Don Juan type whose

inclinations are based upon narcissism and sadism. So-called nymphomania, female craving for men, involves perpetual uninhibited seeking of the father and, typically, repeated disappointment following coition. I have analytic case histories of two nymphomaniacs. One was completely anesthetic vaginally, capable of orgasm only by means of masturbation with a knife, in which vaginal bleeding was a precondition for the orgasm. This constituted a genital-masochistic self-punishment idea. The other patient was also psychopathic, with anxiety and compulsive states, vaginally anesthetic, and only slightly potent when the partner stimulated her clitoris with his finger or tongue. A nymphomaniac observed at the clinic (but not analyzed) by Dr. B. was likewise vaginally anesthetic. These experiences correspond completely with analytic views on libido dynamics. Only an unsatisfied, i.e., orgasmically impotent, individual can manifest nymphomaniac or satyriastic traits. I personally know of no cases of nymphomania or satyriasis, either published or from my own practice, which exhibit orgasmic potency. In addition to this, I must note that the question of orgasm is usually not treated in publications.

It is helpful to give special consideration to the following points in evaluating the genital function:

1. The forepleasure acts may not be disproportionately prolonged; libido released in extensive forepleasure weakens the orgasm.
2. Tiredness, limpness, and a strong desire to sleep following intercourse are essential.
3. Orgasmically potent women often feel a need to cry out during the climax.
4. In the orgasmically potent, a slight clouding of consciousness regularly occurs in intercourse if it is not engaged in too frequently.
5. Disgust, aversion, or decrease of tender impulses toward the partner following intercourse imply an absence of orgasmic potency and indicate that effective counterimpulses and inhibiting ideas were present during coition. Whoever coined the expression "*Post coitum omnia animalia tristia sunt*" must have been orgasmically impotent.
6. Male lack of consideration for the woman's satisfaction indicates a lack of tender attachment.
7. The fear of some women during coition that the male member will become limp too early and that they will not be able to "finish" also makes the presence of orgasmic potency questionable, or at least indicates severe instability. Usually active castration desire is at the root of this fear, and the penis becoming flaccid after ejaculation is interpreted as castration. This reaction may also be caused by the fear of losing the penis, which the woman fantasizes as her own.
8. It is also important to discover the coital position assumed, especially that of the woman. Incapability of rhythmic responsive movements inhibits the orgasm; likewise, maximal stretching of lower pelvic muscles in women from wide spreading of the legs is indispensable for intense orgasmic sensations.

If these points are given consideration, the analyst will not be able to overlook a disturbance of orgasmic potency. In the practice of analysis, one often finds that uninformed women—after the actual analytic work is completed—experience orgasmic potency only through instruction regarding coital positions, etc. It is advantageous if a physician enlightens the husbands, who are usually unaware of their wives' needs.

We have recognized the function of the orgasm as crucial in solving the problem of neurotic libido disturbance and must now inquire into the fate of genital libido in abstinent individuals who appear to be mentally healthy. The degree of libidinal readiness and the rhythm in which libidinal stasis is discharged certainly varies according to the individual. However, it cannot be denied that libido tension is always present, and it is not merely of theoretical importance to discover how the organically nourished libido is utilized when the principal means of orgasmic discharge is not employed. One can only make a statement regarding this based on the analysis of healthy abstinent individuals. Here our experience fails us completely as we are never in a position to thoroughly analyze healthy individuals, let alone healthy individuals who live in abstinence. In speaking of mental health I am implying, circumspectly, a psychic state characterized by the capability of social achievement and integration as well as by a predominantly subjective feeling of well-being. It is not incorrect to claim that whoever lives in complete abstinence has neurotic motivations for doing so, since I cannot imagine a biological function like sexuality being inhibited by any means other than repression. It is equally difficult to imagine that the suppression of the undoubtedly existent libido does not cause effective stasis. We cannot use hypofunctioning of the somatic sexual apparatus to explain this because, as obscure as the question is at present, we must consider that post-pubertal castrati tend to maintain their libido and that libido may persist long after menopause. I prefer to leave this question open. Although we can conceive of intensive work and all true forms of sublimation as means of release, we must still assume that there is an upper limit beyond which libido cannot be dammed up. Analytic experience has taught me not to overestimate my patients' ability to sublimate and that this ability varies greatly from case to case.

THE SATISFACTION OF GENITAL LIBIDO AS A SAFEGUARD AGAINST RELAPSE

Let us now turn to the question of which role genital libido plays in the solving of libido conflicts during psychoanalytic treatment. In doing this we shall discuss several other objections.

Psychoanalytic therapy differs fundamentally from all other therapy in that it seeks to eliminate the neurotic reaction basis. From this standpoint it is causal psychotherapy in the narrowest sense, regardless of how far actual success is removed from the ideal concept. It does not focus on symptoms but on the entire neurotic personality, from which individual symptoms arise like the peaks of a mountain. For this reason its task is disproportionately difficult compared to that of symptomatic psychotherapy. However, under favorable conditions, it may lay claim to doing a consummate job. It is self-evident that the psychoanalytic method of cure encounters more frequent and more intense internal and external obstacles than does symptom therapy. It proceeds from the empirically founded hypothesis that neuroses are manifestations of personality structures opposed to reality, i.e., always involving conflicts between drive-dominated tendencies and denial from external or internal sources.

These conflicts can never be completely solved because essential areas of the personality are incapable of free decision due to repression. The symptoms erupt from the realm of repressed material and accommodate themselves to both the repressed material and the repressing factors. Repressed libidinal tendencies are almost always involved and the symptoms are a substitute satisfaction for them.

Analysis comprises two elements: First, the patient must become aware of the meaning of the symptom. Second, the secret conflict with the drive impulse underlying the symptom must become evident. Only then does the actual curative process begin, and the result is dependent upon many different factors. If the technique is not practiced with skill, renewed repression may result. This is more likely to occur when the drive impulse, in connection with the entire personality, is not otherwise undermined. The repressing ego must also be strong enough to bear consciousness of the drive.² If the drive escapes this fate, a decision must be made. According to the nature of the drive impulse, i.e., whether it corresponds to or opposes reality, the conflict will result in condemnation or approval by the critical ego. Let us consider, as a specific case, that the exposed impulse responsible for the severe symptom of obstipation is: "I want to receive an enema from my mother, as I did in childhood." This was the anal mother fixation of a young man suffering from *ejaculatio praecox*, among other symptoms. This counter-reality impulse must be disposed of by means of condemnation. But exposure of the background of the symptom only opens the *possibility* of condemnation; actual condemnation itself is dependent upon other factors. When the patient became fully conscious of the desire described above, obstipation ceased temporarily. It was replaced by abundance of fantasies whose principal content revolved around the mother (or a mother image) throwing water on him, tying him, or taking him into her arms like a child, etc. In spite of these fantasies being accompanied by guilt feelings, the patient perceived them as harmless. Condemnation therefore had not taken place; on the contrary, the libido stasis intensified from the increased stimulation by the now-conscious fantasies. The anal (and other) drive impulses were conscious but not disposed of. Since the ego was fortified sufficiently to bear this consciousness, it had no desire to forgo the pleasure gains now available to it.

In this phase of analysis one could only wait for reality-adjusted libido tendencies to emerge which could be successfully employed against the passive anal desires. But this reality-adjusted libido tendency could be represented only by active genitality, which was still completely repressed. The patient even tended to exaggerate anal pleasure gains, as if to protect himself from genital tendencies, and he had good reasons for doing so. As a four-year-old boy he had received the impression that genital pleasure gains were highly precarious. His older brother had once caught him in the act of masturbating and threatened to castrate him. During polymorphous-perverse play, his female cousin (five years older than he) pulled at his testicles and the characteristic pain persisted as converted hysterical pain—a warning, so to speak—in the area of the testicles. (A stereotype complaint was that not his penis but his testicles seemed so small.) Both experiences were recalled only in analysis. But even this discovery had little effect. First, genital libido had to be freed from the fear of castration, which inhibited its every expression. Among other things the patient feared that a woman he was

about to make love to would pinch him in the genitals as a joke. It is perfectly understandable that he preferred innocuous anal pleasure gains to the precarious pleasure of the genitals. However, if he was to recover, genital libido would have to win out over anal libido. This victory occurred only after his fear of his father was brought to light. The anal mother fixation was gradually replaced by genital fixation, until this was finally resolved as well. Thus, in analysis, the patient took the developmental step, from the pregenital anal stage to the genital stage, which he had missed previously. In less severe cases involving only incestuous fixation at the genital stage, the process of freeing libido is significantly easier.

Ferenczi justly termed genitality the “perception of the reality of erotic feeling.” I now feel that the goal of every analysis must be to “educate” the individual to perceive this reality. The processes will differ according to the illness and extent of the regression, but the goal is generally valid because a biological function is involved to which there are no exceptions. I shall take it even a step further and say that no analysis may be considered complete as long as genital orgasmic potency is not guaranteed. Regardless of the fact that in many cases we must content ourselves with raising the level of general well-being, and with elimination of the most torturous symptoms, or achievement of the ability to work, etc., these results are therapeutically far removed from our goal and we must continually strive to establish an unequivocal, ego-sanctioned, genital primacy. This position must now be thoroughly substantiated.

Let us discuss the obvious objection that psychoanalysis usually precludes, on principle, the educating of the patient for this or that. Supposedly its only objective is to illuminate the patient’s unconscious and then to leave him to follow his own inclinations. I should like to express only partial agreement with this coarsely formulated view. When Freud took this position, he had something very specific in mind. Besides, one would have to be dogmatically rigid or blind in one’s own daily practice to deny that as an analyst one takes sides daily and hourly in the conflicts of diverse tendencies, and recommends one or the other to the patient with professional authority. But still more is involved. If I were to rigidly maintain Freud’s position, I would not be allowed to conduct an analysis at all, as my postulate is to “guide” the patient away from the pleasure principle to the reality principle. I am aware that psychoanalysis all too often introduces this process against the patient’s will and, on the basis of the reality principle, places all my authority in opposition to the pleasure principle. But erotic reality perception is only one part of the reality principle. One could justly raise the objection as to why a heterosexual genital position must be “imposed” upon the patient. Does not socially proscribed homosexual satisfaction also have a right to exist, assuming that the criteria of mental health—namely, social integration and subjective well-being—are fulfilled on both counts, and that the patient affirms, in analysis, his previously repressed perverse or inverse drive impulses? Certainly no objection can be made to this if, of course, mental health is guaranteed. In practice it usually seems that the advocates of psychoanalysis must support the view that all perversions, including homosexuality, are neuroses with specific mechanisms. Also, subjective well-being is one of the greatest rarities when perversion is present in a socially proscriptive environment. The majority

of neurotics seeking analytic treatment do not perceive the demand for reality-adjusted eroticism as an infringement on personal self-determination, because they themselves desire genital satisfaction, consciously or unconsciously. What Freud opposed was the assumption of the role of priest or savior, or the wish to force a certain religion or general perspective upon the patient. But it is not at all a matter of “forcing” the genital tendency but rather of carrying out a sufficiently deep analysis to enable the genital primacy to prevail against other drive demands.

Cases of individuals who expressly seek treatment because of impotence or frigidity require no further discussion. In male and female abstinent hysterics, the genital tendency is so superficial that the analyst is never even in a position to consider erotic reality perception. The same is true in a great many cases of compulsion neurosis, with the qualification that genitality is extremely repressed here. After some analytic work these cases rise to the level of hysteria. It is interesting to observe, and may be viewed as experimental proof, that very often compulsive symptoms are replaced by hysterical symptoms if the anal-sadistic position has been liberated from repression while genitality is still repressed. There now remain only the severe character neuroses with sadistic (masochistic) anal-urethral primacy, cyclothymics with strongly pronounced oral sadistic positions and perversions, to the extent that they are not genital (genital masochism, exhibitionism). Practical experience shows very clearly that none of these neuroses manifests any improvement unless genital tendencies actively intervene in the recovery process. There are good reasons for this.

All pregenital drives as such, to the extent that they claim exclusiveness, are counter to reality and can be partially disposed of through sublimation if the ego structure is suitable. The capacity to sublimate plays an important role but must not be overvalued; above all, it can never adequately eliminate libido stasis. This is the prerogative of the genital orgasm alone.

Nevertheless, satisfaction of pregenital desires in the forepleasure acts is also a necessary prerequisite for genital satisfaction in many individuals. Here the problem of differentiation of normal love life begins, with its transitions to sexual infantilism without genitality, or the subordination of genitality under a partial drive. Not only psychologically but also dynamically, there is a significant difference as to whether sadism enters in the service of genitality for the purpose of conquering the partner and whether the phallus becomes a sadistic instrument (sex murder). Stekel's statement that every person has his own particular form of sex can only be taken to mean that the forepleasure acts and the manner of cohabitation differ. In neurotic individuals, especially women, one encounters a disinclination for any coital position deviating from the norm; but this very disinclination corresponds to a specific wish for it. Under no circumstances may masturbation be considered an independent sexual form. Whoever persists in masturbation either fears intercourse or is unconsciously homosexual and will eventually become ill due to stifling masturbation fantasies. Relatively guilt-free masturbation following successful analysis will be considered a final mode of satisfaction only in cases where advanced age or physical defects prevent the individual from finding a partner.

At this point I will mention only briefly that sensations localized in the genitals in urethral ejaculatio praecox have no orgasmic value. In women, the situation is more complicated inasmuch as two organs are predestined to produce a genital orgasm, the interior of the vagina and the clitoris. In

some cases which I was able to study, the clitoral orgasm appeared even to surpass the intensity of the vaginal orgasm, although no vaginal anesthesia was present. But the orgasm is only to the slightest degree a matter of the organs involved, which are merely the transmitters of the function. The orgasm is primarily an expression of uninhibited, clearly directed abandoning of oneself to a partner. The libido of the entire body flows outward through the genitals. The orgasm may not be considered completely successful if it is experienced only in the genitals; convulsive movements of the entire musculature and a slight clouding of consciousness are its normal attributes and are an indication that the entire organism has participated. In women who have clitoral orgasms, strong psychic counterimpulses exist, stemming from a masculinity complex against surrendering to the male partner. If these are strong enough, they exclude part of the libidinal desire from participating in orgasmic discharge and frequently result in conflicts before, during, and after the act. The result will be frigidity during intercourse, despite orgasmic capability in clitoral masturbation, or total frigidity if the guilt feelings connected to masturbation are too great. Hence I can accept only vaginal orgasmic potency as the criterion of a normal attitude in women. For the moment I shall leave the question unanswered as to the source of vaginal orgasmic potency. Whereas the orgasmic potency of men may be clearly traced to the erogeneity of the phallic zone in childhood, we may not justifiably assume, in women, that any erogenous response other than clitoral existed in the first genital phase. In any event, a great deal may be said in favor of Freud's theory on this subject, namely, that clitoral eroticism is transferred to the vagina.³ In many cases of vaginal anesthesia with existent clitoral eroticism, I was able to activate a vaginal orgasm by advising suppression of clitoral masturbation while allowing vaginal masturbation.

Our topic now ushers in the further question of what function genital libido assumes in the libidinal economy following recovery. Catamnesis continued for years in analytically treated cases has revealed—as partially explained in my paper “On Genitality”—that patients who, after analysis, sooner or later entered into an orderly sexual life with orgasmic potency manifested a more lasting or better recovery. Other patients who had improved extensively in analysis and had become capable of work but remained abstinent for internal or external reasons, or had intercourse without being orgasmically potent, always manifested a certain instability in their condition. Most relapses, even of cured patients, are found among such cases. The facts indicate unequivocally that *genital libido functions as a point of libidinal attachment to reality and as a prevention against relapse.*

In terms of libido theory, this fact may be explained as follows: Through analysis the patient can be persuaded to forfeit one pleasure or another, but never sexual pleasure. Although earlier I did not reject the possibility of mental health in spite of complete abstinence, this is by no means possible in the case of cured neurotics, for neurotics are characterized by their libidinal intensity, which was also the cause of their illness. But let us note a further aspect of the recovery process. Those portions of the libido and the energy of countercathexis which previously struggled with each other in repression have now been disposed of through sublimation. They have abandoned their points of fixation in earlier, individual, developmental stages; they have relinquished their sexual goals and turned toward a new,

asexual, cultural, or social objective with great satisfaction in this accomplishment. The neurotic engineer who, because of compulsion neurosis, previously despised designing housing projects and was unable to go beyond the correction of blueprints became free and secure and began to enjoy his inventiveness and the creation of ideas. The compulsive artist who repetitiously dealt with the same subject relating to his main complex, without artistic form or enjoyment, experienced the liberation of undreamed-of drive forces. This healing process in the ego creates narcissistic, non-genital satisfaction which, as experience shows, continues only if the healing process in the sexual sphere was equally successful, that is, if the libido freed itself from repression and was directed toward social achievement. In the sexual sphere also, genital libido must be the means by which the personality grasps the erotic world. This part of object love, which has remained sexual, is an indispensable guarantee of the permanence of recovery. If not present, or too weak, ego strivings tend to function separately, causing work disturbances, etc.

At this point it would appear that I have overlooked patients who became ill after a period of mental health, who were therefore in the state just described. They were capable of social achievement and genital-libidinal satisfaction, but became ill nevertheless. Thus genital-libidinal attachment to the external world, as protection against relapse, must not be very reliable. To this I must reply: I certainly do not wish to claim that our ideally rehabilitated patient is safe from all the blows dealt by the harsh external world. However, I do claim, while acknowledging that there is no rule without its exception, that theoretically there can be no such thing as a serious mental illness with extensive narcissistic and object-libidinal attachment to the external world, unless it represents a mere façade concealing readiness for neurotic regression. Furthermore, in every case where illness erupts after a period of apparent mental health, we discover severe neurotic conditions which were the forerunners of the subsequent complete breakdown but were not recognized by the patient as such. (He was ill without knowing it.) Concerning the genital function specifically, I know of no female patient who became anesthetic after a phase of orgasmic potency. Among the male patients as well, those who were either chronically impotent or suffered from unstable potency from the start constitute by far the majority.

Consideration of the genital-libido position also offers valuable reference points when, after extended analysis, we are asked whether or not the patient can be released from treatment. The analyst cannot orient himself simply on the persistence or disappearance of symptoms. Often a patient must be kept in treatment in spite of the symptoms having long disappeared, as one can only assume with certainty that this success is due to transference or that the symptoms have disappeared merely because their meaning was exposed. Such cases involve partial analytic success, which must be guaranteed by removal of the basis for these or other symptoms. *Disappearance of symptoms does not indicate that recovery has taken place.* In other cases, one finds that patients maintain their symptoms to the very last day of treatment and even long thereafter, despite ample exposure and discussion of their significance; later the patient recovers completely. Therefore, *persistence of symptoms does not indicate that recovery has not taken place.* Conclusive evidence of whether the patient has been cured or whether analysis was a failure can be drawn only from consideration of the patient's entire attitude.

In this the transformation of libido structure plays the central role. The attitude of the passive-feminine male neurotic has become firmer, his passive submission to the analyst has been replaced by more stubborn resistance, his identification with the analyst (father) has loosened. Pregenital tendencies previously dominating dreams and fantasies have given way to a pronounced desire for genital union with a woman. In conflicts with his actual father, he has become more flexible. His timidity with women has disappeared. The ego has become strong enough to partly accept sexual demands and to partly condemn them as opposed to reality. Or the masculine, aggressive female patient with former total rejection of sexuality has acquired, in transference, softer, more feminine traits. The desire to surrender genitally to the analyst or other father figures was first noticeable in subtle hints, and later erupted with vehemence. Desire for a child—previously only unconsciously present—was verbalized. Frequently the gait, bearing, and even the facial expression change from austere, masculine, and harsh to femininely soft. The father ideal has been replaced by the mother ideal. In married women the relationship to the husband has improved, and if frigidity has not vanished during analysis, everything points to its ceasing a short time thereafter. Frequently the recovery process involves masturbation.

I am convinced that setting a terminal date for analysis is often effective if the transition of the entire personality to genital primacy—according to Abraham's "post-ambivalent genital phase"—has already been made. Criteria for setting the terminal date may be culled from dreams and fantasies and from the patient's manner of transference, to the extent that the above-mentioned transition is not already verifiable in real acts (coition with orgasm, guilt-free masturbation).

However, in the treatment of married, frigid women there are often insurmountable external difficulties in this respect. If the woman, due to her masculine tendencies, has selected a feminine husband whom she could dominate and torture, and analysis was successful in effecting a transition from masculinity to femininity, and vaginal receptivity replaced clitoral eroticism, the cured patient will no longer be satisfied with her now-inadequate husband. She will desire, in accord with her new attitude, a strong, commanding figure who is dominant in the relationship. Or if readiness for the vaginal orgasm has been analytically liberated and merely awaits activation by the husband, who proves to be suffering from a minor degree of ejaculatio praecox or is incapable of a second act, the only possibilities of escape are then resignation (which involves the great danger of relapse), divorce, masturbational satisfaction, or marital infidelity. The influence of analysis ceases at this point; the decision must be made by the patient's ego ideal, which has also assimilated, through analysis, drive-affirmative elements.

One could further object that we are demanding too much of the normal genital function and that the conflict-ridden atmosphere of the modern civilized individual absorbs libidinal vigor to such a degree that libidinal outbreaks, as seen in primitive peoples, corresponding to the biological tendencies are an impossibility. The sexual life of civilized man is supposedly split into forepleasure mechanisms and perverse acts. This is certainly true, but it was Freud who first pointed out the intimate connection between cultural development and a decrease of sexual potency. The frigid

woman is a product of this civilization. Regardless of this, it is still the object of analytic therapy to liberate “erotic reality perception” in each individual case, no matter how great the lag between ideally conceived and actual success. At this point I recall Freud’s comment that we should be satisfied with rehabilitating the patient to a point to which he himself could have developed under favorable conditions. The more exactly we know the conditions for illness and for maintaining health, the more fundamental the success crowning our therapeutic efforts will be.

*A Hysterical Psychosis in Statu Nascendi**

It is quite rare for a psychoanalyst not practicing in a mental institution to have the opportunity of observing hysterical psychoses, particularly hysterical splits. In any case, there is no specific research to be found on this subject in all of psychoanalytic literature, with the exception of the cases reported by Breuer and Freud in *Studies in Hysteria* (especially the cases of Anna O. and Emmy v. N.) and a few incidental remarks by other authors. Therefore a report on one such case requires no special justification. The few theoretical comments in connection with this analytic account will serve the purpose of throwing open to discussion related theoretical and technical problems.

I

This is the case of a nineteen-year-old female hysteric who in April 1923 began analysis with one of my colleagues in the Vienna group and continued with me after three months. Treatment lasted six and a half months altogether, when it had to be discontinued due to the emergence of an unchanging psychotic split. The patient had suffered from insomnia for more than five years and from a hysterical conversion in the form of abdominal pain for one year. The latter was localized in the region of the appendix, distinctly circumscribed, and described as piercing and stabbing. The pain occurred almost daily, usually in the afternoon and typically for a period of two to five hours. It began moderately, increased gradually to extreme intensity, and then receded as slowly as it began. During menstruation it was especially intense and persistent.

Furthermore, twilight states had been occurring for three years. The patient herself was unaware of these and always believed afterward that she had fallen asleep. Reports from others indicated that the patient suddenly lost herself in the middle of a conversation, often several times a day. She then stood up, moved stealthily along the walls, buried her head in her arms against a doorpost or window frame, crying bitterly and mumbling incoherently. As I discovered later in analysis, these states also occurred at night, when they were of a different character. She then removed all the clothes from her closet, dressed up in her prettiest outfits, spent a long time in front of the mirror, danced and was happy, and concluded by rubbing her breasts with the palms of her hands in erotic delight. Afterward, she forgot everything and wondered why her room was in disorder and especially why her best clothes were lying around on the floor. I must emphasize that the patient otherwise almost always wore the same simple dress and avoided dressing in prettier clothing.

Aside from these symptoms, her character could be termed anything but hysterical. From earliest youth she had been uncommunicative; she avoided all company, enjoyed most of all staying in her room, and rejected any attempts to cheer her. Although depressed, she was superficially gracious in society. She would have no part of flirtatiousness and repulsed all advances by young men with subtle, sarcastic remarks. She had no desire to impress people and, as I discovered in analysis, rather intentionally neglected her outward appearance. Sometimes her behavior was characterized by

inaccessible, autistic, and even negative traits—a far cry from the obtrusive desire to impress seen in the typical hysterical character. She was very well read, fluent in several foreign languages, both written and spoken, and possessed not only an exceptionally keen intellect but was also, as analysis showed, extremely intuitive. She immediately found her way in analysis and after just a few sessions understood the nature of the unconscious, the meaning of symbols, and the function of psychic mechanisms. An occasionally pronounced mannerism has more of the finer appearance of schizophrenia than the coarse exaggeration seen in hysteria and it suited her predominantly autistic personality as well. The first time I saw this patient I was thoroughly convinced she was schizophrenic, an impression I was not able to overcome during analysis, although typical hysterical mechanisms were evident. The impression of schizophrenia was subsequently reinforced by the outbreak of the split. Since an account of this split is my main concern, I shall report only as much material from the three and a half months of analysis as will contribute to its understanding.

The patient was the second of five children. A sister three years older than she died of typhus exactly two years prior to her psychotic outbreak. (This played an important role in the history of her illness.) The sister had previously been completely healthy, happy, and lively. Of the three siblings who were four, six, and thirteen years younger than she, only the brother, age thirteen, showed signs of a compulsive character: he was highly intelligent, a brooder, pedantic, and inhibited. The father, who displayed no significant disturbances, was vigorous and also intelligent. The mother was irritable but also without pronounced neurotic symptoms. There was nothing noteworthy in the more distant family.

In the second week of analysis I succeeded in discovering the meaning and origin of the abdominal pain and of one form of her twilight states. During treatment the patient stood up as though lost and, slinking along the walls, staggered to the window, crying and mumbling words which I immediately recognized as Hebrew. She did not respond to her name and remained in the same position for approximately three quarters of an hour. Then she returned to the couch, came to herself, and said, “Excuse me, Doctor, I fell asleep again.” The next day the same thing threatened to occur, but I prevented it by vehemently shaking her arm and demanding that she remember the Hebrew words she had spoken the day before. She responded that she had not spoken Hebrew for thirteen years, had forgotten everything she had ever learned, and was quite amazed at what I had told her. Gradually, however, she recalled what she had said the day before and then, suddenly, the repressed traumatic situation she had re-enacted in her semiconscious state erupted with all the characteristics of a cathartic explosion. Between the ages of five and seven she had studied Hebrew with a young tutor. One day he had gotten her intoxicated with liquor. She awoke with a stabbing pain in her genitals, naked in his bed. He was kneeling next to the bed at her right side, resting his head on her abdomen just above her right groin (the locale of the later pain) with his finger in her vagina (hence the pain when she awoke). As he saw her awakening, he threw himself on top of her; she no longer knew what had happened then. Later she thought she vaguely remembered his pressing his penis to her mouth. She recalled only jumping out of bed and slinking along the walls. While doing so she had cried and screamed the same Hebrew sentences as those spoken in her stupor: “Give me my clothes, give me my

stockings, give me my shoes. Why are you closing the windows and doors? I am afraid, I want to go home.” He then had her get dressed and she was taken home by a housemaid. Afterward she became ill with a “nerve fever” and constantly hallucinated “torn flowers,” begging her mother to give them back to her. After two weeks she had forgotten the whole thing but clearly remembered her effort to repress the ordeal and described it as follows: “It was like a veil slowly being drawn over the entire experience.” Prior to this she had felt a strong urge to tell her mother everything, but had been rebuffed by the words “You are a complaining, disgusting little thing” and had gone unheard. She was extremely reproachful toward the mother and felt rejected and unhappy. Soon, however, she recovered and forgot the incident; but the fear of waking up in the morning and finding a child in her bed remained with her. After that she was withdrawn, shy, dared not meet anyone’s eyes (without knowing why), never wanted to study Hebrew again, and forgot all she had learned. Shortly thereafter her tutor moved to another city. When, years later, she encountered him again, she simply disliked him intensely.

In analysis I had no reason whatsoever to doubt the truth of her story. The details fit together so precisely that the only question remaining was why this situation was being re-experienced traumatically in her semiconscious states. In many other similar cases such experiences are either not forgotten or do not result in such drastic aftereffects. Subsequent analysis revealed that this response was to be viewed merely as evidence of a readiness for trauma which had existed for a long time¹ and that it had served as the content of a specific symptom and of one type of twilight state.

Following the patient’s account of her traumatic experience, the abdominal pain ceased temporarily and the twilight states did not recur, but the question of why the patient had reacted with these symptoms remained unanswered for the time being. The abdominal pain represented a pregnancy fantasy and had occurred for the first time following hypnosis by a quack (a year and a half prior to analysis) who had wanted to elope with her. She had been enthralled by him for some time, but then her inner defense appeared; she became deaf in order not to “hear his sweet talk or to listen to her parents,” who were “badgering” her with warnings and pleas. After four weeks the deafness disappeared spontaneously.

I shall now briefly discuss her disposition to trauma. At the ages of three and four she had two theories regarding conception. The earlier of the two was, “One has a child when one eats a child”; and the other was, “One has a child when one is kissed.” Both theories preoccupied her and were frequently modified. She was just four years old when her younger brother was born. At the same time (which could be quite precisely determined) she had suffered from a neurotic eating problem and would eat only when her father sat her on his lap and fed her. According to her theory, this signified her desire to have a child by him through oral fertilization. It must be mentioned here that one detail of her traumatic event was never described quite as exactly as the others. She had mentioned the tutor’s throwing himself upon her and pressing his penis to her mouth, but this was uncertain and obscure, which gave rise to the suspicion that here she was fantasizing.

