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The Impulsive Character (Part Three)*

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CHAPTER FOUR

Ambivalence and Ego Formation in the Impulsive Character

No matter how fruitfully psychoanalytic research delves into childhood experiences of the third to sixth years of life, we cannot deny that we lack the basic ingredients for fully grasping how the psyche unfolds. This is because in analyzing adults we can rarely go deeper than the third year of life. Earlier memories do appear from time to time, but they are so vague, so sparsely connected to the organic whole, that we dare not build upon them any safe conclusions. However, this we may safely assume for the present: What happens to a person in the first two years of life is more decisive than what happens later on. The child enters the highly critical oedipal phase with attitudes preformed, at least in broad outline, if not in their final detail. The Oedipus complex may be likened to a lens through which the rays of the impulses are refracted. They give this phase its special imprint and undergo far-reaching modifications through the experiences of this phase. Anna Freud's case of an hysterical symptom in a child of two and one-quarter years shows how obscure this realm still is.[1]

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*Translated by Barbara Goldenberg Koopman, M.D., from *Der triebhafte Charakter,* Int. Pschoanal. Verlag, 1925. Parts I and II appeared in Volume 4, Nos. 1 and 2 of this journal, with introductory editorial comment by the translator.

[1] "Ein hysterisches Symptom bei einem zweieinvierteljahrigen Kinde," *Imago,* Bd. IX, 1923.

The difficulties in methodology seem insurmountable. So far, we have some reports of recent direct observations of children, but they deal only with children after the second year of life. We lack analytically-trained child and infant nurses.

Another, indirect way to fathom the earliest phases of development is clinical research into certain forms of schizophrenia and melancholia, whose fixation points we believe lie in those early, postembryonal states. There are schizophrenics who show attitudes and mechanisms really corresponding to those of the infant or one-year-old child and, indeed, even to those of the embryonal state itself. Tausk's[2] case teaches us a great deal about effacement of the boundary between ego and outside world; Nunberg's[3] case is highly instructive vis-à-vis the most primitive sexual conflicts. Since certain forms of schizophrenia show partial or complete effacement of ego boundaries, along with definite infantile characteristics, it is not merely speculative for psychoanalysis to assume that the child's ego initially and gradually frees itself from chaos, that the ego boundary develops slowly, and that in this primordial phase of ego-unfolding the basis for ego maldevelopment is laid.

A pure impulse or pleasure ego confronts the stimuli of the surround, "identifies" with them insofar as they are pleasurable, and rejects them if they are unpleasurable, even if they stem from the impulse ego itself. The primordial pleasure ego has broader boundaries than the later real ego insofar as it deals with pleasure experiences (Freud),[4] and narrower boundaries insofar as it deals with unpleasure. Pleasure objects of the outside world are perceived as part of one's own ego; since the mother's breast is the central object of this first phase, we feel we may now comprehend the driving force behind the sending out of object libido from the narcissistic reservoir: The maternal breast must finally be recognized as belonging to the outside world; it must be shifted from the ego and drawn to the libidinal attitude attached to it. Thus, for the first time, narcissistic libido is transformed into object libido. The first objects are not total persons from the environment, but the organs of such persons insofar as they are pleasurable. During analysis, the object gradually dissociates into its component organs: For example, with regard to the mother, the breast especially stands out.

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[2]"Enstehung des Beeinflussungsapparates in der Schizophrenie," *Int. Ztschr. f. PsA.,* Bd. V, 1919.

[3]"Über den katatonen Anfall," *Int. Ztschr. f. PsA.,* Bd. VI, 1920.

[4]"Formulierungen über zwei Prinzipien des psychischen Geschehens," *Ges. Schriften,* Bd. V, 1911.

Just as, in retrograde analysis, the tender libido leads back ultimately to a pure organ libido, so the infantile organ libido settles progressively into sublimated forms of tender libido. From the mother's breast, the libido extends to the dispenser of food, love, and relaxation; that is, to the mother.

The Effects of Upbringing

However, right in the very first phase of this important process, denial comes into play: The mother's breast is taken away. Gratification and denial oppose each other at every step of development; indeed, further development from stage to stage comes about only through denial. But in the juxtaposition of impulse gratification and denial we discern, with Graber, the ontogenetic root of ambivalence. The child loves the impulse gratifier and hates the impulse denier. Whenever hatred is older than love, as Stekel and Freud have pointed out, the reason for this is unpleasure at birth. This unpleasure is then forgotten, thanks to the effects of organ pleasure, and reappears in the form of birth anxiety or a wish to return to the womb, as Rank has observed, whenever the impulse denials turn out to be overly severe from the very beginning.

Thus ambivalence is natural and necessary to psychic development. Since everyone has experiences that engender ambivalence, we must ask ourselves—what is the added factor that makes ambivalence pathogenic? It depends on the following: the form and intensity of the denial; the stage of impulse gratification at which it was introduced; and the attitude of the child toward his nurturer at the moment in question. There are four main possibilities:

1. Partial impulse gratification plus partial, gradual denial, and through this, gradual repression. This situation represents the optimum developmental approach. In the state of partial impulse gratification, the child learns to love the nurturer and then takes the denial "for the sake of" this person. We strive to achieve this optimum even in the analytic situation. The impulse satisfaction must be partial from the very beginning. For example, the infant must at the outset get used to feeding at certain hours.[5] Denial must become increasingly strong without, however, leading to total impulse restraint. In this way, the impulse to be repressed can be sublimated or replaced by another partial impulse.

[5]*Editorial note:* Reich subsequently repudiated this approach to infant feeding in favor of self-regulation.

2. The impulse denial does not occur gradually, but proceeds full force, at every phase, right from the start. This is tantamount to total impulse inhibition, such as one sees in some cases of abulia. This is how in many cases—for example, bottle feeding or total repression of genital masturbation—the capacity to love is inhibited.[6] If the impulsive tendency is strong, the ambivalence conflict is biased in favor of hatred. This is true of