Analysis demonstrated that the patient’s libido position was entirely oral at that time, and later as

well. She desired the father orally (note the eating disturbance) and developed oral defiance toward the mother, expressed, for example, in not wanting to answer her questions. During analysis this attitude was repeated in mutism. This thoroughly oral attitude during the oedipal phase had its roots in a repression of genital libido which had taken place long before.

During analysis the patient recalled a scene which could be precisely dated, being connected with a family move to a new location when the patient was not yet two years old. She saw herself as a very small child standing in a partly furnished room (the move took place at age twenty-one months) and crying to her mother: “Mother, Mother, give, give, give back, I won’t do it any more.” This exclamation was often repeated at the time of analysis in periods of excitement and she never knew what it meant. Only during analysis did she recall her mother forbidding her to play with her genitals, as well as the theory she had formed at the time, namely, that there are two sorts of boys: good boys who are allowed to keep their penises and bad boys whose penises are taken away (i.e., girls).

The following is a nightmare she had at age four and never forgot. “I am walking through a beautiful big garden and asking ‘Grandma’ for a present. First, she wants to give me white, white² doves, but I don’t want them. Then I see snakes lying on the ground that I would like to have. When I reach down to touch them they become stiff and still. I awake with a scream.” Clearly a dream of masturbation (touching anxiety). She wanted Mother to give her the snakes, that is the penis, which she had had taken away from her (cf. her cry “Mother, give back” and her theory of the good and bad boys). I should like to mention in passing that observation of coition was behind this (the snakes in her mother’s garden). The primary issue here lies in denial and repression of genital libido even prior to age two and in the fact that the mother was responsible for this. Consequently, fixation was established at the less-tabooed oral phase, as expressed in the patient’s conception theories, the eating problem, and the traumatic experience with her tutor—i.e., the fantasized(?) fellatio. From that time onward, masturbation was never genital but strictly oral, as for instance, in the twilight states, the masturbation with her own breasts (in this the repressed penis fantasy was directed to the breasts = penis). At this point the significance of her older sister becomes clear. The patient was extremely jealous of her vitality. Until the beginning of the war, when the patient was twelve, their relationship had been poor. She was critical of her sister, sometimes malicious toward her, and hated her consciously. During an enemy invasion, when people dared not leave their homes, they grew more intimate; in particular there had been mutual fondling of the breasts. At approximately the same time, the mother bore her last child, which stirred the patient’s old pregnancy fantasy. Her father, whom she had always consciously loved so deeply, was drafted, and then her insomnia and twilight states began.

These neurotic states were at first infrequent and caused little disturbance. Only when the sister whom she had come to love died did the symptoms erupt in their full intensity. She had lost her most important homosexual love object, or rather, the substitute for her mother, whom she loved orally. She withdrew from the world and retrogressed into fantasy.

And now to the outbreak of the psychosis. On the anniversary of her sister’s death, the patient became mute; she also lost her ability to express herself in German. We could communicate only in written French. When I asked her the meaning of her mutism, she first wrote “θάνατος,” meaning

death, and showed me a passage in her diary written two years before which read: "I shall wilt, I shall become silent and die away, my lips will die." Her losing command of German could at first be traced to resistance against continuing analysis. This, however, did not explain her using French exclusively. In regard to this she wrote: "*Il m'est maintenant si difficile de penser autrement que français. Et en outre ca m'était toujours une grande peine et un terrible chagrin le français.*"* (A few days later she told me that her mother had instructed her in French.) Meanwhile, the depression grew worse and strong suicidal thoughts set in. She was dominated by the idea of lying in a glass-lined ball. I discovered (it was winter) that the patient was considering allowing herself to freeze to death in some snow-covered region, a fantasy which had existed in her earliest youth, long before her trauma, and which was entirely erotic in content. It became obvious that the mutism corresponded first to identification with her deceased and dearly loved sister and was further determined by yearning for the womb. It must be emphasized that several days before the onset of mutism, recollection of her mother's castration threat had broken through. Her acute ambivalence toward the mother was expressed in the mutism, but far more distinctly in the later personality split. Intense oral fixation and yearning for the womb were opposed by hate due to the castration threat.

The patient accepted all explanations given her concerning the motives for her mutism—particularly the rejection of analysis expressed in her loss of the German language. The mutism, however, continued. This condition lasted three and a half weeks. Meanwhile, her father, who had been informed of the change in her condition, bombarded me with threatening and imploring letters. As a result the decision was made in consultation to attempt elimination of the mutism by suggestion, namely, to send the patient to a laryngologist for faradization.[†] The patient agreed to visit him the next day. That morning the mutism ceased spontaneously, only to be replaced by a hysterical psychosis and a personality split.

There can be no doubt that the decision to attempt suggestive intervention was a mistake in this case. I should simply have waited, but as easy as it may be to solve such cases in theory, one is usually confronted in practice by overwhelming difficulties. Her father had begun a veritable barrage of letters. The patient's condition seemed likely to last forever. An interruption of analysis was also to no avail.

One afternoon the patient arrived as usual for treatment, but a change was noticeable the moment she entered the room. As if in a trance, she looked past me without recognition. When asked who I was, she replied she vaguely remembered having seen me once before. She did not know why she had actually come and asked whether I had heard the latest, that a good friend of hers, Eva S. (her own name), had died. What should she do now? How should she break the news to Eva's parents? Then she added spontaneously that she had strangled Eva, that she had kissed her to death. The answers she gave to some of my questions were at first not to the point (Ganser syndrome). She did not know who she was, could not find her way on the street, and had lost all sense of direction. I asked her what city she was in. She talked about how strange the people were in this city. On her way to treatment she had not been able to find my apartment and had asked passers-by how to find Dr. Richelieu—"that's your

name, isn't it?"—but everyone had laughed. Eva S., she said, had been so sad before her death and had feared both “the red and the white death.” Later it became clear that “the red death” signified the appointment for treatment by the laryngologist, which had aroused castration fears. We must not overlook the significance of “reaching into the mouth.” The “white death” corresponded to her fantasy of dying in a snow-covered area. When I inquired regarding analysis she said she herself was feeling quite well, and was certainly in no need of analysis. I had the patient move out of the boardinghouse in which she was living and visited her daily at home.

For three subsequent nights she was excited, wanted to leave the house during the night, and said she would not allow herself to be guarded or locked in. During the day she was quiet and friendly. The third night she heard bells ringing, “the tolls of death.” Letters she received were torn up without having been read. (We later discovered, however, that she had removed the money enclosed in one.) On the fourth day she felt better, had slept well, and the depression and abdominal pain had ceased. She was lively, gregarious, and collected. Then temporary illness with fever and symptoms of apical lung congestion set in. Strangely, this disappeared as suddenly as it had come. She now spoke coherently, wittily, and made fun of doctors who “think she is a fool.” Sometimes one actually could not avoid the impression of conscious simulation. She addressed her father as *Sie** but occasionally slipped and used *Du*. She was pleasant and affable toward him, straightened his tie before he left the house, and told him to polish his shoes, that he couldn't go out looking like that. She still maintained she was not Eva S.

The patient spoke of the “deceased Eva” with great affection. She was so unhappy that death was the only solution for her. Questions pertaining to the older sister went unheeded. She herself, in her own blunt opinion, was just a “poor fool.” In a letter to me later, she concluded by saying: “All my best wishes ... But now I am embarrassed—how shall I sign? A nameless little fool.” She accepted the decision to place her in an institution with ironic bitterness but did not resist. However, due to financial difficulties, she could not be kept there, and since she was quiet, her father brought her home. Our hopes that the split would soon disappear have remained barren until now (exactly one year has passed). The patient does not leave the house, speaks little, and sits in her room still firmly believing she is not Eva S. It must be added that she had expressed the desire to come to analysis before her departure for the institution. External circumstances prevented this wish from being granted.

II

It would be futile to discuss the question of whether this was a clear hysterical psychosis or a schizophrenia under the symptomatic guise of hysteria. My consultants in this case. Schilder and Jekels, share my opinion that schizophrenia cannot be excluded. This can be determined only as the illness progresses, but I must stress the unusually long duration of the split. The symptomatology of this prepsychotic personality is typically hysterical (hysterical twilight states, conversion-hysterical abdominal pain); only the character is decidedly schizophrenic (disposition to autism, lack of

hysterical obtrusiveness in object relationships, the patient's exceptional intuition, and finally that which may not be granted validity—the very early impression that the patient was a schizophrenic personality). Also perfectly suited to the schizoid character was her decidedly asthenic habitus (see Kretschmer, *Physique and Character*), although it must not be forgotten that, in Kretschmer's sense, hysterics come predominantly from schizoid types.

Certain considerations force me to save the libido-theoretical conclusions of this case for discussion in a more suitable context. I am content to establish that this was a clear case of regression to the oral phase, similar to that in melancholia. The analogy is even more clearly delineated in the symptomatology: the eating disturbance, the depression, the suicidal thoughts, and the mutism (reminiscent of the orally caused speech inhibition in melancholia). Father, mother, and sister were loved orally, and masturbation was also oral. Further, note the oral identification with the deceased sister, who was once bitterly hated. The patient severely reproached her mother for the disappointment she suffered. Abraham³ stresses that severe disappointment prior to the genital-oedipal phase appears to be typical in melancholia. Without a doubt such a disappointment existed in this case, namely, the castration threat just before age two. But it is also worth noting how early the genital libido had become active, especially since we must assume that the experience in question signified the conclusion of a period which had already existed for an appreciable time.

The patient's tendency to autism had surely been sufficiently determined by the excessive oral fixation and the obvious yearning for the womb. The fixation had made use of the death of the at first hated and later orally loved sister by supplying the delusion with its content, in which the ambivalence was plainly expressed: She had "kissed Eva S. to death." However, the prepsychotic Eva S. identified with her sister. The imaginary suicide on the anniversary of her sister's death had a twofold significance corresponding to the ambivalence: first, the re-killing of the sister, and second, suicide due to guilt (hence similar to melancholia). The submanic mood following the outbreak of psychosis can be perceived, among other things, as a triumph over the murdered object. This brings us to the economic significance of the split. It is to be interpreted as an attempt at recovery with the purpose of liberation from the introjected object, or rather, from that part of the ego identified with it, by means of illusory murder. However, I certainly do not wish to generalize this meaning of the hysterical split.

I want to take this opportunity to draw attention to the frequency with which hysterical splits, or rather, twilight states, are accompanied by mutism. In general, however, hysterical mutism also signifies death. Likewise in dreams, being mute often stands for being dead. Further, I should like to call to mind the expression: "He is silenced forever" instead of "He has died." Another female patient with semiconscious states who was considering killing her children and herself⁴ developed several phases of mutism; the connection with her suicide fantasies was obvious. As pure conjecture I might mention that mutism could also indicate regression to the oral phase of the non-verbal nursing period. This seems quite obvious in the case of "Anna O." (Breuer and Freud, *Studies in Hysteria*).

Thus the meaning and economic purpose of the split (death, relief from the guilty ego) appear to be fairly clear. The dynamics of the split require wide-scale discussion which I will save time by omitting, since I have already addressed myself to this issue in another context.⁵

III

In closing let me pose a few questions of a technical nature. In particular, a review of mistakes I may have made should enable us to avoid them in future. I shall not allow the possibility of my report being exploited to prove the “harmfulness of psychoanalysis” to hinder me in doing this. Freud was the first to emphasize that we are working with “explosive material.” The issue at stake is to learn how to handle it.

The patient began analysis with immediate transference of the traumatic situation. Several times during our first session she quietly mumbled, “I am afraid.” Before I had any idea of her traumatic experience, I recognized her comments to mean that she was afraid of me in regard to a sexual relationship. The patient had come to me from previous treatment by an older gentleman; there she had manifested more the tender aspect of her transference, while here the sensual broke through. I explained this to her, thus removing her initial resistance, and analysis assumed its proper course. Positive transference had, in a typical fashion, become resistance.

Her production of twilight states during the session in the second week of treatment was, of course, also a transference symptom. The purpose of the situation was for her, in her fantasy, to experience the trauma with me. I have already reported how she came to recall the forgotten scene. However, an analysis of the transference situation connected with this did not take place. I had no opportunity to inform the patient that she had also meant me as she had uttered the Hebrew sentences in my office. This time transference had not become resistance since the patient associated, recalled, and complied in a perfect manner for two full months, until new resistance—this time negative and rejecting—began.

Analysis of this resistance led first to discussion of her positive attitude toward the first analyst as well as toward me. She now rejected me because I had refused her and not accepted her disguised propositions. I told her this, and she understood and accepted it with the result that she made further progress and arrived at the analysis of her ambivalence toward her mother. Only now did she recall her mother’s not wanting to listen to her after her traumatic experience, as well as the reproach she had felt toward her at the time and her subsequent dislike of her. Thus, rejection of the analyst was a transference of rejection of the mother. This was augmented by her disappointment, which I discussed earlier. The mother transference, which dominated analysis from this time on, was characterized by the patient’s activating her intense urge to ask questions. Her questions, which were at first banal, soon became more meaningful, such as whether she was still a virgin, etc. During the analysis of this transference situation, the patient recalled the contents of the second type of semiconscious state (masturbation on the breasts), the scene from age two, and details of a period of questioning at the time her brother was born. She had persistently asked her mother what that thing was that her brother had (the penis), until the mother had abruptly put an end to her urge to ask questions by saying, “You are a naughty little thing.” Several days later her sister died and the mutism ensued. This also signified, primarily, rejection of analysis in that she had forgotten her German. The situation was

explained to the patient completely and with all conceivable hidden implications, and although she did accept the explanation, it produced no results.

The case was treated in classic, completely passive analysis. Quite recently Ferenczi and Rank⁶ rightly assigned greater importance to the analysis of the transference situation. The new material they contributed regarding this may be briefly characterized as follows: In passive, classical analysis, the original rule was to analyze transference only when it had become resistance.⁷ In opposition to this, Ferenczi and Rank (particularly the latter)⁸ stress the necessity of always analyzing the transference situation, even if it has not become resistance, for instance, sifting the transference situation out of every dream wherever possible. In doing so they strive to accomplish the analysis of experiences primarily through the transference.

I am convinced that Freud's classic rules are sufficient in all cases of mild neurosis, but the analysis of impulsive characters and severe character neuroses has shown that purposeful inroads can be made only through continuous analysis of transference. I count this case among the most severe neuroses and suspect that here too daily transference analysis may have been necessary. However, I am not sure this new use of transference analysis would have altered the outcome.

Another factor appears to be much more essential. If analytic work is to be fruitful, the patient's ego must be willing to process the conflicts activated in analysis, especially the previously repressed drive impulses now breaking forth. For this to happen it is necessary that the ego be strong enough to tolerate consciousness of the otherwise repressed material. In mild cases we are dealing with a strong ego from the start and there is no need to fear a breakthrough of unconscious material. However, there are cases (this among them) in which the ego does not manifest from the start the integration indispensable for successful analysis. These egos must first be strengthened through ego analysis, whatever form this may assume. It is already known that "latent" schizophrenics may, through analysis, become manifest schizophrenics, and this may be unmistakably traced to ego, or rather, superego, defects. In such cases it is necessary to prevent associations, memories, and above all incestuous conflicts from becoming conscious too rapidly, as they did in the case of Eva S. The reader will have noticed how much taboo material emerged in the short span of three and a half months. The inundation of the conscious with repressed material must then work disadvantageously, as it cannot be sufficiently processed. The ego lacks time to assimilate it bit by bit. In neuroses without ego defects such cumulative breakthroughs never take place; on the contrary, they are characterized by a slow surfacing of repressed material. Our case, however, did manifest such ego defects, which were clearly expressed in the ego split and insufficiently evaluated at the time.

*The Impulsive Character**

A Psychoanalytic Study of Ego Pathology

INTRODUCTION

At present we have no psychoanalytic theory of character that is even partially systematic. The very nature of psychoanalytic methodology demands that the phenomena be first examined separately, not only in individual analyses but in the entire field of psychopathology. Only later does it synthesize the individual results and subsequently progress to generally valid theories. The prerequisite for a psychoanalytic characterology would be exact knowledge of the most detailed mechanisms of psychic development, a demand we are far from being able to satisfy. Even though the most essential elements of the theory of sexual development seem to be coherent, they do not provide sufficient characterological comprehension of the personality. But anyone who is well acquainted with psychoanalytic developments, and especially with Freud's germane writings, and who is able to use them in his own passive and active analytic experience, will realize that the dynamics of the ego are more difficult to comprehend than the dynamics of sexual development.

As Freud has emphasized repeatedly in his basic works, and in 1923 in *The Ego and the Id*, psychoanalysis has scrupulously avoided approaching the personality of a patient with rigid, preconstructed theories. In principle, it has focused on genetic comprehension, a kind of embryology of the psyche, requiring the longer, more arduous path of detailed examination. This has thoroughly influenced therapy, for analytic cure involves first recognizing and understanding defective developments and then, insofar as possible, applying that understanding to their correction. Thus psychoanalytic therapy is at present just as inconclusive as its theory. The ideal presupposition would be complete understanding of the origin and development of the patient's character.

Psychoanalysis has long ceased to be merely symptom therapy; on the contrary, it is constantly developing into a therapy of the entire character. This change may be attributed to Freud's early insight that the essential factor in analytic work does not consist in guessing the unconscious meaning of a symptom and communicating this to the patient, but in recognizing and eliminating resistance.¹ In resistance, however, two basic elements regularly find expression. First, every resistance contains that which is repressed due to the analytic situation, and concomitantly, the repression itself which is offering resistance. Second, there exists, in addition to these specific elements, or contents, a special form of resistance; i.e., every resistance draws, so to speak, on the entire personality for its specific character. Thus, a defense against incestuously founded transference resistance contains the same elements in a case of compulsion neurosis as in hysteria, but in an entirely different form consistent with the compulsive or hysterical character.

At first a comprehension of these elements may well suffice to accomplish the most urgent

analytic tasks, and observation of how the patient's personality manifests itself in his resistance is of no importance. However, once one has ventured beyond symptom analysis, one will recognize that not merely the analytic removal of symptoms but the basis of neurotic reaction, namely, the neurotic character, assumes eminent importance. If one is to effect genuine recovery, in which relapse is out of the question, then character analysis must replace symptom analysis. But it is only recently that character analysis became the central issue of analytic research; nor did it happen *expressis verbis*.² Ferenczi and Rank³ place special emphasis upon the importance of analyzing neurotic behavior and they criticize the method of analyzing the symptom or complex practiced almost exclusively in the past. However, in stressing the necessity of understanding the patient primarily through his actions, they appear to be devoting less attention to the patient's memories, to which Freud always gave priority. The analysis of neurotic behavior certainly constitutes the main point of attack in character analysis, and surely to a much greater degree than in "memory analysis," because general bearing and character peculiarities are most clearly expressed in actions. But actions themselves are poorly adapted to genetic-analytic interpretation without subsequent memories, or rather without analytic reconstruction of the sources of behavior. On the other hand, experience shows that patients who do not act out tend to be unsusceptible to therapeutic influence, notwithstanding intensive work with memories.

Fragments of a psychoanalytic characterology were first formulated in Freud's⁴ description of the "anal-erotic character," and later fruitfully elaborated, notably by Jones⁵ and Abraham.⁶ It was demonstrated that primary drives participate in the formation of character traits: Frugality, a sense of order, pedantry, cleanliness, spite, etc., were recognized as direct, non-neurotic derivatives of anal eroticism. The problem of what causes a primary drive to develop into a neurotic symptom in one case, and into a character trait in another, still remains unsolved. It is implicit in the recognition that urethral-erotic drives cause the neurotic symptoms of ejaculatio praecox (Abraham) and enuresis nocturna (Freud, Sadger, Stekel) in one case, while in another they contribute to jealousy, which must be termed a character trait and not a symptom. This same fundamental problem applies also to the role of sadism in the compulsive character, a type which is more transparent characterologically than, for example, the hysteric. In addition, it is not clear why the universal phenomenon of compulsive repetition,⁷ i.e., the compulsion to experience certain situations repeatedly, dominates only certain cases as a character trait, and in others does not appear to play the role appropriate to its biological nature. There are neurotic characters without neurotic symptoms, and there are symptom neuroses where the character, i.e., the entire personality, does not appear essentially pathological.

All these problems belong in the realm of a psychoanalytic characterology, the methodologic premise for which would have to be a comparative analytic psychology similar in nature to comparative *embryology*.

The medical analyst may well experience increasing satisfaction in understanding symptoms, tracing individual character traits to their origins, and practicing causal therapy. However, one can never deceive oneself regarding the absence of a systematic characterology which is felt all the more acutely as therapeutic experience begins to point forcibly to the overriding importance of character

analysis.

Freud's *The Ego and the Id* may be viewed as the cornerstone of a future psychoanalytically founded characterology. At the threshold of characterological comprehension of personality stands the phenomenon of identification:

The character of the ego [is] a precipitate of relinquished object cathexes ... Since then we have come to understand that such substitution [identification for object relationship] is an important constituent in the formation of the ego and makes a substantial contribution to synthesizing what is usually called character.

This indispensable developmental process may also structure itself pathologically:

If these [the object identifications] dominate and become too numerous, disproportionately strong, and incompatible with each other, then a pathological outcome is likely. The result can be a shattering of the ego with separate identifications sealing themselves off from one another by resistance. The secret of cases with so-called multiple personality is perhaps that the individual identifications alternate in seizing possession of the conscious mind. Even if it does not come to this there is still the matter of conflicts between the various identifications into which the ego disperses, conflicts which in the final analysis cannot all be termed pathological.

Freud then differentiates between the ego and the superego (ego ideal). The superego represents the actual product substituted for the object, and the ego submits to the superego and also offers itself to it as a love object, acting as it did toward the parents at an earlier stage. But the superego is "two-faced": Not only does it say, "Thus (like your father) shall you be," it also embraces a taboo: "Thus (like your father) you may not be, which means you may not do everything he does; some things are strictly his prerogative." Freud has herewith created a framework for further research. In particular the question of the influence of erogenous zones on the formation of the ego ideal was left open in *The Ego and the Id*, and this is most intimately related to the question of specifically erogenous object relationships.

The following points are of decisive importance in the final formation of pathological as well as reality-oriented characters:

1. Which attitudes of the parental personality the child assimilated: (a) as positive, or (b) as negative ego ideal.
2. Whether the formation of the ego ideal in boys followed principally the pattern of the father or the mother (the same applies to girls), and what the qualities of the prototype were for the ego ideal.
3. In which stage of libido development an effective identification took place. The specific determinant of the character form must be sought⁸ in, and temporally related to, the reciprocal interaction of ego development and sexual development (for example, whether an effective identification took place in the genital or anal phase).
4. The conditions under which the realization of the ego ideal's demands took place, because aside from the real ego, which represents the sum of realized ego ideal demands (i.e., being oneself), there remain a number of demands by the ego ideal which have not yet been realized (*wanting* to be oneself). We know that the tension between the real ego and the superego, between being oneself and

wanting to be oneself—or rather, not being allowed to be oneself—is at the root of many illnesses.

5. It must be considered that a primitive pleasure ego is present long before any identification is accomplished, and that its attitude toward the identification is crucial for success.

Even though the ambiguity revealed briefly here becomes clear from a characterological consideration of every analysis, the difficulties in achieving slightly better understanding even in uncomplicated cases of mild transference neurosis are very great. Best suited for this are cases exhibiting gross defects in the ego structure, those in which people are continually struggling with the external world and appear never to have ventured beyond the first stages of identification or superego formation. Neurotics who are typically subject to compulsive repetition, the asocial, intermittently criminal, who systematically complicate or destroy their own existence and have remained entirely infantile in their egos, are best suited for the study of ego-ideal formation *in statu nascendi*. They also afford valuable reference points for the analytic understanding of less severe character anomalies, although they are gross distortions of the latter. These uninhibited, drive-dominated types form a category of their own which thus far has been approached psychoanalytically only by Alexander⁹ and Aichhorn.¹⁰ The fact that they represent, so to speak, a new psychoanalytic frontier is surely to be traced to their generally poor suitability for outpatient treatment. As a rule they show no effective insight into their illness, and if they do make a start in analysis, they usually have great difficulty in learning to use this delicate instrument. All these issues will be discussed later. The case histories at my disposal have been selected for the most part from severe character neuroses which I deliberately chose for treatment in the Vienna Psychoanalytic Outpatient Clinic. I am unable to forgo abbreviated presentation of several case histories, although I am aware that this entails dealing with all the contingent shortcomings. Their publication is all the more justified because the mere description of these patients' experiences will suffice to disclose to the analyst their most essential and specific aspects, even without the usual interpretation.

Thus my efforts will proceed simultaneously in two directions, which will eventually converge. A special discussion of the pathological state which I shall term, with Alexander, the "impulsive character" (until now underestimated psychoanalytically) will run parallel to an inquiry into character development on the basis of this material. I am by no means attempting a systematic characterization, which can never be achieved by the inductive, empirical method of psychoanalysis. I shall have to resign myself to pointing out several typical defective developments in character formation using the better-known mechanisms of psychosexual development as a basis.

GENERAL REMARKS ON NEUROTIC AND IMPULSIVE CHARACTER TYPES

If one wishes to probe psychoanalytically unexplored territory, it is wise to venture forth from already thoroughly understood manifestations of psychic disturbances. As a first premise one may bear in mind what psychoanalysis has demonstrated so clearly, that there are no distinct borders between various types of illness and pathological symptoms, or even between the concepts of "normal" and

“pathological.” Approaching a problem from the “normal” is destined to fail because the dynamics and genesis of the normal psychic state, to the extent that it exists at all, is a much greater problem than, for example, the familiar mechanisms of a hysterical symptom. Nevertheless one is justified in attempting to differentiate, to separate one pathological state or type of illness from another, or from that which is “healthy,” by virtue of the fact that various central mechanisms which result from the differences in the composition of material causing psychic conflicts constitute one illness or another, but belong to the normal state as well. It is a value judgment that one specific constellation is viewed as promoting the capacity to function in reality (presently we have no better definition of mental health), and we abstract this value judgment from the demands of our own cultural community. It is different if we correlate individual pathologies with one another. Actually, it is immaterial whether we consider the neurotic character, the impulsive character, or the psychopathic character to be states lying between health and psychosis (as clinical psychiatry usually assumes) or whether “every neurotic character carries the nucleus of a certain form of neurosis within itself,” as formulated by Alexander, hence constituting a condition between health and neurosis. It depends upon the viewpoint from which we approach the problem and upon the advantage we hope to gain from such a classification. Thus we attach no special importance to the standpoint assumed in this essay, namely, that the impulsive character lies between the symptom neurotic and psychotic in regard to certain specific mechanisms. Alexander describes the neurotic character as the type of person “who does not suffer from any pronounced pathological symptom but rather displays conspicuously drive-accented behavior in life, often even acting under compulsion, and is ruled by especially intense unconscious tendencies.” He continues to say that “one group of neurotic characters, certain impulsive criminal types,” suffer from “a lack of ... defense reactions.” Alexander is justified in pointing out the emergence of transitory symptoms in these patients when, in analysis, they are brought under the pressures of denial. He raises the question “whether the pressure exerted by the factor causing the neurosis—libido stasis—is not strong enough to find release through new channels, in new symptoms, or whether the defense mechanism of the entire organism—repression—is not powerful enough to prevent the achievement of genuine satisfaction altogether.”

In this form the problem is not posed correctly. In the analysis of impulsive characters, one encounters cases of amnesia which have all the symptoms present in typical hysterical amnesia. Other mechanisms of repression, such as fragmentation of genetically connected experiences, displaced guilt feelings, and defense in reaction to destructive tendencies, are at least as intense in the impulsive character as in the compulsion neurotic. (This will be demonstrated later.) Hence one cannot speak of weakness in particular repressions but of what causes a lack of defense. This will be the central issue of the discussion. We shall examine the mechanisms of repression for defects enabling actions to take place which would never attain motility in a simple symptom neurosis.

Concerning Alexander’s remark: “Every neurotic character bears within itself the nucleus of a specific neurosis,” I must point out that there are in fact very few cases which do not show at least one localized neurotic symptom. Thus, although the case Alexander published belongs to the group of character neuroses with no symptoms, the greater majority of impulsive characters exhibit a host of

symptoms, such as phobias, compulsive actions and rituals, compulsive brooding, in addition to their drive motivation, which is usually not experienced as part of the illness. (In character neuroses in women, all the familiar forms of conversion symptoms are especially prevalent.) The symptomatology of such neurotics is characterized by the grotesque quality of their symptoms; one might even term them pathological distortions of middle-class traits. The compulsive thought of killing one's child or a friend, as conceived by the simple neurotic, appears trite and innocuous in comparison to the compulsive urge of an impulsive individual to slowly roast his child over a fire. One can no longer speak of a compulsive urge (despite similarities in structure) when a patient of mine derives her greatest pleasure from setting all her household articles afire and lunging at her child with a burning match. How mild the passive castration tendency of a patient suffering from a compulsion to lose or misplace the articles of daily life appears when compared to the compulsive acts of a female patient who was compelled to produce profuse bleeding from the genitals to achieve masturbational satisfaction and seriously injured her cervix with the blade of a knife, finally causing prolapse of the uterus. Thus, such patients show no lack of localized neurotic symptoms but rather an additional factor not present in the simple symptom neurosis. This not only accounts for the differences as opposed to classic conversion or anxiety hysteria and compulsion neurosis, it also places a considerable number of impulsive individuals suspiciously close to schizophrenia. Grotesque impulsive actions of this nature are not rare in the anamnesis of schizophrenics. A case history to be presented later will demonstrate the difficulty of deciding upon a diagnosis of schizophrenia or transference neurosis even after months of psychoanalytic treatment.

There is one essential point in which the cases I am using differ from Alexander's, showing that there is good reason for the discrepancies in our judgments. I employ the term "impulsive character" when actions and behavioral patterns toward the external world dictated by the repetition compulsion dominate the personality. The issue now is whether the actions are manifest in the undisguised form of primitive tendencies or whether they have been subjected to extensive secondary processing and disguise. Alexander's case was distinguished by a deep-seated need for punishment, causing the patient to (unconsciously) choose friends time and time again who would swindle him out of his money, until finally he was ruined financially as well as emotionally. He was a type of person whom Freud described in *Beyond the Pleasure Principle*:

The compulsion expressed in these cases is no different from the repetition compulsion of neurotics, although there is never any indication of a neurotic conflict resolved through the formation of a symptom. Hence there are people whose every human relationship will end in the same way, such as philanthropists who, after a certain time, are resentfully deserted by each of their wards, no matter how different the relationship was in other respects; they seem to be people who are predestined to taste all the bitterness of ingratitude, whose every friendship ends in betrayal ... lovers, whose every tender relationship with a woman will inevitably pass through the same stages and always end in the same manner, etc. This "continual recurrence of similar situations" is hardly surprising when it involves active behavior by the individual in question and when we discover a constant character trait in the personality which must express itself in repetition of the same experiences. Far more impressive are cases involving passive experiences over which the individual has no control and would thus merely seem to be repeatedly suffering the same fate.

The cases I have selected are characterized by the same “diabolical personality traits” but the impulsive actions and experiences are primitive and permeated with unconcealed masochistic, sadistic, anal, oral, and similar impulses. Hence there may be cases of impulsive characters exhibiting a different dynamic in their psychic conflicts, to which my inquiry into the nature of the repression defect is not applicable.

Three questions which will presently engage our interest have already begun to take shape:

1. Which dynamic similarities or differences characterize the relationship of the impulsive character to the simple transference neurosis? 2. Are there defects in the repression mechanism specific to the impulsive character? 3. If indeed such specific repression defects do exist, are they related to the defects in schizophrenia?

Answering question 3 would also take us a step closer to understanding the generally accepted psychiatric assertion that “psychopathic personality disturbances” partially contain, or are at least closely related to, “the undeveloped rudiments of genuine psychoses” (Kraepelin),¹¹ and especially of schizophrenia.

Our term “impulsive character” is much narrower than the term “psychopathic personality disturbance,” as commonly used in psychiatric literature, where it is usually overburdened. Often phenomena are termed “psychopathic” which also appear as symptoms in otherwise well-structured personalities. But even when the term “psychopathic” is used more narrowly, diversified material is often placed into this category due to a lack of genetic criteria. Bleuler¹² also rightly considers any attempt at a descriptive nosology a mistake. It can only be a question of examining the principal mechanisms. Bleuler writes:

Illnesses in this category cannot be clearly distinguished from one another or from the normal state ... I might venture to say there are no distinctions at all; the degree of intensity and agglomeration required to call a psychopathic individual sick is entirely arbitrary. Surrounding this group are wide zones of transition to—and mixture with—all other nervous illnesses, particularly hysteria. Paranoid tendencies need not end in paranoia in every case. Symptoms of various illnesses can be combined in the same patient ... in particular affective abnormalities and neurotic symptoms are hardly ever lacking ...

Considering this evaluation of psychopathic personality, it is understandable that the categories Bleuler himself touches upon—the excitable, the unstable, the impulsive, the eccentric, the liar and swindler, the contentious, and the antisocial—just barely serve as a provisional orientation. The basic error contained in all such attempts at classification is that one conspicuous characteristic is taken as a criterion for the entire group and consequently it is overlooked that, for example, every impulsive character, in Bleuler’s sense, is just as unstable as he is perverse, and the perverse is an enemy of society and therefore necessarily troublesome. Bleuler’s classifications were borrowed from Kraepelin, although Bleuler did elaborate upon the connection of some forms of psychopathic personality to psychosis. Liepmann¹³ also defines psychopathic personality as “pathological deviations from the normal mental state which, in regard to distinguishing characteristics, are not to be classified as fully developed psychoses since they lack the severe symptoms of the latter.”

The close connection of psychopathic personality to psychosis—especially dementia praecox—

occurred to those authors who did not extend the concept to the point of encompassing mental illnesses of the type of uncomplicated hysteria and compulsion neurosis. Thus, for example, Kraepelin and Bleuler also separated neurasthenia from psychopathic personality, whereas Schneider¹⁴ describes neurasthenia under the heading of the insecure, moody, and asthenic psychopathies. Kraepelin refers to one group of psychopaths as the “undeveloped rudiments of genuine psychotics” and to others as “stray personalities whose development was impaired by unfavorable hereditary influence, congenital damage, or the effects of other early obstructions. When the substantial deficiencies are limited to the emotions and the faculty of will, we refer to them as psychopaths.” In regard to psychosis, Dickhoff¹⁵ discovered that hebephrenia, dementia paranoides, and paranoia, in particular, result from psychopathic peculiarities. “Several psychoses (such as paranoia simplex) are based either entirely or to a substantial extent on the continued development of psychopathic inferiority.” “In psychopathic inferiority of a higher degree, psychoses of varying duration and kind occur with—or more rarely without—external cause, and show little predictable regularity in course or appearance. Prognosis in individual cases is usually good although the probability of further attacks is high.”

Several authors, such as Birnbaum,¹⁶ Gaupp,¹⁷ and Mezger¹⁸ define the psychopathic personality in very broad terms. Mezger considers “every deviation from the actual norm, every abnormality ... sick and pathological.”

* * *

Until now I have used the terms “impulsive character,” “neurotic character,” and “character neurosis” indiscriminately. Now, however, I must make an effort to clarify our terminology—not a simple task in view of the general vagueness of the term “character.” In this undertaking, I shall try to pass between Scylla and Charybdis unscathed. On the one hand, I do not wish to commit the unfortunate error made so frequently in official scientific discussions of living events, that is, losing sight of the living phenomenon as a result of the terminological discussion. On the other hand, I must avoid merely compounding the confusion by using dilettantish terminology. This happens equally as often and throws the door to misunderstanding wide open. Entirely without commitment and strictly as a basis for our examination, we may define “character” as the particular psychic attitude toward the external world specific to a given individual. This, in turn, is determined by disposition and experience in the sense of Freud’s “supplementary progression” (*Ergänzungsreihe*). Thus we consider those individuals to be obvious neurotic character types who display more or less gross deviations in regard to a norm of resolute behavior suitable to both sexual and cultural reality, as well as in regard to social adjustment.

The experiencing of inner strife and conflicts may be viewed as a common feature of all neurotic characters, hence also the incompleteness of actions and attitudes. Psychoanalysis has demonstrated that these features are the consequences of disturbed development and that entire areas of the personality are left behind, bound by fixations to earlier stages of development. We may make a most noncommittal but nevertheless significant differentiation, in the light of present-day knowledge, between neurotic symptom and neurotic character by formulating thus: The localized neurotic

symptom corresponds directly to those partial areas of the personality which have been “fixed” in one stage or another, whereas the neurotic character is always an expression of the total attitude corresponding to the fixation. Thus a fixation (and the psychic conflict resulting from it) always will exhibit simultaneously two modes of expression: first, the neurotic symptom especially corresponding to it (for example, hysterical vomiting as an expression of oral-genital fixation) and second, the neurotic character which corresponds to the disturbance evoked in the complete personality by the partial fixation. To be consistent, we must assume then that even disturbances insignificant in themselves do not leave the rest of the personality unaffected. Thus every neurotic symptom is founded on a neurotic character and we may speak in terms of a hysterical or compulsive (and possibly schizoid) character being topped by its symptoms as a mountain by its peaks. Both the neurotic character and the neurotic symptom are determined in their specific qualities by the phase in which development was arrested. The compulsion neurotic who seeks treatment because of an impulse to stab his friends in the back (a compulsive symptom) will inevitably exhibit the compulsive character traits of pedantic cleanliness, orderliness, and exaggerated conscientiousness. Both the specific symptom and the character traits display typical features of the anal-sadistic phase. In this light the term “impulsive character” can allude to only one specific form of the neurotic character, namely, to a disturbance of the personality as a whole, marked by more or less uninhibited behavior. As we differentiated between the neurotic symptom and the neurotic character, we must now separate compulsive acts, in the sense of uncontrollable compulsive deeds, from the general behavior of the impulsive character. Whereas the former appears as a circumscribed foreign body within an otherwise ordered personality and is condemned by it, the impulsiveness of an impulsive individual is a characteristic of his total personality and hence only rarely recognized as pathological. Impulsive drives are usually diffuse, not always directed toward specific objects, not limited to certain situations, often varying in kind and intensity, and completely dependent upon social conditions; a limitation not found in the unvarying acts of the compulsion neurotic, which are ordinarily not dependent upon external circumstances. The relationship of the impulsive character to the external world is generally more clearly defined and in this sense easier to grasp than circumscribed neurotic symptoms. The actions of the impulsive individual never appear as senseless as do those of the compulsion neurotic and they are rationalized to a much greater degree.

In some cases the borderline between the impulsive character disorder and schizophrenia—especially in its paranoid and catatonic forms—is equally obscure as that between the former and classic transference neurosis. A factor enabling a separation of various particularly blatant forms from unmistakable schizophrenia is the extremely lively relationship to the external world, which often gives the impression of exaggeration. In several cases first diagnosed in the Vienna Psychiatric Clinic¹⁹ as “psychopathically inferior” drifters, liars, and contentious complainers, pronounced megalomaniac and paranoid ideas subsequently emerged, enabling the exaggeration in external relationships to be interpreted as a mere defense reaction against regression to autism. Furthermore, the typical schizophrenic split in the personality is absent, although replaced by extensive

depersonalization, which I found in all my patients who could be classified in this group. Depersonalization itself may not, however, be considered a valid criterion because every mental illness begins, as Nunberg²⁰ correctly points out, with depersonalization as a result of libido withdrawal. The sensing of alienation, be it toward the external world or toward the patient's own body, is rarely as striking or blatant in simple transference neurosis as in impulsive characters or schizophrenics. One patient of mine—a case I shall discuss in detail later on—appeared outwardly to be suffering from severe stuporous states occurring between our Saturday and Monday appointments and continuing for several weeks. She sat crouched on the sofa in her room with the door locked, eating nothing and speaking to no one. This condition always occurred after she was shaken by something that occurred in the analysis and transference seemed to be undermined.

Furthermore, megalomaniac and paranoid ideas are lacking, although ideas of reference²¹ are not infrequent. These, however, correspond structurally to the idea of being slighted and are characteristic of simple transference neuroses as well. Of course, in the impulsive character they are often intensified to the point of delusional contentiousness. Reality testing, the judging of ego boundaries, is untouched, although particular aspects are obscured by affects.

In only three cases of impulsive character which I have treated did auditory and visual hallucinations occur temporarily during analysis. One case involved hallucinations during a continuous hysterical state; in another they were caused by the sudden eruption of affective anxiety; and in the third by an acutely paranoid phase. Although auditory hallucinations are especially frequent in hysterical psychosis, I must nevertheless call attention to the fact that in the first case, analysis had to be suspended due to a persistent twilight state which bore a strong resemblance to schizophrenia. My consultants in the case (Schilder and Jekels) did not want to risk excluding schizophrenia as a possible diagnosis despite typical hysterical symptoms. According to the most recent research into the “schizoid pattern”—especially by Kretschmer²² and Bleuler²³—we may assume that schizoid hysteria activates latent schizophrenic mechanisms when it lapses²⁴ into semiconsciousness during a hysterical personality split. Whoever shares my opinion that schizophrenia cannot be qualitatively separated (in the sense of its organic nature) from hysteria and compulsion neurosis will also never exclude the possibility of hysteria or compulsion neurosis suddenly changing into schizophrenia under certain circumstances as yet entirely obscure.

The overt perversions which are almost the rule in the impulsive character, especially those of the sado-masochistic variety, are also related to defective repression. Using Freud's research on the superego (ego ideal), we can recognize this particular affinity to the sphere of destructive drives as the expression of a disturbance in superego development.

I shall introduce my examination of specific developmental disturbances in the impulsive character with a short discussion of typical neurotic character disturbances such as exist in every symptom neurosis. This will enable differences between the two to be seen more clearly. Generally speaking, it will amount to comparing the dynamics of the inhibited neurotic character to those of the impulsive character.

AMBIVALENCE AND SUPEREGO FORMATION IN THE INHIBITED CHARACTER

From Freud's studies we have learned to recognize that everything we call culture and civilization is based primarily on the repression of drives and secondarily on their sublimation. Humanity's cultural progress from the caveman to the average civilized individual of the present must be recapitulated by each individual in an abbreviated but nevertheless basically complete form. A pure drive ego is placed in a world full of restrictions and obligations and must adjust to it by relinquishing the greater portion of its demands and achieving full satisfaction of only the minutest share of them at a much later date. This adjustment takes place gradually and in more or less clearly defined phases. It is not, however, an automatic process as is, for instance, the development of the human body from the egg cell. First the "psychic embryo" needs certain very pronounced points of reference in its constricting environment and these are embodied in the first educators. These educators function not merely as objects of the first instinctual demands, not merely as objects affording a certain degree of drive satisfaction, as is particularly the case during the suckling period, they also play the crucial role in drive denial, thus imposing the first and most significant restrictions.

It lies in the very nature of drives, however, that they cannot be completely extinguished but only reformulated and redirected toward other goals. In short, no drive will disappear without some form of ersatz satisfaction. The fact that stages of psychosexual development take place is based on this substitution. Hence the anal phase in a child will emerge in complete clarity only after the oral phase has been eliminated by denial. In turn, every drive denial results in a splitting up of the libido involved. At present the most clearly illuminated results of this process are the following: First, more or less unchanged preservation of the drive in its original form, because the partial drives are destined to play an important part in the sexuality of later life as forepleasure. Second, more or less vigorous reaction formation according to the nature of the drive force (for instance, disgust as a reaction against anal-erotic tendencies). Third, sublimation. For example, cleanliness appears as a primitive form of anal-erotic sublimation, and there are subsequent sublimations of a far more complex nature which, as psychoanalysis has been able to prove, create the essential dynamic impetus in every area of the human spirit. Fourth, every erotic impulse serves to establish relationships between the child and the individuals caring for it. The beginnings of articulate object cathexis can already be directly observed in the oral stage. Subsequently they develop into those most intense object relationships in the genital phase which, we assume, reach their peak at about age four. Over the course of time, the ramifications already described briefly do not develop separately but rather remain in a close reciprocal relationship. Thus, object cathexis plays a particularly important part in creating reaction formation and rendering drive abnegation bearable. For at this early age the child is so entirely a creature of pleasure (pleasure ego in Freud's terminology) that it can and wants only to substitute pleasure for pleasure. It first accustoms itself to cleanliness "for love of" its mother. Hence disturbances in the most primitive object attachment are immediately noticeable in the form of spite, particularly well known in its manifestation as anal spite. But when the child, for love of its mother, has renounced a

specific form of pleasure, it has assimilated a demand by the mother and we are confronted with a case of primitive identification, although there is still a great deal of object attachment involved without which the identification would not be tolerable.

These initial identifications are destined to prepare for the later, final, culturally influenced ones. But first a phase of extremely intense object cathexis is introduced, the appearance of which Freud described under the composite heading of the Oedipus complex. The male child begins to try, more or less openly, to replace his father and to entertain thoughts of eliminating this annoying rival; the female child assumes a similar attitude corresponding to her sex. Heterosexual cathexis indicates homosexual object identification. However, this simple oedipal relationship can be complicated in some cases by marked contradictory impulses, although as a rule these are merely suggested. By this I mean that the boy also loves his father and identifies with his mother, just as the girl loves her mother and identifies with her father. Freud feels that it is advisable to assume a “dual Oedipus complex” in any case because of the general significance of dispositional bisexuality. The conflicts of this phase, which are among the most significant experienced by man, form the center of every neurosis without exception. They also mobilize powerful guilt feelings, the actual origins of which Freud considers to be still completely obscure. This guilt develops into the particularly intense hate attitudes present in the oedipal conflict. This does not mean that the hate is first generated here—on the contrary, it appears to have existed long before. We view the first possessive and destructive impulses of the small child as primitive manifestations of this hate. It can be proven that no denial is accepted without hate impulses being generated, although these may be, under favorable circumstances, concealed by successful pleasure substitution or object love. Nevertheless, they are prepared to erupt at any moment should denial become too intense.

Freud contrasted libidinal tendencies with destructive ones which originally are directed toward objects but which, in the course of reaction formation and sublimation, succumb to repression and subsequently function in the development of a social conscience and a sense of morality. They experience a unique destiny, which was studied in melancholia, i.e., they are reversed and directed inward toward the self as masochism with all its manifestations. At this point I shall merely mention Freud's²⁵ assumption that masochism was originally erogenous, taking the form of sadism when directed toward the external world and only thereafter—as was mentioned above—becoming secondary masochism. The situation is actually this: The primitive drive ego is held in check by a power Freud calls the ego ideal or superego. It stems from relinquished object cathexis and consists of all the demands formerly made upon the drive ego by parents or other individuals who attended the child. Finally, the parents are released as objects but retained as the superego, by means of identification. This results in desexualization of object relations. The driving force used by the newly formed ego faculty to keep its drive ego in check—in other words, to achieve repression—is sadism in its sublimated form of “moral” masochism, which must be distinguished from erogenous masochism (perversion).

Realization of Superego Demands

We have seen that superego formation begins with denial and is essentially concluded with denial of the incestuous oedipal desire. Actually, denial is encountered at every stage of libido development, which enables us to place the beginning of superego formation at a time shortly after birth. Even accustoming the infant to fixed mealtimes is a denial of its incessant need to suck. To go a step further, the very first denial is birth itself, as the pleasure of intrauterine life then comes to an end (due to lack of stimuli).²⁶

These primitive and preliminary stages of the superego next undergo complete realization. Since every drive inclines toward perseverance and constancy, there would be no progress in libido development without realization of the demand: "You must defecate at a set time and in a set place." However, as mentioned above, the realization of this demand would be impossible if other pleasure sources were not offered. Later the situation changes. The more developed and integrated the personality of the child becomes, the more it opposes restrictions, particularly in the narcissistic stage preceding complete object cathexis. Almost all children, even those who later remain mentally healthy, pass through a stage of intense opposition to forced restriction. Too much submission on the part of the child may be a sign of later neurotic weakness, i.e., the well-known neurotic inability to succeed in the struggle for existence. Assimilation of educational demands then takes place only partially and the drive ego asserts itself more or less successfully over the superego demands. Thus one facet of individual development is secured, and now infantile masturbation becomes its particular domain. It is understandable that the tension between the unrealized superego and the drive ego creates guilt. Guilt in turn is decreased by whatever realization of the ego ideal's demands is possible. The real ego, which now develops, is composed for the most part of realized superego demands. Far from ever reaching a conclusion, this oscillation between the real ego and the ego ideal continues throughout life. Each time any demand of the superego is realized, each time one succeeds in becoming what one wants to be, the ego ideal is elevated and its demands become more encompassing and more numerous. Here we see a typical conflict between the real ego (being oneself) and the superego (wanting to be oneself). One expression of this conflict may be seen in the inferiority complex and its compensations, as explained by Adler.

However, the real ego of the child and that of the adult differ in one essential respect. Whereas the former is composed strictly of realized superego demands, the latter also contains elements of the sexual sphere, namely, all those reality-oriented sexual impulses not in conflict with the superego. Most conflicts causing later neurosis begin during this transition from the sexually negative to the sexually affirmative real ego, which normally takes place several years after puberty. The sexually negative ego of the child is created by the prevailing mores of child rearing. From a psychoanalytic standpoint it is conceivable, and even endorsable, for the real ego of the child to contain sexually affirmative elements. There is something to be said in favor of allowing children a certain degree of genital satisfaction. For if infantile masturbation is to be counted among the physiological factors of development, then it is senseless, from a prophylactic standpoint, to separate the child's real ego from these factors, thus creating a masturbation conflict which will without exception become active during

puberty—and in many cases pathologically so.

Realization of the superego normally progresses slowly, involving, in the healthy boy, complete identification with the father and in girls identification with the mother. In the interest of clarity, it is necessary to differentiate between drive-affirming and drive-negating superego demands. Expressed in moral terms this constitutes the difference between the positive (“Thou shalt”)²⁷ and the negative (“Thou shalt not”) principle. The demands which entail drive negation are fulfilled from the very beginning, the others only much later. However, it is imperative for psychic health that the superego also contain drive-affirmative tendencies, for when it contains drive denial exclusively, development can be arrested, as seen in the ambivalent, inhibited, ascetic-religious, compulsion neurotic. Conversely, the exclusively drive-affirmative ego ideal will create a real ego which will necessarily conflict with reality. In such cases we employ the term “impulsive character.”

The Influence of Partial Drives on the Formation of the Superego

How does the realization of the superego manifest itself in a boy who remains healthy? In the dual Oedipus complex, heterosexual impulses toward the mother and identification with the father are the predominant factors. At first, identification with the father includes the genital impulses; soon, however, they fall prey to suppression and finally to repression. The analogous superego demand is, in this case: “You may not desire your mother sexually, or rather, genitally,” and the realization of this superego demand establishes the incest taboo. Many of the positive superego demands are also realized. The young boy strives to imitate his father, and the ideal of being “grownup” is central to most of the games he plays—however, with “genital exclusion” (Abraham). If he is not successful in excluding genital impulses, the result will necessarily be the formation of a symptom. The sublimated superego demand, born of identification with the father, runs: “I want to be as big and strong and intelligent as my father.” Penis pride, when it has not been substantially restrained by castration anxiety, then leads to disdain of women (or little girls) because they have no penis. However, this prevents hazardous identification with the mother from gaining the upper hand.

As psychoanalysis regularly proves, the incestuous desire awakens once again during puberty, although normally without reaching the conscious level. If the father identification is strong enough and castration anxiety not too powerful, the end result will be valuable sublimation following a phase of genital masturbation with heterosexual but incestuous fantasies. If the young man is to remain healthy, the ego ideal’s demand realized in childhood, i.e., “You may not desire your mother sexually,” must be substantially modified and reformulated thus: “You may not desire your mother, but you may desire all other women.” Hence, denial of the sexually negative superego takes place by means of the exclusion of the mother. It can be proven that the guilt-free emergence of heterosexual tendencies is a prerequisite for later health. Identification with the father must be strong; it must also include the ability to eclipse the father, even where sexually negative father identification had previously been in effect. But eclipsing the father can be successful only if the phallic stage was fully attained during childhood. Fully developed genital activity soon leads to sexual intercourse, and once a young woman has been won, the sexual devaluation of the mother takes place, which, in turn, is a

precondition for successful choice of a love object. The elimination of incestuous desires in neurotics with a fixation also occurs, in analysis, within the concept of sexual devaluation of the mother. A patient of mine once passed judgment upon his conscious incestuous desires in the following words: "How stupid a man is to want to possess his old, ugly mother at all cost when there are so many beautiful young women in the world." We assume that the normal genital object selection is accompanied by transformations of incestuous attachment similar to those already described.

The eclipsing of the father also leads to release from the original father ideal. Men with neurotic fixations also display a rigidity of the superego, the most common form being imitation of every father image without consideration of personal talents and capabilities. Later we shall return to the various neurotic father fixations ("I must be like my father") of the superego. Healthy men especially show extensive deviations from the father ideal, sometimes even arriving at the precept "You may not be like your father." They are able to assimilate the qualitatively diverse father images, thereby achieving enhanced personality integration. No cultural progress is conceivable if identification with qualitatively different father images—i.e., the erection of new ego ideals after the dissolution of the old—does not take place. This sublimated transformation of the father ideal is closely related to a form of neurotic transformation marked by reactive superego formation which will be described later. It is not inconsequential, however, whether a social revolutionary is "revolutionizing" solely because of a reaction against his father or whether he acts in relation to a revolutionary father image, without respect to his own father's attitudes. The precondition of this favorable superego development is that no inhibiting, object-libidinal attachment to the father be present.

Just as genital identification with the father ensures psychic health, and the possibility of transcending the paternal ideal liberates creative powers in men, in women vaginal identification with the (child-bearing) mother is a precondition for the ability to cope with reality as well as for subjective well-being. Girls—as psychoanalysis has proven—have more to overcome than boys, for penis desire urges them more strongly toward identification with men from the very beginning. Hence it is important that identification with the mother succeed in the oedipal phase. This is most likely to occur when the desire for a child effectively replaces the desire for a penis. Psychoanalysis has further proven that penis desire and penis envy develop first and are then replaced, under favorable conditions, by the desire for a child. Karen Horney²⁸ was able to demonstrate another typical course of development which I can confirm from my experience with female neurotics. In this course an intense desire for a child develops first, with normal mother identification. Only after denial of this desire does the wish for a penis arise. Whereas in the first group the child is a substitute for the penis, in the second the situation is reversed and the fantasized penis is a substitute for the denied child. Nevertheless, the process described first seems to be by far the most frequent. It is more advantageous for psychic health, that is, for later establishment of the maternal position, when identification with the mother is the point of departure, thus preparing, well in advance, the necessary readiness to bear a child. The young girl first acquires the mother ideal, "You must not sensually desire your father," and represses her genital readiness. But the infantile genitality of the young girl has, in most cases, evident

clitoral qualities which she equates with the phallic eroticism of the young boy. Whereas the phallic eroticism of the boy is in accord with the final sexual role for which he prepares, clitoral sexuality stands in contradiction to the subsequently necessary vaginal adjustment of women. As H. Deutsch recently pointed out, the transition from clitoral to vaginal sexuality during puberty is normally completed after an intensification of the former (“activity thrust”). The final renunciation of the penis is accompanied by a strengthening of the mother ideal. However, the source of the vagina’s erogenous qualities is still unknown, and the concept of “transference of clitoral sexuality” does not explain how it is possible that clitoral sexuality, previously subjected to complete phallic-aggressive emotional processing, turns into vaginal-passive sexuality. H. Deutsch considers this reorientation from active to passive goals typical of drives. Whatever the explanation may be, there are certain characteristics of vaginal sexuality readily observable in the analysis of vaginally anesthetic women which allow us to suspect that the vagina is ready to assume clitoral sexuality only when it is closely connected to certain erogenous qualities of a different nature.

Anal drives appear to predominate in establishing vaginal sexuality. In the unconscious, vagina and anus are synonymous. (“The vagina is borrowed from the anus,” according to Andreas-Salomé; see also Jekels²⁹ and Ferenczi.³⁰) In her lecture at the psychoanalytic convention in Salzburg, H. Deutsch was undoubtedly correct in tracing the “sucking” action of the vagina during coition to oral impulses. However, if adult vaginal sexuality is not pre-established in childhood, as is, for example, masculine phallic sexuality, but is later compounded of anal and oral features, then we must assume that partial regression to earlier stages of libido development following the renunciation of the penis³¹ is part of normal development in women.

The normal post-pubertal conversion of a purely drive-negating ego ideal into an ego ideal encompassing drive affirmation holds true for women as well as for men. However, due to the so-called double sexual standard, this necessary conversion does not usually take place, the self-evident result being that the overwhelming majority of women are frigid. There are no statistics concerning this, but unconfirmed estimates run as high as 80 to 90 percent, if the inability to experience vaginal orgasm is used as the criterion by which to judge frigidity.

The generally accepted concept of the “ideal woman,” valid until recently, is almost entirely based on the “ideal mother,” and constructed from anal and oral elements. The bourgeois ideal of the frugal, clean, submissive, and calm housewife also demands that the woman keep the children quiet, cook, and run the household efficiently. One may dispute the value of such a standard and assert that this ideology was created by men to make their lives as easy as possible. As psychoanalysts, we can confirm that men do seek in a wife someone to care for all their needs, denoting, in the final analysis, a mother to nurse them. In the last few years, however, especially since the war, the situation has changed. Certain elements of the father ideal have been incorporated into the mother ideal, and a woman is now expected to have a vocation, contribute to family support, and be as active as the man in every area of human endeavor.

This change in the traditionally inviolate mother ideal (which does not stem exclusively from women) is capable of mitigating the conflicts associated with penis renunciation. Whereas previously

the desire for a penis could be converted only to the desire for a child, according to the rigid mother ideal, it is now possible to sublimate it. At first this sublimation will simply prefigure the father ideal, but perhaps the next generation will consider social and scientific activity on the part of women no longer a realization of the father ideal but of the mother ideal as well. For the moment, in neurotic women, the two are mutually exclusive, as realization of the father ideal is not a sublimation but a reaction. Women who choose “masculine” vocations usually have not renounced the penis and prove incapable of realizing the mother ideal (child-bearing, vaginal receptivity). The analysis of women reactively striving for realization of the father ego ideal through marked clitoral qualities normally leads to one of two results: Either the penis is renounced and a child (or man) is accepted in its stead, or penis desire is partially sublimated. For example, a female patient who has previously felt constrained to pursue a course of study as a reaction, and has rejected every maternal attitude, emphasizing only her masculine characteristics, may suddenly become aware that academics, or perhaps some masculine vocation, is indeed quite compatible with her femininity. She then accepts child-bearing as her biological function and ceases to cling to the paradox, so characteristic of the whole feminist movement, that only men can receive a university education or enjoy sexual freedom. The only possible purpose of a feminist movement would be to develop women as women. G. Meisel-Hess³² recognized most clearly the error of this movement, which was threatened by failure due to an unconscious attempt to achieve the impossible, that is, to gain for woman the sorely missed penis. Now social necessity has brought about the same results in the ranks of the working proletariat as psychoanalysis has in individual cases, namely, the consolidation of maternal attitudes with social activity. Among the academic vocations, thus far, this has taken place only partially in the field of pedagogy. In isolated incidences the concept that social and scientific vocations are masculine and require a penis has been abandoned.

The conclusions of this portion of my essay may be summarized as follows:

1. The prerequisite for reality adjustment is, in women, the realization of the mother ideal and, in men, the realization of the father ideal.
2. Both are entirely dependent upon erogenous maturity:
 - a. The prerequisite for realization of the father ideal is successful activation of the phallic phase and sublimation of the castration complex. This provides the possibility of liberation from the father ideal should a change in the conditions of life demand it. The pregenital drive impulses are then sublimated as social striving and the phallic impulses retain their original nature.
 - b. The prerequisite for realization of the mother ideal is renunciation of the penis and its subsequent replacement by a child (or a man). Clitoral qualities are poorly suited for establishing the mother ideal, which is based to a great extent on partially reactivated anal and oral drive impulses which influence the formation of the female character. Clitoral eroticism is partly responsible for the establishment of vaginal eroticism and partly transformed into social involvement engendering the activity in which women are so very capable.
3. In both sexes the drive-affirmative superego demands are normally based on the genital stage. The complication involved in the genital structure of the healthy female is simply that the erogenous qualities of three organs (clitoris, anus, and mouth) must be united to form one reality-adjusted libido position. Negative superego formation exists at the genital stage only to the extent that it represses incestuous desire. In genitally satisfied individuals this negative superego is rarely involved, as the

incestuous desires demanding repression have been dispersed. All other negative ego ideals are based on pregenital stages, to the extent pregenital libido still demands unmodified satisfaction. Where sublimation has taken place, negative ego ideals become positive and merge with those of the genital phase, forming a harmonious, resolute, and well-adjusted personality. In general, the opposites: healthy–sick, reality principle–pleasure principle, are reflected in the concepts: genital–pregenital, positive–negative superego, sublimation–reaction formation.

Defective Sexual Identification

Giving foremost attention again to the erogenous basis of pathological ego development, I shall now proceed to an examination of pathological superego formation caused by defective sexual identification.

Identification of a daughter with her father (masculinity complex) as well as of a son with his mother (passive-feminine attitude toward the father) are familiar and well-established psychoanalytic facts. “The resolution of the oedipal situation in father or mother identification appears ... to depend upon the relative intensity of sexual disposition” (Freud, *The Ego and the Id*). This sexual disposition functions in certain erogenous positions, for instance, the passive-feminine attitude in men rests on anal libido. However, this by no means exhausts the facts. I have seen male identification with the mother where the masculine attitudes are retained, the prime example of this being the typical narcissistic male homosexual. As Sadger demonstrated, these men seek a mother who has a penis but prefer to select young men as love objects, assuming unconsciously the role of a guiding, solicitous mother. In other respects identification with the parent of the opposite sex exists in every case.

Of ultimate importance, however, is the extent to which this mistaken identification is expressed in the overall bearing, i.e., how clearly it actually colors the feminine personality masculine, and vice versa. In other words, is this mistaken identification in the ego or in the ego ideal? Before proceeding to an examination of specifics, I shall mention two possible causes for defective identification: (1) It can be produced from the very onset by an existing³³ erogenous disposition. Hence a strong anal disposition will detain the male child at the anal stage and function as a basis for extensive future identification with the mother. A particularly strong clitoral disposition will have the same effect on girls with regard to father identification. (2) In addition to these erogenous dispositions, we must not underestimate the experience factor. Analysis can prove that superego formation is predominantly influenced by the parent toward whom the ambivalence was most effective, in other words, the parent most dominant in the denial of drives. It lies in the nature of libidinal inflexibility that as long as object-libido relations prevail, they do not lead to identification. Only when denial and subsequent ambivalence has taken place is the libido withdrawn and the external object assimilated into the ego. Normally girls have a more or less pronounced positive attitude toward their fathers and are ambivalent toward their mothers (the reverse is true in boys). If no further complications arise, this situation develops into normal mother identification in girls and father identification in boys. The corresponding ambivalence conflict lies at the root of these identifications.

Boys experience denial of incestuous desire because of the existence of the father, as do girls because of the existence of the mother. The analysis of neurotic characters with severely defective identifications, however, demonstrates as typical the fact that in such cases not only the so-called normal denial by the parent of the same sex is effectively experienced but also denial by the parent of the opposite sex. The immediate result is the development of acute ambivalence toward the parent of the opposite sex, which leads to further withdrawal of object libido and introjection of this object, thus to the defective identification. It is of decisive importance for ego development whether the effective denial of masturbation, childhood games, incestuous desire, etc., emanates from the father or the mother. But this still omits consideration of the complicating possibility that the character of the denying parent, or rather, the difference in the characters of both parents, must also express itself in the child's ego formation.

If both fundamental elements of defective identification coincide, the inevitable result is a masculinity complex in women or a femininity complex in men. But the ubiquity of the masculinity or femininity complexes is as trite as the fact that every individual has an Oedipus complex. The pertinent question today is not whether these facts exist but rather the manner of their existence and how the conflicts may be resolved. Confining ourselves to this line of questioning will not only avoid one-sided explanations but also introduce the most fertile area in psychoanalysis—the problem of neurosis selection. For the moment we are still groping for an answer to the question of specific etiology; however, here and there certain forms of typical developmental damage are beginning to crystallize. Any attempt to evolve a psychoanalytic-genetic typology, however, would certainly result in an obstruction of the course of research in this direction. Such a typology must stand at the conclusion and not at the beginning of psychoanalytic research. Above all, we are still lacking an analysis of schizophrenia. Hence this attempt will be limited to demonstrating particular typical mechanisms of character formation while we submit the task of filling in the empty spaces to further research.

Mother identification in men assumes two typical forms, which in turn correspond to two different erogenous fixations: mother identification of the ambivalent genital stage (Abraham) and that of the anal stage. The typical representative of the first group is the narcissistic, more or less cognizant homosexual as described by Sadger³⁴ and Abraham.³⁵ These superficially self-secure “compensatory narcissists”³⁶ show the following typical libido development: They have never overcome their Oedipus complex and have remained fixed at the ambivalent genital level,³⁷ however without effective regression to earlier stages. The idea of the mother with a penis has assumed central importance. Two such patients whom I treated had dreamed quite candidly of women, distinct mother images, who had tubes or even actual male genitals in the place of the female genital. Two elements are typically active in this idea. First, the female genital and its lack of a penis cannot be conceptualized due to the patient's own fear of castration—the unconscious clings to the idea of the female penis (Freud); second, the female penis commonly implies the breasts. Such men have never overcome the oral fixation and the active and passive act of fellatio plays an important part in their sexual lives.

After failure to take the initial steps on the path to normal genital father identification (fear of castration by the father), identification with the mother begins. When such men, who incline to active homosexuality from the very beginning, allow their inclinations to manifest themselves, they fall in love with young, girlish men, in other words, once again a woman with a penis. On the other hand, they assume the role of a mother toward them, pose as their protectors, and introduce them to sexual life, although they themselves are either partially or completely impotent heterosexually. When fellatio is practiced, passive and active nursing fantasies are also involved (mother identification). Two of my patients of this type grew up without a father. In one case the father had died very early, and the other was an illegitimate child. Hence the absence of a father does not appear to inhibit activation of the genital stage but rather to intensify it, at the same time allowing the possibility of identification with the mother. When the mother is the source of castration anxiety, mother identification is almost certain, especially if she is the chief educator. The fact that these active and narcissistic homosexuals are also seeking themselves in their love objects is no contradiction to this, as Freud and Sadger ascertained, since all object love is narcissistically motivated. Hence, mother identification is expressed in this very seeking of oneself in the love object (“narcissistic object selection,” Freud).

The situation is entirely different in identification with the mother on an anal basis. Here genital activity is lacking, and impotence—usually in the form of premature ejaculation, with or without erection capability—is ever present. These individuals have weak, feminine characters and display a humble deference to strong father images. Despite a strained paternal superego, their attitude remains one of neurotic resignation. To be sure, the father ideal is present and often powerful, but it remains unrealized, and the desire to be fully masculine, sexually and socially, usually exhausts itself in daydreams. Only the mother traits have been realized and stand in sharp contrast to the unrealized father ideal. These individuals manifest the typical inferiority mechanisms with their “fictitious guideline” compensations, emphasized by Adler. Because they are unable to realize the father ideal, they assume the role of a martyr to conceal their narcissistic belief that they alone are noble and honorable and actually worth more than all the rest of humanity. They say the harshness of the world (meaning its reality demands) and materialism cause their suffering, while in reality they themselves flirt with harshness and materialism and would like to be as potent as their fathers.

A patient of this type once told me frankly that he did not feel analysis could cure him of his impotence and that he would be fully potent only after the death of his father. It seemed very peculiar that he should pass judgment upon his father (age sixty) for plaguing his mother (also age sixty) “with the bestial business of intercourse.” The patient himself suffered not only from premature ejaculation of an entirely urethral-erotic nature but also from an unusual anal fixation. From earliest childhood he had suffered from obstipation, and at times—especially while traveling—he could not defecate for ten or twelve days. Defecation was contingent upon certain circumstances: Either he had to sit on a pot filled with hot water, or his mother had to give him an enema. A specific anal mother fixation existed. Even in earliest youth he had wanted enemas exclusively from his mother, evidently also an anal

character. The entire family suffered from chronic constipation, although the patient's ceased during analysis. His first attempt at intercourse was attended by very peculiar circumstances. He simply turned his back on the woman and fell asleep. Subsequent analysis showed that he had unconsciously expected an enema, thus transferring his specifically anal mother relationship to this new situation. His personality was exactly like his mother's in every detail. He was pedantic, clean, orderly, introspective, suppressed, and he feared and despised his father, as she did. His three older sisters had long since left home and married, but he could not separate himself from his mother, feeling it his duty to "cement the miserable marriage together." The desire to have his mother give him an enema was based on the much deeper desire to have anal intercourse with his father. The patient had never completely overcome the anal stage and had only partially achieved the genital stage. Masturbation was anal and urethral. No genital-heterosexual coition fantasies existed, but rather a desire to lick a woman's breasts or vagina, to crawl between her legs, to be tied, etc. After a short period of genital masturbation at age four, genital impulses were completely suppressed following a castration threat by an older brother, and this in turn was augmented by the intensifying effect of his mother on the anal position.

In his sexually inhibited friendships with other men, he preferred superior, entirely masculine individuals whose personalities contradicted his own. He admired them, felt himself inferior, and always found some trifling pretext for terminating the friendship. During treatment he exhibited completely passive-feminine transference and produced, in connection with the analysis of his obstipation, outright pregnancy fantasies. In one dream he had had a bowel movement but the feces disappeared; then "very tiny" children were playing in the room. The feces produced through normal bowel movement were likewise "very tiny." Other dreams were of the analyst or friends fertilizing him by mouth (oral conception theory).

Realization of the mother ideal, excluding sexual desire from consciousness, was augmented by character traits exactly opposite to those of his father. The father was extremely curious, opening every letter that arrived in their home—the patient went to great lengths to be discreet; the father was miserly, valued money highly—the patient scorned and wasted it; the father showed no delicacy in intimate matters at home and would break wind without considering the family members present—the patient suffered greatly from an inability to break wind (this disappeared promptly after the connection was disclosed); the father was a woman chaser—the patient not at all; finally, in the patient's own words, the father was "overly potent"—while he himself was impotent.

This patient's motto was "Don't be like your father but be exactly his opposite," and it follows that his realized father identifications were completely reactive in nature. Such reactive superego formations can be observed very frequently in the character of neurotic individuals. They color the personality of inhibited, passive-feminine males as well as women with inhibited masculinity complexes and become particularly blatant when the characters of the parents are also strongly contrasted. It is especially detrimental to boys when an austere and unloving father stands in contradistinction to the rest of the family. Mother and children then cling together as if in defense. The boy identifies with his mother, whom he loves and wishes to protect from his father. In doing so

he renounces his genital sexuality and regresses to the anal stage. In the struggle with his father, he resigns, thereby prohibiting development of any significant independence (neurotic resignation).

In the case just mentioned, reaction against the father resulted in identification with the mother. Similar results ensue if the father is mild-mannered, kind, and lenient and the mother plays “head of the household.” In this case, identification with the lenient father will take place rather than identification with the mother. There are feminine men who always emphasize the elements of the harsh, austere mother in their object selections. They feel attracted to the “masculine female” to whom they, somewhat masochistically, submit. This type of love also colors the entire personality.

Defective identification in women may be studied most expediently in the various forms of frigidity. One can distinguish between two main groups of frigid women: One group has retained the maternal nature and the desire for children. In the other, the woman deliberately displays a pronounced masculine manner, often chooses a masculine vocation, and either rejects sexual intercourse completely or, should she marry, remains cold, unapproachable, and austere. In the first group, mother identification is inhibited but still dominant. Frigidity in such women is usually more easily cured than in the second group; it is caused basically by an unconscious and unresolved attachment to the father. Even if penis desire exists, it has been transformed into desire for a child (in which case the child is always equated with the male organ), and penis desire is never sufficiently powerful to effect masculine character traits. This fact demands a sharper differentiation between the concepts of “penis desire” and “masculinity desire.” The latter concept is broader in scope and includes the former; the reverse is by no means always true. Women in the first group can develop a deep love for their husbands or lovers despite their frigidity. They merely fail to understand the admonition placed upon them by their mothers—“You may not sensually desire your father.” Once they can be freed from this attachment to the father and from the taboo they have transferred to all other men, the frigidity ceases immediately.

Women of the second type were not able to bear the disappointment encountered in their love of the father. Subsequently they incorporated the father into themselves and became what they could not achieve, according to the well-known pattern. Here penis desire and compensated castration anxiety are the predominant factors. They have postponed realization of the mother ideal and brought the father ideal³⁸ to realization. The early infantile anamnesis of such women quite regularly contains strong identification with the mother, which precipitates submission to the father as a woman (mother) and the desire to have a child by him. These cases may have a favorable prognosis, as analysis can reactivate the repressed reality-adapted position of the mother ideal. Thus by means of analysis the severe form of frigidity is finally transformed into the milder form (first type).

However, if penis desire and castration anxiety were able to take hold before a simple, so-called normal oedipal situation could develop (due, for instance, to playing with boys too early, during which penis envy was provoked, or due to inhibition of love toward the father from the onset because of rejection by him), then analysis would have a much more difficult task indeed. It would be a gratifying assignment to determine whether manifest masculine-homosexual women were not able, as

children, to develop an effective feminine attitude toward their fathers. I personally have no access to pertinent material in this area, but I can cite cases which display a different character attitude due to this specific development. Roughly outlined, libido development proceeds as follows: The father is austere, aloof, and unloving; the mother kind, suppressed, loving. The girl becomes involved very early in an intense ambivalence conflict with the father. This, according to experience, weakens heterosexual love and creates the disposition for a masculinity complex. All love is directed toward the mother. The mother attachment is predominantly oral and later creates, with or without a masculinity desire, an intense devotion to corresponding mother images, in the manner of a child. Such girls suffer from reality's demands and repeatedly create a spoiled-child situation. Yearning for the womb is also of greater importance than in most other cases and often results in extreme inability to cope with reality.

* * *

Attractive as the prospect may be to examine further atypical deviations from the reality-adjusted character norm, I must refrain in consideration of the inadequacy of empirical findings. I am also well aware that my exposition until now has been a mere outline based on analytic experience and present analytic theory. But the manifold and complex nature of human experience can never be entirely exhausted in conceptualizations. Whoever has had his own analytic experiences will confirm my findings, but also correct and expand them.

Whether or not faulty identification, persistence of oedipal conflicts, or special experiences based on a specific erogenous disposition influence an individual character to the extent that the capacity to deal with reality and enjoy life suffers—with or without the formation of neurotic symptoms—ego ideals nevertheless form the very fabric of the personality itself and the ego “identifies” with them. I feel that it has been demonstrated that realization of certain ego-ideal demands determines the very constitution of the neurotic character. The difference between the drive-inhibited neurotic character, which is at the basis of every symptom neurosis, and the uninhibited drive-dominated character is to be sought in specific disturbances of ego development. The following sections will be devoted to a discussion of these disturbances.

AMBIVALENCE AND EGO FORMATION IN THE IMPULSIVE CHARACTER

Productive as the psychoanalytic exploration of childhood experiences between ages three and six has become, it is nevertheless an undeniable fact that the most essential links in the chain of comprehension of emotional development are still missing. The reason for this lies in our inability, in analysis of adults, to penetrate the period prior to age three, except in rare cases. Earlier memories do emerge occasionally, but they are so dim and their organic connection to other material is so vague that one dares not use them as a premise for further conclusions. At present, however, we may accept as valid the postulate that man in the first two years of life experiences more, with greater consequence, than at any time thereafter. The child enters the critical oedipal phase with attitudes

which, in broad strokes, are generally, even if not conclusively, established. The subsequent Oedipus complex then appears as a prism in which the rays of the drive impulses are refracted. These place their specific stamp upon the child's nature and by means of the experiences of the oedipal phase undergo extensive modification. The case of a hysterical symptom in a child aged two years and three months, as reported by Anna Freud,³⁹ demonstrates just how obscure this area still is. The methodological difficulties seem insurmountable. Direct observations of children as reported until now involve only children over age two and there is a lack of analytically trained child and infant nurses.

A second indirect means of gaining insight into the earliest developmental stages is the continuing clinical exploration of certain forms of schizophrenia and melancholia whose fixation points, we believe, are to be found in the first postfetal stages. There are cases of schizophrenia actually displaying behavioral patterns and mechanisms which correspond to those seen in infants from birth to age one, or even in the fetal stage itself. The case reported by Tausk⁴⁰ is highly instructive in regard to the effacement of the boundary between the ego and the external world. Concerning earliest sexual conflicts, see the case reported by Nunberg.⁴¹

When, in certain forms of schizophrenia, the boundary of the ego is completely or partially effaced and definite infantile traits can be seen appearing simultaneously, it can no longer be called mere speculation when psychoanalysis assumes that the child's ego frees itself only gradually from the original chaos, that the ego boundary is defined slowly, and that the cornerstone of future ego misdevelopment is laid during this first phase of ego formation.

A pure drive ego (pleasure ego) encounters the stimuli of its environment. To the extent that they are pleasurable, it identifies with them, and if they are not pleasurable, it rejects them, even when their source is the drive ego itself. The original pleasure ego has wider boundaries than the later real ego, as far as experiencing pleasure is concerned (Freud).⁴² Concerning non-pleasurable experiences, the boundaries are narrower. Pleasurable objects of the external world are comprehended as belonging to the ego itself, and since the mother's breast is the central object of this phase, we feel we can understand why the narcissistic reservoir is the fount of the object libido. The mother's breast must inevitably be recognized as belonging to the external world and consequently must be "translocated" by the ego. Narcissistic libido is thus first transformed into object libido by the relinquished breast, drawing in its wake that portion of the libido originally directed toward it. The first objects in the infant's environment are not people as entities but merely their organs—to the extent that they provide pleasure. In analysis the objects gradually separate into their constituent organs; for example, the breast becomes the significant organ when the mother is involved. Just as, in analysis, tender libido finally reverts to pure organ libido, so infantile organ libido is progressively transformed into sublimated forms of tender libido. From the mother's breast, the libido proceeds to encompass the mother herself as the supplier of nourishment, love, and tranquillity.

The Influence of Upbringing

Even the first phase of this significant process, however, is accompanied by denial; the mother's

breast is withdrawn. But denial and gratification stand in contrast to one another in every phase of development, and indeed progress from stage to stage is only ensured by denial.

In this coexistence of drive gratification and drive denial, we must cast a glance, with Graber,⁴³ at the ontogenetic origins of ambivalence. The child loves persons who gratify his drives and hates those who deny them. If, as Stekel and Freud pointed out, hate is older than love, it is because of the unpleasure involved in birth itself. This unpleasure is subsequently forgotten, due to the pleasure derived from the organs, and later emerges in the form of fear of birth, or rather the desire to return to the womb, as stressed by Rank, should drive denial be too intense from the very beginning.

Thus ambivalence is necessarily inherent in all emotional development. Since situations giving rise to ambivalence are experienced by every individual, we must inquire as to the additional factors responsible for making ambivalence pathogenic. This depends of course on what form and intensity and in which stage of drive gratification the denial took place, as well as the attitude of the child toward the parent at the time in question. In principle, there are four possibilities:

1. Partial drive gratification and partial denial will result in gradual repression. This is the optimal situation in the course of development, as the child learns to love the parental figure during the partial gratification and will then bear denial "for love of" this person. We attempt to construct these optimal conditions in analysis as well. Drive gratification must be partial from the very beginning just as the infant must, for example, accustom itself to certain feeding times. Then denial has to become increasingly intense, but without ever leading to total drive inhibition. Repressed drives must always be left the possibility of transforming themselves, or rather, being replaced by some other partial drive.

2. Drive denial does not take place gradually but abruptly at the onset of every phase. This will lead to total drive inhibition, as is typical in certain abulic patients. Thus in some cases bottle feeding, or total denial of genital masturbation, may later have inhibiting effects on the individual's ability to love.⁴⁴ If drive inclination is strong, the ambivalence conflict will be intensified in favor of hate, which is justifiably the case in many drive-inhibited compulsives.

3. Drive denial is completely absent, or practically so, during the initial stages of development due to upbringing with no supervision. This can result only in uninhibited drive domination, and since the environment will sooner or later exert its influence, severe conflicts are unavoidable. Whereas the possibilities mentioned in cases 1 and 2 are analytically verifiable, the third possibility in this extreme form is merely hypothetical. However, I am convinced that continuing analytic studies of criminals, prostitutes, and similar cases will shed some light on such contingencies.

4. The fourth possibility we have in mind (partially covered under 3) is one which in my experience relates to the typical, drive-dominated impulsive character. In the analysis of impulsive characters, one finds, with surprising regularity, that extensive uninhibited drive gratification was later countered by traumatic denial. For example, one of my female patients was sexually abused by her father, but was also beaten unconscious by him for her behavior with playmates on the street. Another patient grew up with no supervision whatsoever and engaged in genital play at the age of

three (probably even earlier), only to be beaten horribly by her mother when she happened to be caught. It is also quite common for children to be raised very strictly in one specific regard but otherwise left entirely to themselves. For instance, the father of a female patient was extremely conscientious about having the children eat punctually and finish all their food, but he completely overlooked their playing with feces, masturbating, etc. It is equally common for less supervised children to develop deficient drive inhibitions until the parents one day decide that “the situation is out of hand” and vehemently “put an end to it once and for all.” Since every observant educator has a considerable amount to say on this topic, I shall refrain from enumerating further possibilities. Inconsistent upbringing and insufficient drive inhibition, on the one hand, and isolated, concentrated, or sudden denial (which often comes too late), on the other, are common features in the development of the impulsive character.

Here the ambivalence assumes characteristic forms. Either constant hate and fear of parental figures prevails, with simultaneous uninhibited impulsiveness (occasionally strengthened by spite reactions), or, what is equally frequent, an intense, unfulfilled yearning for love exists in contrast to intense hate. It then depends upon other factors whether this development takes on a sadistic or a masochistic form. Although the intense yearning for love is present, the inability to love is always conspicuous in such cases and more sharply defined than in simple symptom neuroses.

When compared to the ambivalence in compulsion neurosis, a fundamental difference may be seen, in that the reaction formations are deficient and hence sadistic impulses are more or less completely acted out. In the typical compulsive, ambivalence is diverted in an apparently senseless manner to details or matters of no concern. There may be such shifts in the impulsive character as well, but typically the ambivalent relationship to the original object, or a suitable substitute, always remains evident. In this character type, damage done by parental figures is obvious; in simple neurosis, such gross damage is occasionally seen, but in most cases it is nonexistent or at least no more flagrant than in healthy individuals. Impulsive characters have experienced repeated, serious harm in childhood, whereas in symptom neurosis harm was either not done at all, or only occasionally. Typical situations, such as those experienced by healthy persons (for example, castration threats, witnessing of parental coition, etc.), assume especially bizarre forms in the impulsive character. Among the reasons for this are: particularly cruel punishment for slight misbehavior, frequent seduction by a parent, or being raised in a sadistic milieu. There is every conceivable nuance between the bad marriage of the average cultured individual and the violent excesses in the marriage of the alcoholic. Freud’s assumption that neuroses and pathological character formations are for the most part acquired holds especially true in this type of patient.⁴⁵ It is obvious from the very beginning that an environment characterized by incomplete drive inhibition will not only produce deficient ego-ideal formations in a child but also subsequently cause the inevitable drive denial to be more brutal than is ordinarily necessary. This leads to the severe ambivalence of the impulsive character, who may justifiably refer to his not having been taught any other way. Parental inconsistency is later reflected in the child’s inconsistent attitudes toward its environment. However, it would be totally incorrect to speak of a lack of ego ideals in this context. The drive-negative ego ideal has been established and is

present, and at the same time the drive-affirmative ego ideal is acquired. If this were not the case, the result would be uninhibited impulsiveness without neurotic formations, as is the case in some asocial types who completely lack such formations.

The omnipresent guilt feelings, especially in the masochistic forms of the impulsive character, also indicate a strong ego-ideal position. However, the strength of this position must somehow be paralyzed if the uninhibited drive impulses are to be effective.

The pathogenic superego formation, conditioned predominantly by external elements, is further influenced by an internal dispositional factor common to all impulsive characters, i.e., the regularly observable, abnormally early sexual readiness and the undue emphasis upon all erogenous zones. I was able to establish that genital sexuality in particular was completely developed in such individuals at an abnormally early age. In mildly neurotic and in healthy individuals, sexual activity in early childhood is commonplace; the genital phase in particular regularly appears to reach its peak at approximately age four or five. In some cases this results in complete drive-inhibited activity, sexuality and incestuous desire never becoming fully and sensually conscious, although unconsciously present in their full intensity. Contrary to this, impulsive characters experience not only their full sexuality at a very early age but also *conscious* incestuous desire. Hence one sexual phase is not resolved by the next as in a symptom neurosis, but partial drives coexist with more or less equal intensity. The childhood games of such individuals will be found to be typically polymorphous-perverse. Due to negligence in their environment, they have witnessed and understood far more of adult sexual life than is generally the case in simple neurosis. Hence the latency period is either not activated at all or only very inadequately. If one considers the important role the latency period plays in human ego development in regard to sublimation and reaction formation, one will best be able to estimate the damage done during this phase. Because the impulsive character does not experience this latency, the onset of puberty is accompanied by a drastic breakthrough of sexuality, for which neither masturbation nor sexual intercourse is due compensation, as the entire libidinal organization is torn between disappointment and guilt feelings.

The following case history is highly instructive in our present context, as it demonstrates not only a polymorphous-perverse libido structure but the function of guilt feelings seen in other forms of the impulsive character as well. It will also serve as an introduction to a later discussion of the “isolated superego.”

On the Question of Borderline Cases

The case in question is that of a compulsion neurosis which suggested a diagnosis of schizophrenia as well.

A nineteen-year-old female patient sought treatment because of the torturous thought that the world would come to an end or disintegrate each time she did something wrong. Whenever there was work to be done, her thoughts ran, “Why should I work if the world is coming to an end tomorrow anyway?” The next day she was always very surprised to see that the world “had not come to an end

after all.” However, she shows no trace of manifest anxiety; her eschatological fantasies are accompanied rather by a feeling of hopelessness and bleakness—“everything is dead and gone; sometimes I am amazed to see people still moving about.” Although this depersonalization is always associated with her eschatological fantasies, it appears independently several times a day. At the beginning of treatment she did not feel her fantasies were pathological and stated that she firmly believed in the possibility of the world’s ending. The patient at times gives the impression of being lost, and sometimes during the conversation she absentmindedly falters, speaking incoherently and staring into space. My first impression was dementia praecox, which seemed to be confirmed by her parents’ reports that she was often in a dreamlike state for days and had no desire to work.

Before continuing my report I should like to mention that her older and more beautiful sister is entirely well adjusted and apparently displays no neurotic symptoms. Her father is a hard-working and vigorous individual, irascible, quick-tempered, overbearing, and intelligent. The mother is ostensibly in good health but is somewhat limited intellectually.

The typically schizoid symptoms described above stand in contrast to behavior indicating an intense relationship to the external world, especially to her parents and sister, as characterized by obstinacy and defiance. The patient feels inferior in the extreme and not able to accomplish anything, although much is expected of her. She has always wanted to learn all trades, understand mathematics, grasp the construction of machinery, and feels that her inability to do so is a limitation due to her being a woman instead of a man. When she sees a girl learning to ride a bicycle on the street, she immediately thinks that a man would be so much more capable, and perceives the girl’s clumsiness as oppressive. Her feelings of inferiority are closely connected with a conscious tendency to self-torture. To cite just one example: She learned to cook, felt very inferior, often deliberately and consciously did everything wrong, and her greatest pleasure was to be scolded for this by her mother. She herself admits to purposely making many mistakes to irritate people so that she would then be scolded. She learned dressmaking but deliberately wasted material in order to be discharged. During analysis she behaves defiantly, rebelliously, and after several sessions asked, “Well, why don’t *you* throw me out?” Her self-torture is regularly accompanied by eschatological fantasies. However, she tortures others as well, especially her mother. For instance, she deliberately tries to trip her so that “she’ll fall and be shattered.” It amuses her to invent cruel fantasies with masochistic, as well as sadistic, objectives. A few examples of the former: A sword is run upward through her vagina until it reappears at the top of her head; or she is forced to walk barefoot across a board of nails, causing her to bleed.

The first fantasy is related to a case of gonorrhoea she had at age four—as she stated precisely—supposedly contracted from her governess. She also dated the beginning of her “insanity” at age four. She was under the care of a specialist for six years, and the sword fantasy had its actual basis in the pain she suffered through the dilation of the cervix. The second fantasy was related to her incessant and continuing masturbation from earliest childhood. It had begun at age four, when her father made the usual castration threats, tied her hands for the night, etc. All the sadistic fantasies may be traced back to the masochistic ones. She spoke to her mother in this way: “Go take a board, put nails in it, and beat Father over the head with it,” or “Get up on the windowsill sometime and jump out. If I

should be eating at the time, don't think I'll try to stop you. I'll simply finish my meal and then come down to the yard to look at your smashed corpse." The patient feels such comments are neither irritating nor morbid. She relates them quietly, showing no sign of emotion. On other occasions she is likely to throw her arms around her mother and to kiss her. It took a long, concentrated effort during analysis to convince the patient that her eschatological fantasies, which seemed connected to trivial incidents, actually correspond to her guilt feelings, which are, in turn, a consequence of her sadistic impulses. The patient finds it especially entertaining to "claw" with bent fingers close to her mother's eyes, as if to blind her.

The patient feels oppressed by her father but respects him nevertheless because he is "smart" and the man in the house. The father, apparently an extremely sadistic individual, beat the children without mercy (often with switches) for the slightest misbehavior. In spite of this, or actually (in accord with her masochistic attitude) for this very reason, she respects him, and since she has even incorporated parts of his character into her own personality, she behaves toward her mother exactly as he does. She smashes dishes when she is angry, and is cruel and hostile toward the mother, while she admires and adores (at least later in life) her great rival, the beautiful, favored sister—as does the father also. The mere presence of her mother irritates her: "she is stupid, weak, puts up with anything, and doesn't deserve respect."

It is obvious how the brutal father ideal spread to the patient's own ego and how strongly she identifies with him. In addition to this, there exists, on a deeper level, masochistic submission to the father running parallel to the sadistic attitude toward the mother. Both sadistic and masochistic tendencies are completely conscious, and it is precisely this complete consciousness of the tendencies which typifies this case as compared to a simple neurosis in which they are usually severely repressed. The patient also lacks the typical compulsive overconscientiousness; on the contrary she is usually quite unscrupulous.

An equivalent to compulsive conscientiousness may be seen, however, in her principal symptom, the eschatological fantasies. These correspond to enormous guilt feelings toward her mother despite their being associated with trivial, commonplace incidents. (A broader, in-depth determination will follow.) The transference of guilt feelings to trivial events implemented her manifest sadistic attitude to begin with. In analysis I succeeded in reconstructing the original connection, and only then did the patient begin to perceive her sadistic impulses toward her mother as compulsive. At that point, the impulsiveness became a typical compulsive symptom.

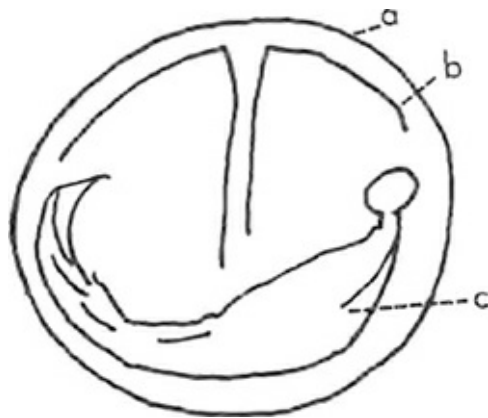
In the typical compulsion neurotic, guilt feelings are directly connected to the symptom, assuming an overt compulsive thought or impulse exists. In contrast to this, one of the typical mechanisms of the impulsive character is the sharp separation between sadistic impulses and guilt feelings. As further proof, I might add that in overly conscientious compulsives who have entirely repressed their sadistic impulses, guilt feelings also attach themselves to trivial events, just as in the impulsive character.

Later I shall examine precisely the most important question regarding the impulsive character, i.e., what determines the separation of guilt feelings from manifest sadism. For the moment I shall

reconstruct the libido history of this patient, whose sexuality is uninhibited in the extreme.

The patient masturbates almost daily with abundant masochistic fantasies and without orgasmic sensation. She does not have sexual intercourse. Furthermore, one may characterize her libido structure as completely polymorphous-perverse. One masturbation fantasy contained the eating (together with her father) of stuffed vaginas, which were first cut out and then filled with feces. Here we see elements of all three libido stages: eating (oral) instead of coition; vaginas (genital); filled with feces (anal). The entire fantasy is basically masochistic, as she is forced to do this. Manifest normal coitus fantasies play an insignificant role; the oral components of the masturbation fantasies, however, have their own very particular history. During childhood the patient and her sister had both been overly finical about food. To combat this the family doctor (!) had recommended forcing them to eat by all possible means and, should they vomit, forcing them to eat that as well. This actually happened on many occasions. Understandably enough, the patient subsequently did not succeed in repressing and sublimating oral and anal tendencies, and persisted in eating feces and vaginal secretion until the age of seven or eight. Even at the time of analysis she found it highly pleasurable to smear vaginal secretions between her fingers.

Womb fantasies were also predominant in the symptomatology of the case, as well as in libido development. Coupled with the eschatological fantasies, which in the final analysis were dictated by guilt feelings and signified a temporary regression to the womb, there was also a visual image: She imagined herself lying in a “world globe.” This drawing was made by the patient herself.



a. the world globe, c. the patient herself, and b. the “eyelids” which, like an open “fan, line the inside running in the direction of my body.”

I do not hesitate for a moment to interpret this description as a womb fantasy.⁴⁶

In order to comprehend fully the libido structure of such a patient, we must compare it to that seen in classic hysteria and compulsion neurosis. In pure anxiety hysteria we encounter, in analysis, repressed genital libido as the central pathogenic factor. Even should a different libidinal factor emerge during the course of depth analysis or in the original symptomatology, we still have no reason to doubt that the main fixation in anxiety hysteria belongs to the genital stage. According to Freud, hysteria is a disorder of the genital phase. When, in an oral-conversion-type hysteria, for example, hysterical vomiting, we find an oral fixation in the center of a libido profile, it is usually not long until the significance and purpose of the oral symptom, as well as the analysis of the entire personality of

the hysterical character, demonstrate that the oral zone has assumed genital significance (“displacement upward” as described by Freud and Ferenczi). In a typical pure compulsion neurosis with either sadistic impulses or anal-erotically based cleansing rituals, the pregenital anal-sadistic fixation is of central importance (Freud). This creates the symptoms as well as giving the compulsive character its specific stamp (i.e., exaggerated conscientiousness and orderliness, etc., as a reaction formation against sadistic and anal impulses). In melancholia the oral fixation is of central importance, a fact proven conclusively by Abraham and clearly visible to every analytically trained clinician. In a case of combined compulsion neurosis and hysteria, it is likewise not difficult, by means of depth analysis, to relate various symptoms and particular character traits to their corresponding fixation points. Although a number of still-unsolved, important questions focus on the developmental thrust from the anal-sadistic to the genital phase, this is entirely a specific etiological problem. However, in purer and milder forms of hysteria and compulsion neurosis, circumscribed fixation and developmental retardation of one section of the personality and more or less well-defined libido positions can be established. In a pronounced impulsive character, such as this case, there can be no question of such diagnoses. If one attempts to relate a group of attitudes or symptoms to a genital or anal fixation, one is obliged to ascribe equal significance to the oral phase. A thorough analysis will also show no actual point of fixation at any single libido-development stage, but simply the more or less equally strong coexistence of all the known partial drives, usually in inseparable combinations and interrelationships. To employ a rather drastic analogy, one gets the impression that an elephant has romped through the porcelain shop of infantile development.

Our patient demonstrates constant, sharp, ambivalent behavior toward both mother and father, manifesting itself particularly in cruel words and actions toward the mother. Her superego is entirely masculine-oriented: She admires her strong, coarse father and thus behaves toward her “stupid,” weak mother as he does. The identification is completely conscious. The inferiority feelings which formed the central issue of her complaints may be traced directly to this identification with him and to jealousy of her sister, whom he favored.

Analysis showed, however, that her father had probably not only inflicted severe damage by his sadistic behavior, not only provided the model for a sadistic ego ideal, but that he bore the main responsibility for her defective drive inhibitions as he had approached the children with undisguised sexual intentions. My assumption that the patient had contracted gonorrhea from him seemed justified when I learned that he also suffered from chronic gonorrhea. The patient herself had dated the onset of her illness at age four, the time of the gonorrhea infection, and had always been immensely wary of her father; there were constant fantasies of a “sexual attack” by him.

The father had also damaged the children’s ability to control their anal impulses. By forcing them to eat their vomitus, he had encouraged coprophilic tendencies, which had been present from the very start.⁴⁷ Hence it is understandable that anal impulses were feebly repressed. He beat the children mercilessly for the minutest offenses, while he himself made not the slightest effort to control his anal impulses.

One may raise the objection that the older sister remained healthy despite having been raised in the same milieu. In response I must mention that she had always been held up as an example and was dearly loved and shown every preference—all factors sufficiently influential to affect the outcome. In general, I have no insight into the sister's libido destiny and no way of knowing what actually did promote a more favorable result. She hated her parents as much as did her younger sister, but managed to sever her ties to them in time.

Our case demonstrates pronounced schizophrenic as well as classic compulsion-neurotic mechanisms. Some readers will diagnose it as pure schizophrenia. The nature of the principal compulsive symptom (the eschatological fantasy) is schizophrenic in content as well as in mode of experience. The patient's tendency to autism, her deficient repressions, and her consciousness of sexual desires all speak for schizophrenia. However, in the absence of delusions or hallucinations, the blatant emotional dissociation and distraction necessary for a strict diagnosis are lacking. Although at present there is no prospect of a final diagnosis, I do not consider it useless to discuss whether schizophrenia or compulsion neurosis is more likely; only further analysis can make this determination. If I employed Bleuler's⁴⁸ broader concept of schizophrenia, I would lean toward a diagnosis of latent schizophrenia with compulsive symptoms. If, on the other hand, I used Kraepelin's⁴⁹ narrower definition, I should exclude dementia praecox, nevertheless placing the patient in the "psychopathic category" described by him as "the undeveloped preliminary stages of actual psychosis." One can see that the whole discussion could easily end in a semantic contest.

A theoretical discussion of "borderline cases" is all the more relevant at this point, as my essay has to do with a pathological state manifesting, in a representative majority of cases, not only various single schizophrenic symptoms but also a complete libido structure balanced in regard to neither its autistic nor its object-libidinal aspects. Hence we must ask ourselves in almost all distinct cases of impulsive character whether we are not actually confronted with schizophrenia.

For the moment this question can be answered, from the psychoanalytic standpoint, only in terms of libido dynamics. Even in psychoanalysis there is mention of "latent schizophrenia," but this may not be interpreted as implying an existing schizophrenic position which is merely obscured by neurotic transference symptoms and attitudes. Such an assumption would completely contradict the dynamic libido principles as we perceive them, and would function as a static point of reference in an area which can only be comprehended dynamically. As long as typical schizophrenic symptoms, such as stupor, delusions, incoherent speech, or hallucinations are lacking, we may not use the term "schizophrenia" or "latent schizophrenia." If, however, we do use the latter expression, we must always bear in mind that it can only imply a serious tendency toward detachment of the libido from the external world. Often latent schizophrenia is deduced from an exaggerated narcissistic libido position. However, neuroses exist which have nothing to do with schizophrenia, in spite of a narcissistic position lacking none of the intensity seen in schizophrenic narcissism. On the other hand, some paranoid schizophrenics also manifest very intense object attachments.

Until now, no satisfactory answer has been given to the question of how the narcissistic position in

schizophrenia differs from that of the narcissistic, inaccessible transference neurosis. It is by no means my intention to approach this question here, but the continued analytic exploration of borderline cases, as represented by this patient, should serve as a warning against assuming schizophrenia as a finished product which then “becomes manifest.” I once treated a forty-year-old female psychopath who had given the impression of being a latent schizophrenic from earliest youth, particularly since puberty. She was a querulous individual who felt that she had been mistreated by everyone and persecuted by fate. She suffered from states closely resembling catatonic stupor, as well as from phobias, compulsive fantasies and impulses, and conversion symptoms. She had been treated several times in the psychiatric observation ward and had been diagnosed first as a psychopath, then as a compulsion neurotic, and finally as a paraphrenic, without her illness ever having undergone a substantial change since puberty. Some compulsion neuroses which may be categorized as cyclothymic due to the rhythmic pattern of their depressions appear to exclude the possibility of schizophrenia entirely. In others, the relationship to schizophrenia appears to be very close (for example, in the case I have chosen).

The entire problem becomes more lucid if we free ourselves from the bias, which still frequently prevails in analytic circles, that the organic nature of schizophrenia (Jaspers⁵⁰ speaks in terms of the schizophrenic “process”) is in principle different from the other “psychogenic” neuroses. Schilder⁵¹ also is still of this opinion. In psychiatric literature, the connection between the outbreak of a psychosis and actual experiences is often overlooked because the authors are so involved with the concept of a ready-made, organically preformed psychosis. Hartmann⁵² was able to observe two sisters, both of whom became schizophrenic simultaneously when their father died. How can this fact be reconciled with the concept of preformed psychosis? Two views in particular have been brought to bear: The assumption that schizophrenic etiology is endocrine, or, especially since Kretschmer,⁵³ constitutional, in nature. Neither view contradicts psychoanalytic theory. Freud had long considered the possibility of endocrine etiology, even in transference neurosis, and his entire concept of erogenous zones, which is given such an important, central position in his theory of neurosis, is based on this very assumption (“sexual hormones”). But this does not account for the principal difference between transference neurosis and schizophrenia. The assumption of a specific set of schizophrenic constitutions, for example, the “schizoid phenomena” (Kretschmer), also does not contradict the psychogenetic aspects. This set of schizoid phenomena, however, encompasses a much broader spectrum than the field of schizophrenia alone. Compulsion neurosis and especially hysteria also belong in this group. Even the pathological alterations in the cortex found in aged, demented schizophrenics do not contradict our theory because, first of all, we do not know what changes (perhaps cyto-architectonic) take place in hysteria and compulsion neurosis (until now, none has been discovered), and furthermore, the scarcity and inadequacy of the findings we have are disproportionate to the frequency of schizophrenia. This holds true even if we overlook a question worthy of discussion, i.e., whether these changes, which have lasted for decades in cases of dementia, could not be interpreted as “inactivity atrophies.” Assuming this is the case, there still remains the question of how a compulsion neurosis is transformed into schizophrenia. In any event, I feel it can only be to our

advantage not to build a wall between the two illnesses. The interrelationships are obvious.⁵⁴

While analyzing impulsive characters one can observe transitory delusion formations *in statu nascendi*, but one can also observe how a drive impulse, ordinarily not perceived as a compulsion, is transformed into compulsive action. In such cases only the form changes while the content remains the same. One erythrophobic patient of mine developed a completely systematized persecution and injury obsession for five days during analysis due to acute homosexual transference. He said he was an Aryan and I a Jew, and therefore I must necessarily want to injure him in some way. He felt I was watching him; he was afraid of me; he said I was a sensual swine, had sensuous lips, and was giving him sensual looks. In reality, he had merely projected homosexual desires, which had recently emerged in analysis, onto me. After this phase had subsided, he recognized the desires as his own and began to accuse himself of being sensual, of making love with his glances, etc. As H. Deutsch⁵⁵ explained so convincingly, exaggerated, neurotic mistrust (especially in compulsion neurotics) is caused by the individual's own repressed sadistic tendencies being attributed to someone else. We all know the role mistrust plays in paranoia. A female patient who will be discussed later, in whom schizophrenia could not be excluded, developed a passing auditory and visual hallucinatory phase during treatment. She had received news of the death of a loved one but did not want to believe it; she heard the person's voice, heard knocking at the door, and distinctly saw the person standing in front of her during treatment. The pronounced negation of the loss she had experienced and her desire that the deceased be alive were fulfilled in hallucination. In all such cases reality testing is temporarily shrouded, causing the content of an experience to be perceived as a delusion. Cases in the category in question lean especially toward temporary impairment of reality testing. There can be no doubt that this is related to a withdrawal of cathexis, i.e., a narcissistic regression. We should like to learn more about the nature of this connection. The flooding of the ego with narcissistic libido must effect changes in that part of the conscious mind which receives perceptual stimuli (Freud's perception system) and governs the censoring of reality. It would appear that the road connecting the "narcissistic reservoir" to the object-libidinal position is much wider in such cases than in pure transference neuroses. It is a gross assumption to say that the "breadth" of communication between external world and ego makes possible this great readiness to withdraw. The libido of these patients is constantly fluctuating, and acute withdrawal of cathexis follows the slightest denial or disappointment in reality. The difference between this and libido withdrawal in simple transference neuroses without schizophrenic mechanisms has already been clarified by Freud: The transference neurotic withdraws his libido from real objects following a disappointment and cathects fantasized objects with it. Schizophrenics, or rather transference neurotics with schizophrenic mechanisms of the type in our illustrative case, divert the withdrawn libido into the ego, even relinquishing the fantasy cathexis. In this way the object-libidinal fantasy cathexis functions as a safeguard against narcissistic regression. Any wide-open path to autism, regardless of its nature or source, will always unfavorably influence the decision to retain the fantasy cathexis.

ISOLATION OF THE SUPEREGO

The case discussed in the last section may be viewed as a paradigm for a group of impulsive characters with partly compulsive and partly schizophrenic mechanisms, such as one often has the opportunity to observe in the psychiatric ward. An analytic examination of such cases provides the trained observer with a better means of understanding other neurotics with similar mechanisms. However, my case left a great many questions unanswered. The main difficulty lay in my inability to deduce from the patient's superego structure a convincing explanation for her lack of repression. The most striking characteristic of her ego ideal—the attempt to imitate her father in every respect (father superego)—is also a quality of female compulsion neurotics whose repression is defective only within the realm of their symptoms but otherwise intact.

It is a well-known fact that when seeking the answer to a cardinal question, one often has to wait for a suitable case which will then suddenly shed light on a number of other similar cases.

A female patient with genital masochism, whose character remained entirely infantile and whose analysis I began a year and a half ago, provided the explanations I had been seeking for so long. The structure of her ego was relatively easy to understand, as it was more simply constructed than the personality of my last patient or of the other impulsive characters I had occasion to treat. The most essential libido positions had remained fairly constant from earliest childhood, making it unnecessary to ferret out subsequent additional, usually confusing complications.

Remember the question posed at the beginning of this discussion; briefly formulated: How can uninhibited impulsiveness coexist with amnesia and repression? In other words, what is the nature of the ego ideal, which doubtless exists but does not entirely fulfill its familiar function of drive repression?

A twenty-six-year-old unmarried female patient sought treatment at the psychoanalytic outpatient clinic due to continual sexual excitation. She would like to be satisfied but feels nothing during coition, not even the entry of the penis. She lies there "tense" and "listens" for the satisfaction. At the slightest bodily movement any pleasurable sensations immediately disappear. Furthermore, she suffers from insomnia, anxiety, and excessive masturbation. She masturbates with a knife handle up to ten times a day, becoming extremely excited but not allowing herself to experience a climax. She interrupts the friction several times until completely exhausted. Either she does not experience an orgasm or she deliberately causes genital bleeding, subsequently achieving satisfaction from her accompanying masochistic fantasies. The bleeding from the vagina is the source of her satisfaction. She fantasizes penetrating deep into the uterus: "I can be satisfied only in the uterus." During masturbation she fantasizes that her genitals are a little girl whom she calls Lotte. She carries on a constant conversation with her, assuming the roles of both parties. "Now, my child, you are going to be satisfied" (during analysis); "Look, the doctor is with you. He has a beautiful long penis but it must hurt you." Lotte: "No, please, I don't want it to hurt." (*She cries.*) "You must suffer as punishment for your sexiness, you little tramp. It must hurt even more; the knife must come out of your back." And other similar conversations. Masturbation is a mortal sin for the patient; no punishment can be severe enough. During the act she consciously fantasizes all the men of her acquaintance, but also "Mommy,"

a female analyst who had previously treated her for eight months. (After two years of remission, the patient had suffered a relapse.)

The patient's father as well as her older sister and a younger brother are ostensibly in good health and well-adjusted. The father, however, is apparently overpowered in his unhappy marriage to a tyrannical woman. The mother is ambitious, unloving, austere, and at the same time extremely competent. She has always ruled the household. An older brother is serving a prison sentence for rape.

The patient feels mistreated and rejected by her mother and attempts to assume this same role of unloved child in her intense transference as well (analysis is dominated almost entirely by this process). Following the resolution of her attachment to the female analyst, her ambivalence toward her mother emerges fully. She begins to yearn for "Mommy" but at the start does not recognize this as longing for her own mother for the reason that she could not possibly love a mother who has always rejected, beaten, mistreated, and neglected her (this was actually true). She fantasizes nursing on the current "Mommies" of her selection, and the desire to return to the womb is dominant. Her complaints of having to suffer because of others and bear the punishment for their misdeeds became understandable when a fantasy she had had at age eight was disclosed: The mother is employed in one tavern and she in another. Her mother, whose marriage to her father is frightful, is often visited by a tall gentleman whom she addresses as "Count." Once the patient is introduced to this man. Now the child feels she is being rejected by her mother because she is actually the count's child and hence a disturbance to her mother. She fantasizes (it could not be determined whether this was reality or fantasy) that the count is raping her, assisted by her mother (see her masturbation fantasy). She feels a huge penis entering her vagina, causing horrible pain. She is in a dark room; someone is standing there screaming that she may not cry, that she must be still. Later, analysis disclosed a similar fantasy (or vague reminiscence?) at age four. She is carried by her parents' lodgers, two men, into their rented room. One holds her down while the other forces his oversized penis into her vagina. She wants to scream but cannot. She has full recollection of very early sexual experimentation with boys her age in a basement. At age ten she had sexual intercourse with her older brother. At age six, while playing with her two-year-old brother, she discovered his penis and tried to insert a knitting needle into it. This caused bleeding, whereupon the patient tugged at it and the boy screamed. The patient was then beaten and had her hair pulled by her mother.

At age twelve she took a job as a baby-sitter and for two years enticed her employer almost every night, without ever engaging in intercourse with him. At age fifteen she thought she was pregnant and menstruation ceased for three years, beginning again after the discontinuation of her first analysis. She now had the idea of tying a piece of wood to her vagina. Later she often arrived for treatment with a knife handle clenched in her vagina. Without it in her vagina she cannot fall asleep.

The beginning of masturbation in its present form took place at age fifteen, after she had spent the night in the same room as her father. She had had a nightmare but had forgotten it. She awoke the next morning lying on the floor. The bed frame was broken and her father asked her, without offering any information, what she had done during the night. This particular detail has not been clarified in analysis to date. However, it seems likely that the proximity of her father had excited her and led to

her nightmare. It also seems likely that she had masturbated.

The relapse occurred after she had made the acquaintance of a sadist who whipped her, pulled her hair, scolded her, and forced her to commit criminal acts. On two occasions she had had to bring him little girls, steal for him, etc. Nevertheless she called him “her best friend,” could not live without him, and followed him for hours through the city streets. In analysis it was exceedingly difficult to separate her from him, which finally succeeded only under threat of stopping treatment. She then immediately transferred her masochistic attitude to the analyst, brought a whip to her session, and began to undress in order to be whipped. Only the most decisive intervention could stop her. She followed me through the streets, visited me at ten o’clock at night in my home, saying she could no longer bear it, that I must have intercourse with her or whip her, she must have a child by me, and that only I could satisfy her. This behavior continued for about eight months and no explanation on my part, no persuasion could deter her. Each time she did something wrong she masturbated more frequently and intensively: “as punishment, I must die.” In the eighth month of treatment she attempted to poison the older sister and her husband. This has been unquestionably established under circumstances I may not report. Due to her amnesia, the entire incident sank into oblivion, although she betrayed it in dreams and in particularly brutal masturbation. Several days previously she had brought rat poison to her session, saying she loved it so much that she had to collect it.

The patient was allowed to remain in analysis only with severe prohibitions and under the threat of discontinuing treatment.

In the fourteenth month of treatment, during a more peaceful phase, the patient recalled totally repressed scenes from the parental bedroom. From these, sadistic views and theories regarding intercourse and childbearing could now be elucidated, and a good deal of fear was resolved. The patient took a job and managed quite well from then on. As is characteristic in such cases, she began to eat compulsively and gained considerable weight, indicating oral pregnancy fantasies. To counteract her inclination to extend analysis indefinitely, I now set a long-term final date (six months ahead), as the most important factor had apparently broken through. During discussion of the bedroom scenes, masturbation with guilt feelings flared up once again and had to be prohibited. This was particularly indicated as local damage had already been caused, such as a prolapse and flexion of the uterus.

The arousal of pure incestuous desire, which previously had been completely repressed, did not result, however, in self-condemnation. On the contrary, the patient now began consciously to fantasize having intercourse with her father and conceiving a child.

Her fantasies sometimes became vivid hallucinations. She saw a devil who mocked her, saying that she would never be able to resist masturbation no matter how hard she tried. His features were alternately those of the count and those of her mother. The devil represented her brutal and incestuous desires, from which she was trying to defend herself, her mother, and—as the prohibited object—her father.

I shall summarize the findings in this case: We are confronted with a patient who remained

entirely infantile in both sexual and ego structure. The masochistic genital masturbation is impulsive and uncontrollable, although it was not experienced as compulsion in the beginning and is not recognized as being pathological. The veto of the introjected mother, “You may not desire your father sensually and you may not masturbate,” is transformed into, “You [the genitals, the patient] are a lewd whore and must die by masturbation for your sins.” Hence masturbation functions as a compromise between the satisfaction of incestuous fantasies (“I can be satisfied only in the uterus, with a long penis”) and a disastrous combination of death wishes and destructive tendencies connected with genital pleasure. During the act of masturbation she identifies with her genitals, “the little girl,” while her ego identifies with the punitive mother. The overly austere superego has been borrowed entirely from the mother and its demands are completely fulfilled during masturbation. That part of the ego derived via introjection from the mother stands in contradistinction to the patient’s own underdeveloped ego, which is characterized by:

1. Its masochistic submission to the punitive mother (and later to the superego);
2. Its complete identification with the genitals—with the little girl, the pleasure ego;
3. The totally repressed genital object attachment to the father; and finally
4. The oral and uteral relationship to the mother.

Penis desire does exist but did not result in the formation of a masculine character; the patient remained infantile-feminine, as evidenced by the active, conscious desire to have a child.

In the sexual sphere, we may assume a central fixation at the genital stage. This is anchored masochistically in an inordinate castration complex, and, in addition, it competes with the oral fixation to the mother. But now the question arises as to whether, and wherein, an ego fixation also exists in this case. To answer this question, we must be guided by the development of the ego in simple neuroses.

If we draw a comparison with compulsion neurosis, we can easily establish that in this illness the ego is considerably more developed than the sexual components of the personality. In the sexual sphere, the pregenital, anal-sadistic phase predominates, while the ego is not only fully developed but also usually advanced to culturally prominent manifestations. To the objection that the animistic and magical inclinations (superstition) of the compulsion neurotic indicate fixation of the ego at an earlier stage (Freud, Ferenczi), I counter that here one can speak only in terms of a partial fixation of the ego if the entire personality is taken into consideration, whereas in this patient the entire ego remained at a primitive stage. But what is the nature of this total fixation and what are its components?

I feel that the distinguishing characteristic of this case lies in the enormous discrepancy between ego and ego ideal. The superego represents the mother, while the ego stands strictly separated, infantile, weak, and ravaged by incestuous desire. Normally a child’s ego adapts to the external world by incorporating parts of that world as a superego, thereby introducing reaction formation and sublimation. The child’s development is gradual; bit by bit the real, external world is assimilated as a superego demand and deeply fused with the existing ego. These portions of external reality—partially modified—are then assimilated into the ego structure, and a dynamic drive ego is forced to modify itself and does so entirely by means of compromise. In the analysis of normal, or even slightly

neurotic, individuals, one cannot trace superego formation to specific identifications. Should one succeed in doing so, however, one would find the ego ideal in the most manifold and complex connections, or rather fusions, with the sexual and other ego portions. The further we trace the progression from normality to severe pathology, the more clearly we perceive the phenomena of the isolated superego, and the more we recognize the importance for mental health of this ego ideal's organic fusion with the developing personality.

Although the ego is composed of a series of identifications and is actually created by identifications, we must bear in mind that something had to exist beforehand in order for these identifications to take place. This pre-existent something can only be a more primitive and differently constructed ego, an ego composed entirely of impulsive tendencies of a sexual and destructive nature. Freud taught us to understand the complexity of the development which this primitive drive or pleasure ego must undergo if it is to become a normal adult ego. From the very beginning, the attitude of the drives toward the external world is completely ambivalent. It is love for the parental figure which first causes destructive tendencies to be partially directed toward the self, and indeed a barrier is normally erected in the sublimated form of the "conscience" in which the individual also learns to renounce a portion of sensual pleasure. The manner in which demands are received is now dependent to a great degree on the external world itself. Two eventualities, already mentioned, may cause this process of identification to have a pathological outcome:

1. The drive ego is from the beginning able to resist pleasure denial, i.e., resist identification with the denying parental figure. According to its nature as a pleasure ego, it always tends to do so. The strength of this resistance is dependent upon the intensity of the autoerotic-organ pleasure experienced—the more intense the organ pleasure and the earlier effective organ pleasure is experienced, the more difficult it will be to erect a prohibiting ego ideal. We have recognized that this particular factor is strongly influenced by constitutional (hormonal?) elements.

2. Ambivalence toward the authoritative parental figure is so strong that every identification is contradicted by an equally intense counterimpulse. In order better to understand identification produced by excessive ambivalence, I stress once again that identification must be sustained by positive object love. A child will accept denial more readily if it is for love of a beloved parental figure. Finally, this for-love-of aspect will recede, leaving only denial, in the form of an ego-ideal demand. However, if equally strong defiance and a negative attitude compete with this for-love-of aspect, the denial will be assimilated as an effective factor but will, at the same time, remain isolated. This isolation may, in effect, be equivalent to repression, and the assimilated denial will then act in an impulsive fashion, as would a repressed sexual desire. It will strive, due to completed identification, to express itself, but will be restrained by the negative attitude of the pleasure ego and will hence not be organically incorporated into the personality as a whole. A conflict in the ego will ensue which is comparable in every respect to the repression conflicts in the sexual sphere. (The relationship between isolation and repression will be discussed later.)

Let us now attempt to apply the theoretical auxiliary concept of the isolated superego to the case at

hand. It was the penetrating, intense ambivalence toward the mother that placed its specific stamp upon the patient's personality from the very beginning. Her positive trait, the striving toward the mother, was sustained by oral fixation on her mother's breast and by yearning for the womb. She did not want to recognize her adulthood and felt not twenty-six years old but two. Supposedly she had been rejected, cursed, and damned by her mother and would not achieve peace until the mother had accepted her once again. The desire to nurse at the mother's breast was entirely conscious.

The negative factor, the striving away from the mother, is based on uninhibited submission to incestuously emphasized objects. Only the father figure was subjected to extreme repression before analysis. Even at age three the poorly supervised child engaged in coarse sexual play with her brothers and other young boys. One day the stern veto of her mother was suddenly applied. The children were caught and the patient brutally beaten. The mother's beating and scolding ("You are a lewd whore," etc.) only had the effect of infinitely increasing guilt feelings, but simultaneously the spiteful, negative attitude of the child, fortified by the sexual pleasure she was experiencing, prevented the mother's veto from triumphing over the already-flourishing impulsiveness. Thus the ego was deprived of a major portion of its opportunity for further development, since the mother ideal ("You may not engage in sexual play") had been assimilated but not actually fused into the other elements of the personality. It remained in the infantile stage of identification with the pleasure-contributing genitals but was condemned to struggle with an assumed superego which contradicted it flagrantly. The battle cry of the never-ending struggle is not, as in other cases, "I want to, but may not, masturbate or desire my father," etc., but rather, "I must die from the pleasure of masturbation or intercourse." This attitude culminates in the symptom of genital masochism.

Hence superego isolation implies a particular structural organization of the personality. I believe I have been largely successful in tracing this structure to its specific identifications, but I must still briefly touch upon the relationship of structural peculiarities to the dynamic and economic aspects. When I state that in the impulsive character the superego is not as "organically" fused with the ego as in inhibited neurotics, and that it is separated or isolated, this illuminates the impulsive character from the standpoint of personality structure. The dynamic consequences are then a resultant lack of superego effectiveness in a repressive and reaction-forming capacity, as well as a deficiency of this effectiveness in the mechanism of drive-dominated impulses in "crimes of guilt" (Freud). The isolated superego functions like a repressed drive and creates the need for punishment, which usually seeks satisfaction in overt masochistic manifestations. This leads us to the economic significance of such dynamics: the drive-dominated impulses assume the secondary function of alleviating guilt feelings via the pathological route of satisfying the need for punishment. However, we must be careful not to overvalue this economic factor. Although essential, it is nonetheless a secondary formation. The primary motive in its unassailable position is represented by the original organ pleasure which, in this personality structure, may be experienced without manifest guilt feelings.⁵⁶

But there is still another reason why we cannot seek the motive of impulsiveness in the need for punishment alone, although this is clearly a prominent mechanism behind crimes of guilt in the sadistic and self-punishment in the masochistic, drive-dominated individual. But punishment need is

present in almost every drive-inhibited neurotic character as well, even though in such cases the illness itself serves the purpose of masochistic satisfaction. Therefore, if the scoundrel tormenting those around him is actually to rationalize his guilt feelings and if the impulsive masochist is to penalize himself effectively, the need for punishment must be augmented by the dissociation of the ego just described. The need for punishment is verifiably present in impulsive individuals to a great degree, but it is not specific to this illness.

The impulsive character of another patient took a very interesting turn. From earliest childhood to age twenty-two she had lived in perpetual conflict with her parents because of her ambivalence. She lied, deliberately misbehaved, ran away, roamed about with men, masturbated, repeatedly beat her mother with no feeling of guilt, and often experienced "rape" without actually ever having intercourse, of which she was terribly frightened. At the same time she suffered from anxiety and intermittently from insomnia. At age twenty-two she finally submitted to someone who was a father image, whereupon guilt feelings were unleashed. Her mother put her out and the patient fled to Vienna, where she became ill with hysterical vomiting and stomach pains. She underwent two laparotomies needlessly because the doctors did not recognize the functional nature of her symptoms (cardiospasm). Suddenly impulsive activity was arrested; the patient became quiet and depressed, and repeatedly attempted to construct situations analogous in every detail to the rejection by her mother. During analysis she followed this pattern of behavior. Prior to her symptomatic illness she had resisted acceptance of the superego, and only when incestuous desire had been fulfilled by intercourse did the ego ideal, isolated until that point, become fully effective as a repressive agent. It arrested the impulsiveness and created a symptom neurosis. (The vomiting and stomach pain corresponded to a pregnancy fantasy.)

If one contrasts a number of such cases of uninhibited impulsive behavior, and emphasizes particularly those manifesting (in addition to impulsiveness) symptoms of previous repression, such as fear, compulsive thoughts, phobias, etc., one will soon encounter the contradiction that acute ambivalence toward a parental figure does not always create pathological isolation of the ego ideal. There is another typical possibility, namely, that the behavior of parental figures, which should serve as a model for the formation of the child's ego ideal, may not be directed against the original impulsiveness but may, on the contrary, be completely in accord with it. Psychoanalysis is inclined to underestimate the significance of the lack of a model for ego ideal formation. Aichhorn proved that illegitimate children who have been raised without a father, or who were orphaned at a very early age, frequently manifest asocial traits. However, it is not entirely clear why such children did not adopt an ego ideal from other parental figures, or, if they did, why they show lasting instability of inhibitions. It would be of great value to examine the question of whether, and to what extent, frequent change of parental figures causes enduring debilitation of defensive faculties. It would be readily understandable if frequent changes in the type of influence exerted over a child resulted in labile and inconsistent ego ideals.

A twenty-eight-year-old patient displayed this kind of discrepant, heterogeneous ego ideals when

brought to the outpatient clinic by the Vienna Department of Welfare in a state of hysterical mutism. At the same time, she was suffering from severe anxiety expressed in sudden cringing, a defensive position of the arms, and abrupt fleeing motions. The mutism functioned as a hysterical defense against the execution of a compulsive idea. The patient lived with her three children in dire need and sustained them all with the ridiculously small amount of money she earned by mending. She had decided to kill the children and herself as well, but the plan was frustrated by the crying and screaming of her youngest child, a two-year-old girl. Then she was overcome by the compulsive urge to inform the world of her decision, and simultaneously by the fear of being committed to an institution. (This had already happened once before for attempted suicide.) Now she had become mute as a defense against acting out her compulsive urge. The mutism had occurred one night after a nightmare in which she dreamed that her second child was dead. She had been pregnant with this child when her first husband died and had, at the time, cursed the child within her and thought it would be better off dead.

The patient had been married twice. Her first husband was killed in an accident, and she divorced the second because he was an alcoholic and mistreated her. It must be noted that she was completely frigid despite numerous affairs. It soon became obvious that she had not only considered murdering her children (which impulse she herself condemned) but also planned other thoroughly criminal acts in full consciousness, without condemnation, hence non-compulsively. For example, she had wanted to poison her father-in-law and to this end made the acquaintance of a druggist who refused, however, to give her the poison. During treatment, which lasted for three weeks, she trailed me, lay in wait for me in my doorway and in the clinic garden to “vent” her rage at me, or at least “to tear out some of my hair.” She even tried to obtain a revolver to shoot me, and harbored the conscious thought that it would be most satisfying to castrate both her father-in-law and her analyst. She also had pyromanic impulses to which she submitted, without condemning them, thoroughly enjoying the submission. She set fire to everything she could lay hold of in the house and encircled her child with fire. At age ten she had set a haystack afire to take revenge on the owner, who had scolded her. Also, at age ten, she had set fire to a neighbor’s house, endangering almost her entire village. She then reveled in joy over the panic of the others who were to suffer also, not just she alone.

Her childhood was, in fact, quite bleak. Born an illegitimate child, she was abandoned by her mother and brought up in a foundling home for four years. Next she was taken in by distant relatives and systematically taught—along with their own children—to steal. There were also incessant beatings. She slept in a small, narrow room with eight other people (some adults) and not only witnessed the most intimate sexual practices but was misused by her uncle and by a young man. She did not enjoy the stealing, however, and did it only because she was freezing. She hated her environment, but only because of the frequent beatings. Whenever possible she took revenge. She was malicious, misbehaved in school (which she attended only irregularly), and took great pleasure in beating little boys, teasing the teachers, and setting fires (she suffered from enuresis up to age twelve). At age twelve her new school principal took an interest in her, had her removed from her home, gained her confidence, taught her to read and to understand what she read, and offered to carry the cost

himself for having her raised and educated. Her relatives, however, took her away from him, and her old life began once again. Now, for the first time, she started to experience fear; she tried to restrain her impulses but was only partially successful. Although her hate for her oppressors was unbounded, the principal's influence had already become effective and the hate impulses were counteracted by those corresponding to her newly acquired superego and to the benevolent school principal. She obtained books, read a great deal, acquired a reasonable education, and developed a relatively good style of writing. I had an opportunity to read several letters she wrote from Steinhof.* At age fourteen she became acquainted with her own mother, who then took her back to the city, where a life of misery and need continued. The old impulses were as strong as ever but were partially curbed. Although her first husband tortured her immeasurably without conscience, after his death she accused herself (attempted suicide, was confined) and experienced a phase of agitation intensified to the point of insanity: She thought he was still alive and following her in the streets. She then had several affairs which ended unhappily, and could not bear to stay with her second husband. Finally, she grew incapable of work and decided to kill herself and her children.

Analytic treatment at the outpatient clinic became impossible because of her dangerous actions. Hence I could gather little information analytically pertaining to her sexual development. However, the glaring contradiction between the deficient formation of a culturally effective ego ideal until age twelve and the subsequent influence of the school principal was quite clear. Only then did she repress her impulses (although usually without success), and at the same time she had acquired a conscience, in addition to her fear of being beaten. The uninhibited drive activity was partially arrested by this acquisition of a late, but nonetheless intense, superego, and was neurotically rechanneled. However, it was not sufficient for complete repression, probably because it had been activated too late in life. I am using the term "repression" only in the broadest sense. For example, I do not doubt in the least that the patient's frigidity corresponded to repressed penis desire, despite the existence of conscious castration desire. We must also ask ourselves what the repression of masculinity desires achieved, even though we are unable to comment on this. However, it must not be forgotten that the patient was beaten and we must assume that the phylogenetic readiness to repress or the guilt feelings were able to utilize these "training measures" as a means of repression. She had been raped by her foster father but had offered resistance. Subsequently she had brought defenses against men along with her into adulthood and simultaneously a neurotic inclination to enter into love affairs despite her total frigidity. Was it only hate that had taken effect in this child? Was her resistance real because she had never experienced any tenderness? Or was this the repression of deep masochistic love? These are other questions I cannot answer.

Under no circumstances, however, may we view this case as opposite to that of the genital-masochistic patient. It seems to be inconsequential whether a culturally valuable ego ideal is acquired at age twelve or at age four. It is essential that the right degree (however difficult this may be to determine) of pleasure concession and drive curtailment be applied from the day of birth. Every inconsistent, sudden outbreak of severity will necessarily result in ego misdevelopment more or less

similar to that blatant manifestation of the isolated (or repressed) superego I have described. There is no doubt that other typical ego defects exist.

On the Question of Superego Repression

In pursuing the discussion regarding the structural and dynamic differences between compulsion neurosis, hysteria, and the impulsive character, we shall meet with the possible objection that the egos of the compulsion neurotic and the hysteric also oppose the brutal austerity of the superego. In regard to this Freud explains in *The Ego and the Id*:

In certain manifestations of compulsion neurosis, guilt feelings are clamorous but cannot justify themselves to the ego. Hence the individual's ego opposes the imputation that it is guilty and demands that the analyst reconfirm its rejection of these guilt feelings ... Analysis then shows that the superego is influenced by processes *unknown to the ego*.⁵⁷ The repressed impulses responsible for guilt can actually be discovered. In this case the superego knew more about the unconscious id than did the ego.

From this, the difference between the impulsive character and the compulsive becomes clear: In the latter, the ego itself, despite its opposition to the superego, knows nothing of the repressed material (contrary to the ego in impulsive character) and thus behaves something like the slave who rebels internally against the brutality of his master but continues to serve despite his rebellion. The ego of the impulsive individual, however, rebels willfully and overtly. The success of this rebellion in the one instance and its failure in the other may be traced to the fact that the drive-inhibited compulsive's reaction formation was successful (details later); that is, he assimilated the prohibiting personality completely despite a possible rebellion against it at a later date, while the impulsive individual never identified completely but with only a part of his ego.

The situation is different and more complicated in hysteria. Here, as Freud pointed out, guilt feelings remain unconscious.

The mechanism of remaining unconscious is easily surmised in such cases. The hysterical ego protects itself from the distressing facts with which it is threatened by its superego in the same fashion that it would otherwise protect itself from an unbearable object cathexis—by an act of repression. The ego is therefore responsible for guilt feelings remaining unconscious. We know that the ego otherwise represses in the service of its superego, but this is a case where it employs the same tactics against its austere master. In compulsion neurosis, as is well known, phenomena of reaction formation predominate; *but here [in hysteria] the ego succeeds only in keeping the material related to guilt feelings at a distance*.⁵⁸

Hence, in drive-inhibited hysteria, the ego is responsible for the repression of the id's drives, in the service of the superego, due to unconscious acceptance⁵⁹ of its demands. Simultaneously, however, it defends itself from the superego's strict warnings by (systematically) repressing guilt feelings, which in subsequent analysis must first be sifted out of the mass of anxiety and conversion symptoms.

Every case of drive-inhibited hysteria and compulsion neurosis discloses an unconscious acceptance of prohibiting superego demands. The differences between the two lie in the divergent ego attitudes toward guilt feelings. At this point, however, we are interested mainly in the question of superego repression, since we must demonstrate the relationship between repression and isolation. I

mentioned earlier that when isolation amounts to repression, then the superego behaves like a drive erupting from the repressed state.

On closer examination we immediately encounter the following ponderous objections: Are not the main superego demands always unconscious? May the incest taboo, for example, ever become conscious? If it did, would incestuous desire not also become conscious? This intimate interlocking of desire and taboo banishes both to the unconscious and, when viewed as a problem in *The Ego and the Id*, provided the foundation for the theory of the necessary unconsciousness of one part of the ego, i.e., the superego.

But “unconscious” does not imply “repressed.” The issue becomes clear if we adhere closely to Freud’s differentiation between dynamic and systematic (system unconscious) repression, as well as between successful and unsuccessful repression. Only unsuccessful dynamic repression is pathological. The core of the superego is supposedly always systematically and successfully repressed in healthy individuals and in drive-inhibited neurotics. The dynamic of repression does not extend beyond the prevention of material becoming conscious, and the systematic repression is entirely compatible with the unconscious acceptance and execution of superego demands by the ego. This unconsciousness actually seems to be a prerequisite for acceptance, as it is obvious that the core of superego demands is frequently conscious in the pronounced infantile type of impulsive individual.⁶⁰ (This incidentally is often the case in schizophrenia.) Here systematic repression is defective, and dynamic repression is unsuccessful and lacking to a great extent.

I believe it is now clearer that:

In drive-inhibited neurosis the core of the superego has been successfully and systematically repressed, and dynamic repression does not extend beyond preventing material from becoming conscious. The ego is permitted to know nothing of the superego core but only of its rationalizations. Generally, however, the ego heeds superego demands in order to repress id impulses. We know that the failure of this repression creates symptoms. In drive-inhibited symptom neurosis, psychic conflicts take place between the ego, in alliance with the superego on the one hand, and repressed elements of the id (the tabooed object relations) on the other.

In the impulsive character, the superego is dynamically and unsuccessfully repressed; systematic repression is defective. It is easy to see that the defective quality of systematic repression (like that of partial drives and of sadism) is the result of dynamic superego repression by the pleasure ego. In this case, the psychic conflict involves three factors: on the one hand, the ego (allied with the superego) defends itself against the id (as it does in drive-inhibited neurotics); on the other hand, it allies with the id against the superego. This dual conflict (double counter-cathexis) accounts for the conspicuous inner struggle of impulsive individuals.

The concept of superego isolation includes unsuccessful dynamic repression but also has further implications: It implies first a particular structural organization of the personality; and second, a normal transitional stage in all superego formation, which will be discussed later. In justification of my terminological innovation, let me remark that this is only one special case of superego repression. The concept of isolation may one day very well be incorporated into the concept of superego

repression, assuming the theory of dynamic ego repression (as a counterpart to that of sexual repression) is enlarged upon and its relationship to personality structure recognized.

Isolation of the Superego as a Normal Transitional Phase in Ego Development

At this point, I must consider a further objection. I have deduced superego isolation genetically from infantile ambivalence toward an object (later it functions as the superego), and I have described this misdevelopment as an attribute specific to the impulsive character (as opposed to the drive-inhibited, classic compulsion neurotic). However, this ambivalence is a central factor in compulsion neurosis as well, and lies at the root of many symptoms, such as compulsive doubt, indecision, etc. Why then did ambivalence not cause superego isolation in these cases as well? Compulsion neurosis is distinguished particularly by extensive realization of negative ego-ideal demands, for instance, overconscientiousness, pedantry, the inclination to ascetic ideologies, sexual abstinence, etc. The objection is easily countered by consideration of the fact that the decisive factor is the form of ambivalence, that is, its mode of outward manifestation as well as the point of time in psychic development that it became effective. In regard to the latter, see my explication regarding the difference between the two pathological states in the previous section. As far as the mode of outward manifestation of ambivalence is concerned, the following may be said: An ambivalent emotional attitude may remain permanently manifest (manifest ambivalence per se) or it may be swayed in the direction of either love or hate. In analysis we encounter an impressive phenomenon first described by Freud as reactive love or reactive hate (latent ambivalence). In the former, hate transformed into love is added to the original loving attitude; in the latter, love transformed into hate, due to disappointment, is added to the original hate. In compulsion neurosis, typical findings indicate that manifest ambivalence is expressed in symptoms usually transferred to banalities, and that reactive love (or hate) is then directed toward the original ambivalently cathected object. This ambivalence toward the object is first made manifest in analysis. The impulsive character, on the other hand, permanently maintains manifest ambivalence toward the object and continues in this attitude toward the ego ideal. Hence there is an additional transformation of the original manifest ambivalent attitude in the compulsion neurotic which is either partially or completely lacking in the pronounced impulsive character, i.e., reactive emphasis of one aspect of ambivalence or the other and transference to banalities. The reactive transformation of ambivalence to a manifest unequivocal attitude as implied by love or hate takes place, of course, as a result of repression and this, as we know, is defective in impulsive characters. This repression and reaction formation in compulsion neurosis may also be traced to the austerity and firmness of the drive-negative ego ideal. In the impulsive character, defective repression and reaction formation, as well as permanently manifest ambivalence and superego isolation, are all congruent. A schematic delineation of the extreme types will clearly demonstrate their differences.

Compulsion Neurosis

Manifest ambivalence

Impulsive Character

Manifest ambivalence

Reactive transformation of ambivalence	No reactive transformation or dominant hate
Austere superego incorporated into the ego	Isolated superego
Intense repression and reaction formation	Defective repression
Sadistic impulses combined with guilt feelings	Sadistic impulses without guilt feelings
Overconscientious character, ascetic ideologies	No conscience; manifest sexuality; corresponding guilt feelings possibly anchored in neurotic symptoms or totally repressed
Ego submission to superego	Ego position between pleasure ego and superego; ambivalence toward both; <i>de facto</i> obedience to both

The second item thus contains the dichotomy in development between compulsion neurosis (or any other symptom neurosis) and the impulsive character. The choice of a developmental alternative depends upon experiences prior to the anal-sadistic stage. If effective ambivalence does not develop prior to this stage, and no damage exists from previous phases, development toward compulsion neurosis (or hysteria) will begin. If intense ambivalent positions exist prior to this time, assimilation of an ego ideal will be unsuccessful. In accordance with our previous delineations, sexual activity at too early an age, especially activation of genital eroticism prior to the full development of the oedipal phase, strengthens the primitive pleasure ego's narcissism to such a degree that ego ideals can be erected only in an isolated form. As a further decisive factor, we must consider all damage stemming from love objects or parental figures, as discussed earlier.

This exposition was not intended to contribute more information on the pathological ego and superego development than that yielded by an examination of the latter's position in the impulsive character. The genetic ego psychology initiated by Freud and Ferenczi⁶¹ will conceivably also have to take into account characteristic ego developmental stages such as those already established for sexual development. We may view the phenomenon of superego isolation as a permanent and therefore pathological condition of a very normal phase through which every individual must presumably pass on the developmental path from a primitive pleasure ego to a member of the cultural community. The cultured real ego is first formed via the ego ideal and via the realization of its individual elements.⁶² A great portion may always remain unrealized, and psychoanalysis is able to provide clear insight into the pathological results of such deficient realization. The acquisition of an ego ideal does not take place without a struggle. It lies in the very nature of the drive-dominated pleasure ego to protect itself from disciplinary restrictions. However, the defense against restrictions is paralyzed by object cathexis and this results in the erection of an ego ideal. But a phase of acute manifest ambivalence toward the restricting object, or rather toward the later ego ideal, is interposed between complete opposition and factual assimilation. There are two further possibilities: Either manifest ambivalence is transformed into latent ambivalence through reactive emphasis of love or hate, or ambivalence toward objects and toward the ego ideal is overcome. I shall consider the latter normal; it is also the goal of analytic therapy in every individual case. Obviously, when ambivalence is overcome in the

ego, the result will be the same in sexual object relationships (achievement of the unambivalent genital stage). The first possibility mentioned above is observable in compulsion neurosis and hysteria. Thus we arrive at the following schematic outline:

1. The stage of the primitive pleasure ego: unequivocal repulsion of restrictions.

2. The stage of manifest ambivalent object cathexis or, from a superego standpoint, of an ambivalent attitude toward the superego and a disposition to uninhibited impulsive activity as described in my delineations.

3. The stage of reactive ambivalence transformation. The ego identifies with the restricting parental figure (realization of its demands on an ambivalent basis). At this point defective identification begins.⁶³ If this fixating process takes place in the anal-sadistic stage, the disposition will incline toward compulsion neurosis; if it takes place during the genital stage, it will tend toward hysteria.

4. The stage of (relatively) ambivalence-free ego structure. Obscure as the development and dynamics of this reality-adjusted ego position may be, analytic experience indicates that it cannot come into existence without drive-affirmative elements being present in the ego ideal, that is, without the opportunity to establish a well-balanced libido economy.⁶⁴

This schematic outline can serve only as a preliminary orientation. I shall add that phases 1 to 3 must apply to every stage of libidinal development, inasmuch as the conflict between pleasure striving and pleasure denial repeats itself in every sexual phase. In this way we can differentiate between impulsive characters and compulsion-neurotic and hysterical types according to whether fixation of the isolated ego-ideal phase took place in the anal-sadistic or the genital phase. I am prepared for the objection that the attempt to differentiate between such phases in transverse or longitudinal developmental sections must remain unproductive speculation because we shall never be in a position to satisfactorily reconstruct infantile attitudes prior to the age of five. Whenever this objection refers exclusively to analytic reconstruction of childhood, it will stand undisputed to a certain extent, even if particular emphasis is placed upon the counterobjection that the soundest element of Freudian theory (the concept of libido developmental phases) was acquired in this manner and that anyone can convince himself of its correctness, i.e., the precise sequence of oral, oral-sadistic, anal-sadistic, and genital phases, by direct observation of children. My classification of developmental superego phases, which I explicitly termed preliminary, is based, however, only to a minute degree upon analytic reconstruction. It is supported, rather, by experience gained from treatment of impulsive characters and particularly from the analysis of their ambivalence conflicts and transference positions. During analysis they continually vary their superego structures in keeping with the state of their transference. This in turn is an exact reproduction of previous object relations, so that we gain (with vision sharpened by *The Ego and the Id*) deep insight into infantile ego development.

I shall conclude this section by referring to a more general problem: Self-love (“secondary narcissism,” in the sense of Freud and Tausk) and object love are life-affirmative (life instinct) elements, while guilt (need for punishment) is a life-negative (death instinct) element in man. They stand in an antithetic relationship to one another, but occasionally guilt feelings transform self-love

into a more primitive form of narcissism, the so-called primordial narcissism of intrauterine existence. The most typical illustration for this confluence is melancholic suicide. But guilt feelings develop later in ontogeny than does narcissism, hence the predominance of life-affirmative tendencies. Fully developed narcissism, supported by unambivalent genital eroticism, is most effective against guilt feelings. Hence it is highly significant for the subsequent destiny of the individual in what developmental phases of narcissism effective guilt feelings arise to weaken the life-affirmative tendency. The very intensity of disturbances would appear to depend upon how early guilt feelings begin to take their life- and reality-negating effect. The problems of this formulation may be numbered among the most difficult to grasp empirically, but they are also counted among the central issues of the specific etiology of mental illness.

SOME COMMENTS ON THE PROCESS OF SCHIZOPHRENIC PROJECTION AND THE HYSTERICAL SPLIT

My assumption of an isolated superego has proven heuristically valuable in two respects, namely, the formulations of further dynamic causes of the schizophrenic projection process and of the hysterical personality split.

When my genital-masochistic patient heard of the death of the analyst who had previously treated her and who had become a mother image for her, she lapsed into acute (hysterical?) psychosis. She suffered from auditory and visual hallucinations. “Mommy” would knock at her door at night and call her down into the grave. During one session she actually saw “Mommy” lying in the grave beckoning to her. She heard voices telling her she must not masturbate because “Mommy” wouldn’t permit it. She prayed in terror for hours in front of the deceased’s picture and even saw it move. We have good reason to suspect that the same causal mechanism was operating behind these hallucinations as in schizophrenic projection. The same projection process takes place here in the province of the ego, i.e., the superego appears, or rather reappears, in the external world (like the persecutor-critic in paranoid schizophrenia); the process of introjection is reversed. Hence it is logical to assume that those elements, those ego ideals, which are not intimately fused to the personality as a whole and remain isolated components of it are most readily and most easily subjected to the fate of paranoid transferral from the ego to the external world. The fact that the contents of an illusory projection, whether in the form of a persecution mania or of a paranoid hallucination, also include drive impulses (usually homosexual) condemned by the ego is no contradiction to this concept. The neurotic individual may be compared to the innkeeper who removes two fighting customers from his tavern but nevertheless still has to put up with the noise they make outside his door. The clinical phenomenon of resistance contains both repressed material and the repressing agent (Freud).

This at least partially answers the long-standing question concerning Freud’s theory of paranoid projection of homosexuality. Freud had explained the projection process from an economic standpoint, namely, as an attempt to achieve relief: “I don’t love him at all—actually I hate him—because he is persecuting me.”⁶⁵ This economic explanation, however, does not include the reason for

the paranoid schizophrenic seeking relief from the pressure of his impulses via projection rather than, for example, via typical repression mechanisms. We may now assume that it is a non-fused element of the ego which makes projection possible and directs the tabooed impulse toward this specific means of release. In this way defective ego development, in the sense of deficient fusion of ego ideals derived from the external world, may be responsible for a disposition toward illusory projection onto the external world. But observation of paranoid schizophrenic phenomena in themselves yields no information as to the nature of this defect or as to the time at which it must occur in order for the disposition to be created. That ambivalence plays a significant role is clearly demonstrated by the ambivalent quality of every persecution mania. The analysis of paranoid character neurosis speaks merely for the postulation of such a fixation point. If my views on the origin of this disposition are correct, then we have gained a clue for the temporal determination of schizophrenic fixation, and we feel that a hypothesis is unobjectionable as long as it is capable of explaining a phenomenon.

Schilder drew attention in one of his lectures to the loosening of ego ideals in schizophrenia and used this to explain, among other things, the consciousness of symbolic meaning. He also posed the question as to when schizophrenic fixation takes place, although he did not offer an answer. An intimately related train of thought, running parallel to his work, contains the question of the origin of formal disturbances in psychic life. It proceeds from the refutation of the false premise that one can find the fixation stage of schizophrenia in the same manner as that of melancholia (oral-sadistic stage), compulsion neurosis (anal-sadistic stage), and hysteria (genital stage). When examining the question of schizophrenic fixation, we must first consider the particularly strong significance of its characteristic formal disturbances. Second, one must not forget that in schizophrenia all types of mental illness can be discerned, although altered in their formal aspects (compulsion neurosis, hysteria, melancholia, hypochondria, etc.). Third, the assumption of a narcissistic fixation is far too broad a concept to have exact connotations. In the final analysis, it will be a question of a specific stage within the narcissistic-autoerotic developmental phase, presumably the phase in which the interconnection between the original ego and the object is breached⁶⁶ for the first time, resulting in the first identification⁶⁷ and in the development of the faculty of reality testing. Schizophrenic fixation must be sought in the phase of the first object identification.

* * *

Another method employed by the ego to rid itself of its function as mediator between the superego and primitive tendencies (in contrast to the relieving of the superego by way of illusory projections) is the hysterical personality split ("double conscience," Janet). No projection takes place here, i.e., the antagonist is not expelled from the ego (which would be at least a decisive measure even if ineffective); the ego simply identifies alternately, first with one antagonist, then with the other. Hence during masturbation (which must be viewed as a particular type of hysterical state of emergency) our nymphomaniac identified completely with her punitive mother, while her pleasure ego identified with her genitals. Outside of this state, she played the part of a small child toward any figure even remotely suitable. She tried to be amorous with her analyst, her nurse, etc., but would also swear and show

extreme defiance when rejected. She entered into innumerable markedly incestuous affairs, constantly seeking a man (her father) with a long penis. However, when she did have intercourse, the image of her threatening mother hindered her in the form of voices calling her a lewd whore or in the form of a devil condemning her actions.

The case of a female hysteric in a twilight state, which finally resulted in a persistent personality split, gave rise to the assumption that this very split represents an attempt at restitution. I was able to convince myself of this in two other cases as well. The patient in her prepsychotic twilight state relived an otherwise totally forgotten seduction by a teacher, and she also masturbated on her breasts and donned her most extravagant clothes, whereas she usually dressed very simply. Thus, in the semi-trance, her ego surrendered to impulses otherwise completely repressed and tabooed and placed itself at their disposal by providing motor discharge for the impulses themselves. In ordinary waking consciousness, the ego subjected itself to the austere, mother superego which had preached asceticism. At age two, she had already experienced prohibition of genital masturbation by her mother. It appears to be a characteristic trait in such cases for the ego to side first with impulses tabooed by the superego and then with the superego itself. It is a slave of two hostile masters, loves them both, and strives to serve them both. The conflict, however, is not solved by means of a symptomatic compromise, as in symptom neuroses, but by one master not being permitted to know of the other's existence (i.e., a split into two states of consciousness).

This case also demonstrated pronounced ambivalence toward the mother from earliest childhood, which need not be explained in detail at this time. I shall mention only that the positive inclination toward the mother was based on intense oral attachment and a longing for the womb, whereas the negative could be traced primarily to genital denial perceived as radical castration. Accordingly, the case was similar to that of our nymphomaniac patient (with the essential difference that the latter had never achieved complete drive satisfaction during early childhood). The ego's ambivalence toward its ideals was finally relieved by the patient's allowing her ego, namely, that ego which had identified with the pleasure self, to die. ("I have kissed Eva S. [that is, myself] to death." "I am not Eva S., I have no name.") Defiance of the mother had dominated the child's behavior from the very beginning. Here also the origin of the tendency toward a personality split must be sought in defective incorporation of the prohibiting mother ideal. The ambivalence is entirely contained in the expression "kissed to death." Release from the depressive, prepsychotic personality, which was aware of the illness, resulted first in a hypomanic reaction. She lost her symptoms (insomnia and hysterical stomach pains) and felt well.

In the psychotic phase she told me that she knew far more about Eva S. now than Eva had known during her lifetime, although she did not want to tell me what she knew. We can see, however, that since the repressed material no longer belonged to her—as she had assumed in her madness—but to Eva S., whom she had "kissed to death," she was allowed to know more about it.

In this way the tendency to the schizophrenic and hysterical split may be traced to defective fusion of assimilated ego ideals with the pleasure ego. The question of the differences between the two forms

of the split remains unanswered.

Roughly schematized, the facts involved may be summarized as follows:

In schizophrenia with delusions and hallucinations, there is conflict and deterioration in the ego. The conflict is resolved by way of illusory projection of the ego ideal together with the tabooed id impulse.

In the hysterical personality split, resolution of ego conflict is attempted by alternating preference of the ego for one of its two masters, with temporary amnesia.

In the impulsive character, partisanship is simultaneous, and occasionally conflicts are resolved by schizophrenic projection or hysterical splitting.

These illnesses, with their ego dissociation, stand in contrast to the drive-inhibited character or symptom neurosis with its uniformly compact ego (i.e., ego plus superego).

However, I do not wish to create the impression that I am denying the existence of ego conflicts in drive-inhibited neuroses. Such conflicts most certainly do exist, for example, between opposing ego identifications. It is merely a question of whether the conflicts are such that they alter the uniform defense of material in need of repression, which is readily compatible with existent ego conflicts.

THERAPEUTIC DIFFICULTIES

From its inception psychoanalytic therapy has encompassed ever-widening areas of psychic disturbance. Originally intended only as a cure for hysteria, it soon drew compulsion neurosis into its scope and proved a most adequate method of treating this illness as well. Therapeutic experiments with melancholia and related cyclic conditions have already been undertaken by Freud and Abraham but the results have not been verified. This is also the case with experiments in early stages of schizophrenia. Actually there is no reference in psychoanalytic literature as to possibilities⁶⁸ for treatment, or possible success already achieved, although occasionally there is mention in analytic circles that the possibility of influencing this most severe form of mental illness through analysis is not to be dismissed a priori. The preconditions of future influence must first be precisely established, in keeping with the basic psychoanalytic principle that only what has been understood can be altered. However, these preconditions can hardly be learned from advanced institutionalized schizophrenics. For the moment at least, only early cases are useful, or those manifesting typical schizophrenic mechanisms along with neurotic transference positions without actually being completely schizophrenic, i.e., cases similar to the patient with eschatological fantasies. Furthermore, since our inability to influence schizophrenia is due not only to the patient's transference incapability but also to defective ego ideals, we must be willing to grasp the opportunities offered by the analysis of impulsive characters, to the extent that they are typical, in exploring therapeutic possibilities and difficulties.

“In the mature man a child lies hidden who wants to play.” These words of Nietzsche's anticipated Freud's classic formulation of neurotic conflicts. When, in analysis, we strive to subdue the “child,” i.e., the unconscious, infantile elements opposing adjustment to reality, we appeal to the “man” in the

individual. Our therapeutic efforts are unsuccessful if the man is unwilling to struggle with the child, but they are crowned with success if we win the man for our cause, motivating him to come to terms with the child, either to train it anew or allow it an allotted measure of controlled freedom. In transference neurosis, the greater portion of the personality is soon won over and identifies with our therapeutic intentions, but in the impulsive character this is by no means the case. Here the ego has remained more or less infantile, and all therapeutic difficulties in these cases arise from this psychological structural difference.

As an initial typical difficulty, we are confronted by deficient or absent awareness of illness. Whereas this awareness is the motivation for the symptom neurotic to seek treatment and prompts him, long before any transference takes place, to open himself to the analyst, the impulsive character is at first totally unaware of his fundamental illness. But even in simple transference neuroses, recognition of the illness initially concerns only disturbing symptoms while neurotic character traits go unnoticed. Nonetheless, the symptoms serve as a welcome point of entry into pathogenic material and the subsequent gaining of expanded awareness is no longer difficult. How different is the case of the impulsive character!

The attitude of such patients is predominantly one of mistrust. Sometimes they cannot be made to speak at all. If, in the first session, one can gain the patient's confidence by taking his side from the outset and under no circumstances assuming the position of antagonist or preaching a sermon, one can soon decide whether the patient's lack of awareness of his illness is indeed profound, as, for example, in cases of pronounced schizophrenia, or whether intense, palpable conflicts have forced him into the situation of maintaining his position against a stronger person by means of hysterical attacks, crying spells, fits of frenzy, and the like. Since the adversary is usually not the more understanding and compliant of the two, but rather assumes the educating attitude of a spouse or father and is generally quite neurotic himself, rationalization of the prevailing conditions has been able to establish itself firmly and it would be a waste of effort to struggle against it. Usually only a change of milieu, i.e., separation from the antagonist, makes analysis possible. This, however, is quite often difficult to effect, especially among the poor.

Awareness of pathological phenomena, whether neurotic symptoms or character traits, can exist only if the ego is allied with a superego which sharply and successfully combats impulsive activity. If, however, the superego conforms to pathological attitudes and has remained isolated, or if the symptom altogether lacks an irrational, absurd character, then there will also be a lack of insight. Accordingly, our patient with the eschatological fantasies was unable to grasp the nature of her attitude toward her mother because her superego had been borrowed from the father and resembled his own. The superego of the genital-masochistic patient had remained isolated from the real ego ("You must die by masturbation") and consequently she also lacked insight into her illness. One even encounters deficient awareness of illness occasionally in patients with circumscribed hysterical symptoms. A patient with hysterical vomiting, closely connected to actual serious conflicts with her sister-in-law, thought it perfectly natural to vomit after being agitated.

Recognition of illness may be acquired in various ways. One typical possibility is for intense

transference to lead to identification with the analyst, in this way transforming an unrecognized drive impulse into a typical compulsive action. As our genital-masochistic patient became conscious of deeply repressed hate feelings toward her mother, realization of her mother's curse ceased during masturbation. The urge to masturbate now emerged as a typical compulsive symptom involving guilt feelings and condemnation as well as anxiety attacks if she attempted to suppress it. In this phase, punitive actions and remarks against the genitals ceased and she began to masturbate with heterosexual coition fantasies and corresponding guilt feelings. The old ego ideal in its new form effected condemnation.

The change of attitude toward the symptom was even clearer in the patient with eschatological fantasies. Because of unfortunate experiences in other similar cases, I had studiously avoided behavior which might in any way remind her of her father or mother. For the moment I refrained from prohibiting and from active interference in her daily life, which would only have strengthened insurmountable, acute ambivalence toward me. I limited myself, without further analysis (which by the way was also impossible), to explaining that all her actions were based on revenge, that she had suffered greatly from her parents, that her older (more beautiful) sister had always been favored, and that she was consequently trying to take revenge by "turning the household upside down." I took the position that she was indeed justified but that she was ruining herself in demanding justice. At first, she developed vigorous defense reactions toward me. Gradually, however, positive transference began to prevail, to the extent that she agreed to try behaving quietly at home. Although she barely managed this, and only with tremendous self-control, the attempt itself could be viewed as progress. After fourteen days she reverted to previous behavior. I now explained that if she did not quiet down, her parents would take her out of analysis (this assumption was justified). Meanwhile, transference had become so strong that she began to fear discontinuation of treatment. Only now did she perceive her sadistic impulses toward her mother as compulsion and suffer from them. She also began to realize the uselessness of her behavior and, of her own accord, correctly related the guilt feelings originally attached to the eschatological fantasies to her sadistic impulses. The situation was now critical as, once her sadistic outpouring toward the external world had been arrested, she began to direct it toward herself and wanted to commit suicide.

This critical turning point appears to be typical in such cases following recognition of the illness. I discovered this in two other cases as well. If recognition of the pathological character of aggressive behavior toward the environment occurs, and is correctly related to active guilt feelings (which are never far removed), suicidal impulses will erupt. Our patient added the following (quoted verbatim): "I understand that appearing insane was my way of trying to gain my parents' attention and respect. I feel so inferior [referring to the rivalry with her older sister from childhood], and if this is taken away, what will I have left?" For a long while she was unable to do without this secondary gain.

The transformation of the ego ideal is effected by analysis of the underlying object relationship. When the original object is devalued, partially through intellectual processing but mainly through the new attachment to the analyst, the dynamic basis of the old superego is removed. Insight into illness

occurs in the following more or less typical phases:

1. No insight. Pathological reactions are in perfect accord with the effective superego, or the isolation of the superego from the ego enables complete submission of the latter to drive-dominated impulses.

2. Increasing positive transference. The analyst is made the object of the patient's libido. This suppresses the old ideal to the object level. Insofar as narcissistic libido was attached to the old ideal, it is now converted into object libido. The new object, the analyst, may function as the basis of a new superego formation, to the extent that he assumes the standpoint of the reality principle and explains that attitudes not understood until now are opposed to reality.

3. Effective recognition of illness (insight). A part of the new, and furthermore thoroughly incestuously assessed, object (the analyst) is introjected, constituting a new ego ideal. The old, complete with its source, is condemned. Only now can actual analysis begin.

In phase 1, such patients immediately transfer their attitudes and aggressions to the analytic situation, but it is especially hate, mistrust, and ambivalence which threaten to make any attempt at analysis an illusion. Mistrust and ambivalence are typical attributes of the compulsion neurotic as well. There, however, they are merely effective in rejection of the analyst, while the patient remains generally accessible to analysis. In the impulsive character they result in actions; the analyst becomes a bitterly despised enemy and serious intentions of murdering him may occur. The female patient last discussed in the section starting on p. 294 had drafted precise plans to waylay me in the street and shoot me; she had even been to a weapon shop to buy a revolver.

When the actions are dictated by a need for love and not by hate, they also manifest all the characteristics of deficient ego ideal. The love is bluntly solicited and the analyst's efforts to remind the patient of the nature of love transference are not understood. It was exceedingly difficult to prevent my nymphomaniac patient from undressing or masturbating during analysis. Another female patient quickly developed the unshakable hope that the analyst would have an affair with her and discontinued treatment after it was clearly explained that this could never be. One patient who demanded point-blank to have homosexual intercourse with me became furious when refused, threw pillows at the wall, thrashed about, and was extremely difficult to quiet. Transference forms of this kind are inconceivable in simple transference neurosis, where the transference becomes conscious only by way of delicate indications, while sensuous desires must either be culled from dreams or are immediately condemned the moment they become fully conscious.

Since such drive-inhibited patients usually have severe, acute conflicts with their parents or parental substitutes, and are generally individuals who have repeatedly suffered grave disappointments, they compulsively attempt to take their conflicts into analysis with them. To the extent that neurotics act out these compulsive repetitions in analysis, one can, within reasonable limits, avoid disappointing them by being more friendly and obliging than they have become accustomed to from their environment. But what is one to do when the patient provokes situations which necessarily precipitate rejection? The nymphomaniac patient, so frequently cited as a typical case, was brilliant at maneuvering me into being strict and would often declare that she did not want

to end our session. Gentle persuasion was useless. Only when she was told she would be removed by force did she leave, crying and frequently screaming that I was too strict, nobody loved her, she was being scolded, and so forth. She experienced this denial masochistically and masturbated with corresponding fantasies. Another patient whom, after many months of concentrated effort, I brought to the realization that she was being unpunctual and disobedient only because she wanted me to strike her, later candidly admitted that she had been conscious of this all along and only wanted to try my patience as she had her father's. She had experienced his beatings as pleasurable.

When criminal impulses exist, strictest prohibition, combined with the threat of discontinuing treatment, must be employed. Generally speaking, one must work with significantly stronger transference than usual if one is to suppress the actions at all. This Scylla stands opposite the Charybdis of fixation, especially in masochistic patients, which one is frequently no longer able to resolve. My experiences until now have shown that one cannot cope with extremely severe cases for this very reason. Only daily discussion of transference, with strong emphasis on the futility of wish fulfillment, can somewhat counteract this.⁶⁹ In milder cases, conversion to phase 3 described above is usually quite successful. One of the greatest difficulties is the inability of patients who have remained infantile to associate in analysis. Either they cannot or will not understand what is required of them.⁷⁰ The abundant acting out also hinders associative efforts. If, however, one occasionally does succeed in enabling them to free-associate, and memory finally begins to function, one encounters a new difficulty as demonstrated in the following example.

After more than a year of analytic effort I had succeeded in making the nymphomaniac patient capable of work. A six-week interruption for a vacation had worked advantageously inasmuch as partial weaning from the doctor took place. Her misbehavior had slackened and recollection of repressed material progressed well for three weeks; the patient recalled incestuous desires from age three and four which had previously been completely barred from memory. Shortly thereafter, her father, eighty years old and senile-demented, arrived in Vienna. The patient grew uneasy, began to feel increased guilt, and fantasized having intercourse with him. As flagrant as this phenomenon was, it is typical to some extent in pronounced impulsive characters: i.e., tabooed desires are not condemned after they become conscious, as is regularly the case in simple transference neurosis, but press for release. The extent to which this happens is dependent upon the degree of ego-ideal consolidation achieved at that point.

Thus, the theoretical maxim would be: In cases of defective ego ideals, ego analysis must precede all else. However, no matter how gratifying and understandable a theoretical maxim obtained in this way may sound, the practical situation is always more complicated. First of all, we do not know, for the moment, what form this so-called ego analysis is to take, and we doubt that it can be separated from the rest of analysis,⁷¹ unless heavy-handed persuasion is used, with no consideration of determinations and association. Without gentle influence and persuasion, such cases are impossible to treat, at least in the beginning. Instructive intervention must first clear the path for actual analysis. Making this introductory phase autonomous, perhaps calling it "psychagogy" and contrasting it to

analysis, would mean falling prey to the grossest misinterpretation and would merely document a basic lack of knowledge of psychic dynamics. One might object that I myself admit that the uncovering of repressed impulses in such cases results in the urge for motor discharge and hence analysis itself is contraindicated. I would also gladly intercede in favor of pure instruction if I was only convinced that it could achieve what analysis cannot. The results produced in asocial individuals by instruction as reported by Aichhorn are extraordinary, but for one thing his asocial individuals are not identical with our impulsive characters, even if they do show numerous similarities. Second, no analyst and not many institutions can afford to have their furnishings wrecked for the purpose of affective relief. Third, anyone who has come into contact with such individuals will admit that they distinguish themselves especially through their inability to yield to persuasion, either temporary or permanent (spite!). Hence I maintain that instructive intervention is always necessary to clear the path for subsequent analysis. The question of how detrimental eruption of impulses can be prevented must be left unanswered, as my experience is not sufficient to answer it satisfactorily. In very general terms one may adhere to the rule that unconscious material must be uncovered slowly and with extreme caution—or even retarded—particularly when schizophrenic mechanisms are involved.

The only conceivable means of counteracting socially dangerous impulsive activity is unfortunately impossible today; by this I mean psychoanalytic institutional treatment. For the moment, mental hospitals, with very few exceptions, are no more than detention institutions for the protection of society where the mentally ill individual is completely overlooked. If one traces the fateful path of those once institutionalized, one will see the following: The patient is first confined due to attempted suicide, is subsequently released, but returns sooner or later. Gradually a strange affinity to the institution is formed. Each time his impulses grow more urgent and dangerous, until finally he either succeeds in committing suicide or is permanently institutionalized as a psychopath or a schizophrenic.

Psychoanalysis has been able to demonstrate how greatly the environment, material need, lack of understanding and brutality on the part of parents, an early childhood full of conflicts, and certainly also predispositions contribute to forming ill and distorted individuals. Mankind protects itself from them by detention, which, in turn, under present conditions, has a negative effect. Should the conscience of mankind someday awaken, and should it also strive to make amends for the damage to the sick caused by so many of its members, then certainly psychoanalysis will be the very first to be called upon to cooperate in the efforts toward liberation from neurotic misery, hopefully under circumstances more favorable than those existing today.

Notes

Foreword

* See “Concerning the Energy of Drives,” pp. 143 ff.

Libidinal Conflicts and Delusions in Ibsen’s *Peer Gynt*

* Presented to the Vienna Psychoanalytic Society, October 1920. Previously unpublished.

* Extracts from *Peer Gynt* throughout this article, except when otherwise noted, are from the translation by Peter Watts (Copyright © 1966 Peter Watts), published by Penguin Books Ltd. Page numbers refer to the 1970 revised Penguin edition.—*Ed.*

* I have taken the liberty of making this translation into English myself as here the Penguin translation was not applicable.—*Trans.*

* Here I have translated directly from the German, as I am not aware of an English translation of this passage.—*Trans.*

1. Schlenther, “Einleitung zur Gesamtausgabe der Werke Ibsens” [Introduction to the Complete Edition of Ibsen’s Works].
2. “Ibsen, Peer Gynt, der grosse Krumme und ich” [Ibsen, Peer Gynt, the Great Boyg, and I] (1918).
3. *Ibsens Traumgestalten* [Ibsen’s Dream Forms].
4. Ibsen, *Nachgelassene Schriften*, II Band, *Peer Gynt* [Posthumous Writings, Vol. II, *Peer Gynt*], from the first act.
5. Shortly before his death Weininger wrote: “I slay myself in order not to have to slay another.”
6. According to a remark made by Federn, the reflection in the lake rushing toward Peer during his plunge from the cliff can be recognized as the visually projected narcissistic libido.
7. I had occasion to analyze a similar delusion (involving loss of consciousness) in a hysterical patient. The unconscious background turned out to be so-called piggy-back riding in childhood.
8. The Old Man of the Dovre promises Peer half his kingdom as his daughter’s dowry, while Peer demands the whole.
9. In the performance of *Peer Gynt* in the Vienna German Folk Theater, this scene is portrayed as a dream of Peer’s. Later on, we shall see just how correct this concept actually is.
10. My colleague Schmiedeberg was correct in drawing attention to the schism in Peer’s love ventures, i.e., the sensual (Ingrid) and the tender (Solveig) components.
11. The fact that Peer is actually *awakened* from his dream by the chiming of bells emphasizes to us that the author intended to have Peer experience these two scenes in dream form also.
12. Note the projection of unconscious desires—as demons—onto the external world (Freud, *Totem und Tabu* [1913]/*Totem and Taboo* [1919]).
13. For further information regarding these three terms, see Freud, “Zur Einführung des Narzissmus” (1914)/“On Narcissism: An Introduction,” *Collected Papers* (1925).
14. Possibly also intimidation by the father.
15. It is well known from Freud’s *Interpretation of Dreams* that waking up is a defense mechanism against strongly repressed unconscious desires.
16. Proof of the lucid insight of the dramatist into the meaning of psychic reality.
17. It is a known fact that efforts toward restitution made by schizophrenics often begin with the recognition that their fellow patients are insane.
18. *Der Mythos von der Geburt des Helden. Versuch einer psychologischen Mythendeutung* (1909)/*The Myth of the Birth of the Hero: A Psychological Interpretation of Mythology* (1914).
19. “Die Nausikaa-episode in der Odyssee” [The Nausicaä Episode in the Odyssey], *Imago* (1920).
20. The first steps in this direction were taken by Oskar Pfister’s “Die Entstehung der künstlerischen Inspiration” in *Zum Kampf um die Psychoanalyse* [The Origins of Artistic Inspiration, in *The Struggle for Psychoanalysis*] (1920).
21. “Der Dichter und das Phantasieren” (1908)/“The Relation of the Poet to Day-dreaming,” *Collected Papers* (1925).
22. It is obvious that this is only an outline of my views. It cannot be more than that and I am well aware of its inadequacies.
23. Only this kind of sublimation comes into question here.
24. I am forced to forgo an inquiry into the personal nature of anagogic interpretation as seen in Eckart’s paper. Although it would be of great theoretical interest and practical importance, even a superficial attempt would take me far beyond my limitations.
25. Freud, *Totem und Tabu* (1913)/*Totem and Taboo* (1919). Theodor Reik, *Probleme der Religionspsychologie* (1919)/*The Psychological Problems of Religion* (1946).
26. To differentiate from the act of writing it down.
27. For the sake of greater clarity, this is to be taken as the inner animation of the content and not as the emotional coloring of the external world.

A Case of Pubertal Breaching of the Incest Taboo

* From the Seminar for Sexology in Vienna, 1920. Published in *Zeitschrift für Sexualwissenschaft*, Vol. 7, 1920.

1. My italics.
2. My italics.

Coition and the Sexes

* From the Seminar for Sexology in Vienna, 1921. Published in *Zeitschrift für Sexualwissenschaft*, Vol. 8, 1922.

* Reich uses “working mothers.”—*Trans.*

1. *Zeitschrift für Sexualwissenschaft* (1921).
2. I must emphasize here that in all matters pertaining to this there can be no question of a value judgment on my part. Only the facts are important.
3. “Beiträge zur Psychologie des Liebeslebens” (1924)/“Contributions to the Psychology of Love,” *Collected Papers* (1925).
4. However, underestimation of women is also seen in the impotent and usually in connection with homosexuality, when women are refused for narcissistic reasons.
5. Children, as well as the male penis, are often perceived as a substitute for the woman’s own penis, which she sorely misses.
6. In neurotic women who have not sufficiently repressed their clitoral sexuality, the desire to have a penis may be awakened instead of the desire to have a child. This results in castration fantasies, often in hysterical activity prior to the orgasm, or, in other cases, in frigidity or vaginismus.

Drive and Libido Concepts from Forel to Jung

* From the Seminar for Sexology in Vienna. Published in *Zeitschrift für Sexualwissenschaft*, Vol. 9, 1922.

* This refers to the German word *Lust*, which must be kept in mind when dealing with the use of the word “pleasure.”—*Trans.*

1. *Die sexuelle Frage* [The Sexual Question] (1904).
2. *Handbuch der Sexualwissenschaften* [Encyclopedia of the Sexual Sciences] (1912).
3. *Das Sexualleben des Kindes* (1908)/*The Sexual Life of the Child* (1912).
4. I cannot at the moment investigate the question of whether other, nonsexual pleasure also exists.
5. This conscious desire, yearning, would be an approximate circumscription of the pre-Freudian libido concept (see Forel).
6. This differentiation, however, is not invariable. Perversion can also arise from unsuccessful repression, for example, the homosexual love of effeminate boys caused by a return of the repressed idea of the mother having a penis.
7. “Über der sado-masochistische Komplex” [On the Sado-Masochistic Complex], *Jahrbuch der Psychoanalyse* (1913).
8. “Beiträge zur Analyse des Sadismus und Masochismus” [Contributions to the Analysis of Sadism and Masochism], *Internationale Zeitschrift für Psychoanalyse* (1913).
9. More correctly, the second object selection, since the mother’s breast and all other pleasure-providing objects of the external world must be viewed as the very first objects, which are subsequently introverted.
10. According to Freud, the scope of a regression is the main influence in generating a certain illness: Hysteria and compulsion neurosis through regression to the stage of the first object selection, and to the stage of sadistic-anal organization respectively; psychosis through regression to the narcissistic-auto-erotic phase.
11. Cf. especially Freud, *Drei Abhandlungen zur Sexualtheorie* (1905)/*Three Contributions to the Theory of Sex* (1910), “Analyse der Phobie eines 5-jährigen Knaben” (1909)/“Analysis of a Phobia in a Five-year-old Boy,” *Collected Papers* (1925); and further: Hermine von Hugh-Hellmuth, *Aus dem Seelenleben des Kindes* (1918)/*A Study of the Mental Life of the Child* (1919); and C. G. Jung, “Über Konflikte der kindlichen Seele” [Conflicts in the Mind of a Child], *Jahrbuch der Psychoanalyse* (1918).
12. Weininger, “Der Jude und das Weib,” in *Geschlecht und Charakter* [“The Jew and the Woman,” in *Sex and Character*].
13. Sigmund Freud, *Triebe und Triebchicksale* (1915)/“Instincts and Their Vicissitudes,” *Collected Papers* (1925).
14. *Die mnemischen Empfindungen* [The Mnemic Sensations] (1909).
15. Similar theories have often been proposed from the biological standpoint: Pfeffer: “The flagella of spermatozoa are attracted by substances secreted by the egg cells.” Nägeli’s theory: The sexual attraction consists of electro-chemically effective forces. (Found in O. Hertwig, *Allgemeine Biologie*.)
16. The nature of the infantile orgasm has not yet been explained.
17. Freud, “Zur Einführung des Narzissmus” (1914)/“On Narcissism: An Introduction,” *Collected Papers* (1925).
18. Freud, *Totem and Tabu* (1913)/*Totem and Taboo* (1919).
19. *Wandlungen und Symbole der Libido. Beiträge zur Entwicklungs-geschichte des Denkens* (1912)/*Symbols of Transformation* (1956).
20. To be explained later.

Concerning Specific Forms of Masturbation

* Published in *Internationale Zeitschrift für Psychoanalyse*, Vol. 8, 1922.

1. Masturbation. A Symposium in the Vienna Psychoanalytic Society, 1912.

2. Sandor Ferenczi, "Technische Schwierigkeiten einer Hysterieanalyse" (1919)/"Technical Difficulties in an Analysis of Hysteria," *Psychoanalytic Review* (1924).
3. During the symposium Hitschmann confirmed the importance of genital eroticism daring to venture forth in the form of masturbation in regard to the treatment of frigidity also.
4. On the advice of the analyst the patient, after some time, moved into another bedroom.
5. The patient's identification with his mother proved a much more important source of his homosexuality, inasmuch as he enjoyed instructing boys in sex and introducing them to sexual practices. (Sadger, *Die Lehre von den Geschlechtsverirrungen (Psychopathia Sexualis) auf psychoanalytischer Grundlage* [The Theory of Sexual Aberrations (Psychopathia Sexualis) on a Psychoanalytic Basis] (1921).
6. The first indicates desire for manhood without repression of genital eroticism and the second with repression. The heart takes on the role of the clitoris (throbbing, beating).

Two Narcissistic Types

- * Published in *Internationale Zeitschrift für Psychoanalyse* in 1922, written partly in response to Franz Alexander's article "Castration Complex and Character," which appeared in the same journal.
1. Important in determining the predominance of localization is, among other things, the libido-development stage in which fixation took place, or rather the stage that was reached in the course of regression.
 2. In his monograph, Alexander called them the inferiority character (melancholy type) and the presumptuous character (hypomanic type).
 3. I must differentiate between this and manifest, normal, non-compensative but rather subliminal narcissism, which achieves genuine extensive satisfaction in the real ego despite frequent considerable tension with the ego ideal.
 4. The special neurotic resistance to treatment by the compensative narcissistic type has already been described by Abraham, "Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische methodik" (1919)/"A Particular Form of Neurotic Resistance against the Psycho-Analytic Method," *Selected Papers* (1927).
 5. —A comment concerning the suggestions made by Hattingberg (at the last convention), that the patient should always be sitting for the purpose of allowing a friendly rapport to arise between patient and analyst. I cannot imagine how Hattingberg can ever achieve true analytic success, that is, the final dissolution of transference, if he forfeits so much distance.

Concerning the Energy of Drives (1923)

- * Published in *Zeitschrift für Sexualwissenschaft*, Vol. 10, 1923.
1. Freud, *Vorlesungen zur Einführung in die Psychoanalyse* (1917)/*Introductory Lectures on Psychoanalysis* (1919); "Das Unbewusste" (1915)/"The Unconscious," *Collected Papers* (1925); "Die Verdrängung" (1915)/"Repression," *Collected Papers* (1925); "Der Begriff des Unbewussten in der Psychoanalyse" [The Concept of the Unconscious in Psychoanalysis].
 2. Freud, *Introductory Lectures on Psychoanalysis*.
 3. Freud, "Zur Einführung des Narzissmus" (1914)/"On Narcissism: An Introduction," *Collected Papers* (1925).
 4. See "Drive and Libido Concepts from Forel to Jung" [above, pp. 86 ff.—Ed.].
 5. *Drei Abhandlungen zur Sexualtheorie* (1905)/*Three Contributions to the Theory of Sex* (1910).
 6. *Über den nervösen Charakter: Grundzüge einer vergleichenden Individual—psychologie und psychotherapie* (1912)/*The Neurotic Constitution: Outlines of a Comparative Individualistic Psychology and Psychotherapy* (1916).
 7. *Die Pubertätsdrüse und ihre Wirkungen* [The Puberty Gland and Its Effects] (1919).
 8. Aschner, *Die Blutdrüsenkrankungen des Weibes* [Endocrine Gland Diseases in Women].
 9. Freud, *Three Contributions to the Theory of Sex*.
 10. Ferenczi, *Hysteric und Pathoneurosen* [Hysteria and Pathoneuroses] (1919).
 11. In this matter it is irrelevant for the psychoanalyst which decision is reached in the controversy between Steinach and his opponents as to whether the nutritive or the generative elements of the testes and ovaries will be found to be of hormonal significance.
 12. *Three Contributions to the Theory of Sex*.
 13. *Zur Psychoanalyse der paralytischen Geistesstörung* (1922)/*Psychoanalysis and the Psychic Disorder of General Paresis* (1925).
 14. Victor Tausk, "Zur Psychologie des alkoholischen Beschäftigungsdelirs" [On the Psychology of Alcohol-Related Delirium] (1915).
 15. Richard Semon, *Die mnemischen Empfindungen* [The Mnemic Sensations] (1909).
 16. *Matter and Memory* (1912).
 17. As compared to Paul F. Schilder, "Die neue Richtung in der Psychopathologie" [The New Direction of Psychopathology], *Monatsschrift für Psychiatrie und Neurologie* (1921).
 18. Following Semon's *Die Mneme* [The Mnema] (1908).
 19. Since the following pertains to the sexual drive alone, only sexual sensations are implied. The question of whether a non-sexual pleasure exists is not discussed here.
 20. *Three Contributions to the Theory of Sex*.

21. Compare to: Messer, *Psychologie* [Psychology]; also Husserl, *Jahrbuch für Philosophic und phänomenologische Forschung* [Yearbook for Philosophy and Phenomenological Research]; Schilder, *Selbstbewusstsein und Persönlich-keitsbewusstsein; eine psychopathologische Studie* [Consciousness of Self and Consciousness of Personality; A Psychopathologic Study] (1914).
22. *Matter and Memory*.
23. *Time and Free Will* (1913).
24. My italics.
25. In a lecture on sexuality and eroticism in childhood (“Sexualität und Erotik im Kindesalter”) held at the Vienna Psychoanalytic Society, Sadger quoted Otto Adler directly as having said that the orgasm in coition was caused by the contraction of muscles. In the discussion which ensued, Freud commented that the orgasm resulted in this muscular contraction and that it is incorrect to view this as constituting the orgasm. He stated further that the muscles were the executive organs, the channels through which the sexual excitation is released. (*Zeitschr. f. ärztl. Psych.* 1913, S. 307.) I can agree only partially with this concept. The orgasmic pleasure sensations are located in the lower pelvic muscles. They may not be confused with the sexual excitation which causes them.
26. Freud, *Jenseits des Lustprinzips* (1920)/*Beyond the Pleasure Principle* (1922).
27. Bergson (*Time and Free Will*) denies the justification of speaking in terms of the quantity of a sensation, since it is only qualitatively determinable. He demonstrates that our feeling, for instance, intense pain, occurs only by our carrying the cause (greater stimulus) into the effect and by our expanded muscle activity simulating the feeling that the sensation is growing more intense. This does not alter in any way the significance of a sensation appearing qualitatively different to us from the objective standpoint, or more intense from a subjective view. (In this context I shall only touch upon the fact that thorough clarification of the difference between extensive and intensive quantity would appreciably limit the field of such knowledgeably critical reflections.) I shall grant him the fact that tickling of the erogenous part of the ear lobe affects only the facial muscles, although a tickling sensation on the glans penis during the orgasmic contractions in coitus involves the entire body musculature, causing the latter pleasure sensation to appear quantitatively far greater than the former. However, in reality, it is a qualitatively different sensation. When such sensations are sought once again, the individual does not hesitate and always prefers those more intense feelings centered in the penis to those on the ear lobe. In view of the unsettled nature of these questions, it is amazing how frivolously certain authors allow the concept of energy a place in the psychic realm, for instance Stärke, in *Psychoanalyse und Psychiatrie* (1921)/“Psychoanalysis and Psychiatry,” *International Journal of Psycho-Analysis* (1921): “I recommend expanding the economic aspect by dividing the concept of libido quantity into a concept of quantity (Helm), capacity (Ostwald), content (Meyerhoffer [mass, entropy, etc.]) and into a concept of intensity (square of velocity, temperature, potential, etc.)” Libido can never be interpreted as an extensive quantity (mass, content).
28. “Das Unbewusste”/“The Unconscious,” *Collected Papers* (1925).
29. However, we must also consider the possibility that phasogenic ecphorization (Semon), i.e., ecphorization without external stimulus, could be partially congruent with the concept of ecphorization through internal stimuli.

On Genitality

* Published in *Internationale Zeitschrift für Psychoanalyse*, Vol. 10, 1924.

1. “Wege der psychoanalytischen Therapie,” *Internationale Zeitschrift für Psychoanalyse* (1919)/“Turnings in the Ways of Psychoanalytic Therapy,” *Collected Papers* (1924).
2. “Über einen Fall weiblicher Homosexualität” (1920)/“The Psychogenesis of a Case of Homosexuality in a Woman,” *Collected Papers* (1924).
3. “‘Ein Kind wird geschlagen.’ Beitrag zur Kenntnis der Entstehung sexueller Perversion” (1919/“‘A Child Is Being Beaten.’ A Contribution to the Study of the Origin of Sexual Perversions,” *Collected Papers* (1924); *Introductory Lectures on Psychoanalysis* (1919); “The Psychogenesis of a Case of Homosexuality in a Woman” (1924).
4. Karl Abraham, “Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische Methodik” (1919)/“A Particular Form of Neurotic Resistance against the Psycho-Analytic Method,” *Selected Papers* (1927).
5. Cf. “Two Narcissistic Types” [above, pp. 133 ff.—*Ed.*]
6. The patient had solved some of these problems by deduction without having to remember the actual experiences.
7. See case 2 in “Concerning Specific Forms of Masturbation” [above, pp. 128 ff.—*Ed.*].
8. The long duration of analysis and the mode of recovery in cases 1 and 2 exclude the possibility of suggestive success. In case 3 it was resistance to further analysis which accelerated solution of the problem.
9. Even when all symptoms have vanished after incomplete analysis, I prefer to speak in terms of freedom of symptoms and not of recovery, as the psychoanalytic concept of recovery is necessarily much stricter than that employed in the usual sense. In the analysis one should only use the term “recovery” when the patient is subjectively and socially rehabilitated, incapable of a relapse (Federn), and when the most extensive release of all libido elements has been effected.
10. Assuming that overpowering guilt feelings due to genital incestuous desires have not gained the upper hand and require further analysis.
11. The fact that some patients take too firm a hold on a certain theme during analysis, manifesting a more active, narcissistic, and exhibitionist drive background, may not be a coincidence and agrees with our concept of the effect of partial drives on the course of treatment. They appear to be saying, “See what I can do”; whereas those unstable patients who take flight are usually passive,

anal characters who view disclosing the unconscious as the giving of a gift, or as castration according to the known pattern.

12. Abraham, "Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische Methodik" (1919)/"A Particular Form of Neurotic Resistance against the Psycho-Analytic Method," *Selected Papers* (1927).
13. Paul Federn, "Beiträge zur Analyse des Sadismus und Masochismus" [Contributions to the Analysis of Sadism and Masochism], *Internationale Zeitschrift für Psychoanalyse* (1913).
14. The antagonistic relationship between narcissism and guilt feelings was discussed in an unpublished lecture by the author at the Vienna Psychoanalytic Society.
15. The passivity of masochistic patients is, of course, entirely different and usually more unruly.
16. Cf. Freud, *Three Contributions to the Theory of Sex* (1910); *Introductory Lectures on Psychoanalysis* (1919); and Ferenczi, *Hysterie und Pathoneurosen* [Hysteria and Pathoneuroses] (1919).
17. See Sandor Feldmann. "Über Erröten. Beiträge zur Psychologie der Scham" (1922)/"On Blushing. Contributions to the Psychology of Bashfulness," *Psychiatric Quarterly* (1941).
18. Cf. "Concerning Specific Forms of Masturbation" [above, pp. 125 ff.—*Ed.*].
19. Presented at a psychoanalytic congress.
20. The man in case 6 who manifested a strong oral-erotic fixation and supposedly longed for intercourse perceived his penis as a breast and the vagina (which in dreams he envisioned as having teeth!) as a mouth to which he was offering his breast. The castration trauma contributed to this. Following the urethral phase, the patient regressed to the oral phase instead of reaching the genital. Jealousy of his siblings, whom he watched being nursed while he himself was not nursed, caused the "oralization" of the genitals. Later he had offered his schoolmates his penis to suck.
21. See also "Concerning the Energy of Drives" [above, pp. 143 ff.—*Ed.*].
22. Cf. also Ludwig Jekels, "Einige Bemerkungen zur Trieblehre" [Some Remarks on the Drive Theory], *Internationale Zeitschrift für Psychoanalyse* (1913).
23. This, of course, does not imply the physiological, endocrine aspects of genitality. It can only be a case of the psychic representation. Or, to express it in non-dualistic terms: because of psychic inhibition, increase of stimulation caused by endocrine secretions was unable to form a psychic representation. One question remains unanswered. Let us assume that due to psychic inhibition, the biological process of "phasogenic ephorization" (Semon), i.e., the activation of a mnemonically determined function, in case 6 the activation of genital libido in ontogenesis, can be prevented. If this is true, can analysis effect the first ephorization of the mnemonic function? Can analysis awaken mnemonic drive impulses whose effects were not experienced in personal development?

Psychogenic Tic as a Masturbation Equivalent

* A case from the Vienna Psychoanalytic Outpatient Clinic. Published in *Zeitschrift für Sexualwissenschaft*, Vol. 11, 1925.

1. A Viennese neurological clinic.
2. Ferenczi, "Psychoanalytische Betrachtungen über den Tic"/"Psycho-Analytic Observations on Tic," *International Journal of Psycho-Analysis* (1921).
3. "Der Tic, sein Wesen und seine Behandlung" [The Tic, Its Nature and Treatment].
4. Ferenczi, *Hysterie und Pathoneurosen* [Hysteria and Pathoneuroses] (1919).

Further Remarks on the Therapeutic Significance of Genital Libido

* From a lecture at the Eighth International Psychoanalytic Convention, Salzburg, April 1924. Published in *Internationale Zeitschrift für Psychoanalyse*, Vol. 11, 1925.

† See above, pp. 158 ff.—*Ed.*

1. I do not include here the cases where, after one unsuccessful attempt at intercourse, the patient rushes to the doctor and, after an enlightening suggestion, shows no further disturbances.
2. See "The Impulsive Character" [below, pp. 237 ff.—*Ed.*] and "A Hysterical Psychosis in *Statu Nascendi*" [below, pp. 222 ff.—*Ed.*].
3. In regard to this, see my comments in "The Impulsive Character."

A Hysterical Psychosis in Statu Nascendi

* Published in *Internationale Zeitschrift für Psychoanalyse*, Vol. 11, 1925.

* "It is now so difficult for me to think except in French. And yet, before, French was always a great strain and a great sorrow."—*Trans.*

† Treatment with electric currents.—*Ed.*

* The polite form of address in German, normally not used within the family.—*Trans.*

1. Cf. Karl Abraham, "Disposition zu traumatischen Erlebnissen" [Disposition to Traumatic Experiences], in *Klinische Beiträge zur Psychoanalyse* [Clinical Contributions to Psychoanalysis] (1921).
2. In her verbal and written report of the dream she used "white, white doves." The patient interpreted the white doves as a symbol of

chastity (her mother's demand). A deeper meaning seemed obvious. The apparently senseless repetition of the adjective is actually meant to express the number two and thus only the breasts can be implied.

3. *Versuch einer Entwicklungsgeschichte der Libido auf Grund der Psychoanalyse seelischer Störungen* (1924)/*A Short Study of the Development of the Libido* (1927).
4. Also in a snow-covered area! Is this frequency coincidental or is it a typical suicide fantasy?
5. Cf. "The Impulsive Character" [below, pp. 237 ff.—*Ed.*].
6. *Entwicklungsziele der Psychoanalyse; zur Wechselbeziehung von Theorie und Praxis* (1924)/*The Development of Psychoanalysis* (1925).
7. Freud, "Weitere Ratschläge zur Technik," *Internationale Zeitschrift für Psychoanalyse* (1913–15)/"Further Recommendations in the Technique of Psychoanalysis," *Collected Papers* (1924).
8. *Das Trauma der Geburt und seine Bedeutung für die Psychoanalyse* (1924)/*The Trauma of Birth and Its Importance for Psychoanalytic Therapy* (1929).

The Impulsive Character

* Published as *Der triebhafte Charakter* (Copyright 1925 by Internationaler Psychoanalytischer Verlag, Vienna).

* A Vienna mental institution.—*Trans.*

1. See *Zur Geschichte der psychoanalytischen Bewegung* (1914)/"The History of the Psychoanalytic Movement," *Psychoanalytic Review* (1916).
2. In the meantime, a thoroughly informative work has appeared in which character analysis is actually considered necessary. See Karl Abraham, *Psycho-analytic Studies on Character Development* (1925).
3. *Entwicklungsziele der Psychoanalyse* (1923)/*The Development of Psychoanalysis* (1925).
4. "Charakter und Analerotik" (1908)/"Character and Anal Eroticism," *Collected Papers* (1924).
5. "Anal Erotic Character Traits," *Journal of Abnormal Psychology* (1918).
6. "Contributions to the Theory of the Anal Character," *International Journal of Psycho-Analysis* (1923).
7. Freud, *Beyond the Pleasure Principle* (1922).
8. Freud already mentioned in *Three Essays on the Theory of Sexuality*: "It cannot be a matter of indifference whether a certain tendency emerges sooner or later than its countertendency ... any temporal discrepancy in the formation of the components regularly causes a change in the result." Thus it is now important to find typical deviations from the normal temporal course of development and to correlate them with certain pathological results.
9. "Kastrationskomplex und Charakter: eine Untersuchung über passagere Symptome" [Castration Complex and Character; An Examination of Passing Symptoms], *Internationale Zeitschrift für Psychoanalyse* (1922).
10. "Über die Erziehung in Besserungsanstalten" [Education in Reform Schools], *Imago* (1923).
11. *Klinische Psychiatrie* (1916)/*Lectures on Clinical Psychiatry* (1916).
12. *Lehrbuch der Psychiatrie* (1916)/*Textbook of Psychiatry* (1923).
13. *Die Beurteilung psychopathischer Konstitution* [Evaluation of Psychopathic Constitution] (1912).
14. *Die psychopathischen Persönlichkeiten* [Psychopathic Personalities] (1923).
15. *Die Psychosen bei psychopathischen Minderwertigen* [Psychoses in Psychopathic Inferiority] (1898).
16. *Über psychopathischen Persönlichkeiten* [On Psychopathic Personalities] (1909).
17. *Über den Begriff der psychopathischen Konstitution* [On the Concept of Psychopathic Constitution] (1917).
18. *Die abnorme Charakteranlage* [The Abnormal Character Structure] (1912).
19. I should like to take this occasion to express my sincere appreciation to Professor Wagner-Jauregg for allowing me to study the copious material at the clinic.
20. "Über Depersonalisationszustände im Lichte der Libidotheorie" (1924)/"States of Depersonalization in the Light of the Libido Theory" in *Practice and Theory of Psychoanalysis* (1961).
21. S. Kretschmer, *Der sensitive Beziehungswahn* [The Reference Delusion] (1918).
22. *Körperbau und Charakter* (1921)/*Physique and Character* (1925).
23. "Syntonie—Schizoidie—Schizophrenie" [Syntonia—Schizoidia—Schizophrenia], *Zeitschrift für die gesamte Neurologie und Psychiatrie* (1923).
24. See "A Hysterical Psychosis in *Statu Nascendi*" [above, pp. 222 ff.—*Ed.*].
25. "Das ökonomische Problem des Masochismus" (1924)/"The Economic Problem of Masochism," *Collected Papers* (1924).
26. Rank, *Das Trauma der Geburt und seine Bedeutung für die Psychoanalyse* (1924)/*The Trauma of Birth and Its Importance for Psychoanalytic Therapy* (1929); and the excellent essay by Dorothy Garley, "Über der Schok des Geborenwerdens und seine möglichen Nachwirkungen" [Concerning the Shock of Being Born and Its Possible Consequences], *Internationale Zeitschrift für Psychoanalyse* (1924).
27. In a private discussion the question was once raised whether such positive ego-ideal demands exist from the very beginning. I admit the possibility of all later "thou shalt" ideals developing from prohibitions from complicated channels.
28. "On the Genesis of the Castration Complex in Women," *International Journal of Psycho-Analysis* (1924).
29. "Einige Bemerkungen zur Trieblehre" [Some Remarks on the Drive Theory], *Internationale Zeitschrift für Psychoanalyse* (1913).
30. *Versuch einer Genitaltheorie* [Toward a Genital Theory] (1924).

31. H. Deutsch has informed me that she arrived at the same conclusions using a different approach. *Zur Psychoanalyse der weiblichen Sexualfunktionen* [The Psychology of the Female Sexual Functions] (1926).
32. *Das Wesen der Geschlechtlichkeit* [The Nature of Sexuality] (1919).
33. This must be qualified inasmuch as erogenous dispositions can be intensified by suitable behavior on the part of the nurturing persons. Thus an unusually long nursing period will strengthen the oral position and an anal milieu the anal position.
34. *Die Lehre von den Geschlechtsverirrungen (Psychopathia Sexualis) auf psychoanalytischer Grundlage* [The Theory of Sexual Aberrations (Psychopathia Sexualis) on a Psychoanalytic Basis] (1921).
35. "Über eine besondere Form des neurotischen Widerstandes gegen die psychoanalytische Methodik (1919)" "A Particular Form of Neurotic Resistance against the Psycho-Analytic Method," *Selected Papers* (1927).
36. See "Two Narcissistic Types" [above, pp. 133 ff—Ed.].
37. Karl Abraham, *Versuch einer Entwicklungsgeschichte der Libido auf Grund der Psychoanalyse seelischer Störungen* (1924)/*A Short Study of the Development of the Libido* (1927).
38. A peculiar result of this conflict is described by Freud in "Über einen Fall weiblicher Homosexualität" (1920) "The Psychogenesis of a Case of Homosexuality in a Woman," *Collected Papers* (1924). A girl turns away from her father and becomes the wife of a masculine woman. The particular preconditions for the solution to this problem remain unknown (austere mother—mild father?).
39. "Ein hysterisches Symptom bei einem zweieinvierteljährigen Kinde," *Imago* (1923) "An Hysterical Symptom in a Child of Two Years and Three Months," *International Journal of Psycho-Analysis* (1926).
40. "Entstehung des 'Beeinflussungsapparates' in der Schizophrenie," *Internationale Zeitschrift für Psychoanalyse* (1919) "On the Origin of the 'Influencing Machine' in Schizophrenia," *Psychoanalytic Quarterly* (1933).
41. "Über den katatonischen Anfall," *Internationale Zeitschrift für psychoanalyse* (1920) "On the Catatonic Attack," *Practice and Theory of Psychoanalysis* (1948).
42. "Formulierungen über zwei Prinzipien die psychischen Geschehens" (1911) "Formulations Regarding the Two Principles in Mental Functioning," *Collected Papers* (1925).
43. *Die Ambivalenz des Kindes* [The Ambivalence of Children] (1924).
44. See "On Genitality," case 6 [above, pp. 170 ff—Ed.].
45. Rousseau speaks of "the witless moods ascribed to nature herself, and planted merely by education," in his *Confessions*.
46. I should like to draw attention to the peculiar positioning of the fan. It is entirely reminiscent of the position of the amniotic membrane. I shall refrain from every attempt at interpretation, but I want to mention that as far as I could discover, the patient had never seen a diagram of the fetal position, and that this fantasy had been present from earliest childhood.
47. The fantasy of vaginas filled with feces.
48. "Dementia Praecox oder Gruppe der Schizophrenien," *Handbuch der Psychiatrie* (1911)/*Dementia Praecox, or the Group of Schizophrenias* (1950).
49. *Klinische Psychiatrie* (1916)/*Lectures on Clinical Psychiatry* (1916).
50. *Psychopathologie* (1920)/*General Psychopathology* (1963).
51. *Seele und Leben. Grundsätzliches zur Psychologie der Schizophrenie und Paraphrenie, zur Psychoanalyse und zur Psychologie überhaupt* [Mind and Life. Fundamental Considerations on the Psychology of Schizophrenia and Paraphrenia, on Psychoanalysis and on Psychology in General] (1923).
52. "Ein Beitrag zur Lehre von den reaktiven Psychosen" [A Contribution to the Theory of Reactive Psychoses], *Monatsschrift für Psychiatrische und Neurologie* (1925).
53. *Körperbau und Charakter. Untersuchungen zum Konstitutionsproblem und zur Lehre von den Temperamenten* (1921)/*Physique and Character: an Investigation of the Nature of Constitution and of the Theory of Temperament* (1925).
54. The question of schizophrenic etiology was classically systematized in an article by Wilmanns ("Die Schizophrenie"). In this he gave due credit to the psychoanalytic standpoint. He also compiled a complete bibliography on the subject.
Al. ases of impulsive characters with strong dyssocial admixture which I explored, or simply observed, share one trait in common, namely, that uninhibited actions were present from earliest childhood. Gerstmann and Kauders ("Über psychopathieähnliche Zustandsbilder bei Jugendlichen" [On the Quasi-Psychopathic Frame of Mind in Youth], 1924) have now published interesting case histories of individuals who likewise developed an asocial impulsive nature, as well as hyperkinesia, under postencephalitic conditions. Analysis must not overlook such possibilities. However, the cases cited have not been thoroughly examined in regard to the patient's pre-encephalitic personality, and in particular, there is no mention of the libido transformations. We may draw no further conclusions, but it should be mentioned that the problem of the extent to which brain disease is responsible for psychogenic processes has been repeatedly discussed, especially by Schilder. It is as absurd to maintain that a disease of the diencephalon "creates" dyssocial tendencies, as to say that delusions are "produced" by brain damage in general paresis. Occasionally a somatic process does happen to interrupt the purely psychic sequence. ("Cortex-Stammganglien: Psyche-Neurose" [Cortex-basal ganglia: Psyche-neurosis], 1922, and "Über den Wirkungswert psychischer Erlebnisse und über die Vielheit der Quellgebiete der psychischen Energie" [Concerning the Effective Value of Psychic Experiences and Concerning the Multiplicity of Sources of Psychic Energy], 1923.)
55. "Zur Psychologie des Misstrauens" [The Psychology of Mistrust], *Imago* (1921).
56. In the exposition of Sachs: Hanns Sachs, *Zur Genese der Perversionen* [On the Genesis of Perversions] (1923). "If [in perversion] repression is nonetheless to be even partially successful, it must compromise by allowing one partial complex to remain pleasurable and to be assimilated, or, so to speak, sanctioned, by the ego..." I shall leave the question unanswered as to whether or

not this ego sanction, or rather the avoidance of displeasure in perversion, presupposes an ego structure similar to that in the impulsive character.

57. My italics.

58. My italics.

59. In cases of ascetic-religious compulsive neurotics we may speak in terms of conscious acceptance of superego demands, though it need not be emphasized that this is also based on a deeper, unconscious acceptance.

60. These facts only seemingly contradict those described in the section beginning on p. 243, namely, that the impulsive character manifests repression equally intense as the drive-inhibited neurotic. These clinical facts correspond completely to the isolated position of the ego ideal inasmuch as it is hindered in accomplishing repression but not rendered entirely ineffective. Furthermore, there is the possibility that only a part of the ego ideal experienced the fate of being isolated.

61. Sandor Ferenczi, "Entwicklungsstufen des Wirklichkeitssinnes," *Internationale Zeitschrift für Psychoanalyse* (1913)/"Stages in the Development of the Sense of Reality," *An Outline of Psychoanalysis*, ed. J. S. van Teslar (1923).

62. I am not forgetting that direct identifications exist in the ego. It may well be highly significant for personality structure whether basic identifications took place in the ego or in the superego (cf. my exposition regarding defective sexual identification.)

63. Cf. the section starting on p. 254.

64. Cf. "Further Remarks on the Therapeutic Significance of Genital Libido" [above, pp. 199 ff.—*Ed.*].

65. "Psychoanalytische Bemerkungen über einen autobiographisch beschriebenen Fall von Paranoia (Dementia paranoides)" (1911)/"Psychoanalytische Notes on an Autobiographical Account of a Case of Paranoia (Dementia paranoides)," *Collected Papers* (1925); "Über einige neurotische Mechanismen bei Eifersucht, Paranoia und Homosexualität" (1922)/"Certain Neurotic Mechanisms in Jealousy, Paranoia, and Homosexuality," *International Journal of Psycho-Analysis* (1923).

66. After completion of this manuscript, an article by J. H. Van der Hoop appeared: "Über die Projektion und ihre Inhalte" [On Projection and Its Contents], *Internationale Zeitschrift für Psychoanalyse* (1924). Although the author takes a different approach in his examination of the nature of projection, he arrives at conclusions similar to mine: "Psychologically, schizophrenia must be viewed as an intense state of introversion in which ever-increasing regression to an infantile-archaic development phase takes place. This is characterized by a very slight or even nonexistent separation of subject and object which causes projection to exert extremely strong influence on the external phenomena." However, intense introversion is not ample explanation since, in itself, it is merely a resulting phenomenon of fixation at this phase.

67. To avoid any misunderstanding of my intentionally selected term "first identification," I must call to mind that I differentiate (with Freud) between two phases of identification: (1) according to *Group Psychology and the Analysis of the Ego* the identification prior to all object selection ("narcissistic identification"), and (2) identification following the object stage and resulting in final ego-ideal formation by object relinquishment or by object incorporation as a superego (*The Ego and the Id*). Freud's exposition in *The Ego and the Id* contradicts that in *Group Psychology* inasmuch as narcissistic identification is assumed in the latter to be a stage preliminary to object selection, whereas, in the former, identification is preceded by object cathexis. This is only a seeming contradiction, however, as pre- and post-object-libidinal identifications are easily combined. Freud, *Group Psychology*: "Identification is the earliest and most archetypal form of emotional attachment"; and in *The Ego and the Id*: "However, object selection in the first sexual period, which pertains to mother and father, appears to result in a normal course of development in such identifications, thereby intensifying primary identification."

68. Recently a greatly appreciated attempt to explain the theoretical preconditions for influencing schizophrenia was undertaken by Wälder, "Über Mechanismen und Beeinflussungsmöglichkeiten der Psychosen," *Internationale Zeitschrift für Psychoanalyse* (1924)/"The Psychoses: Their Mechanisms and Accessibility to Influence," *International Journal of Psycho-Analysis* (1925).

69. Due to incomplete results, it is not yet possible to report on current experiments in solving this intense masochistic fixation through systematic interruption of treatment ("weaning from the analyst").

70. The manner in which some impulsive individuals who are also intellectually defective lose their debility once the unification of the ego has been successfully accomplished gives rise to the assumption that intellectual defects are also psychically based.

71. The theoretical elements of ego analysis (for example, analysis of identifications, particularly those of the superego, analysis of narcissism, etc.) are easily grasped empirically, but in practice cannot be separated from the analysis of libido transference. Above all, libido transference is also the vehicle of ego analysis.

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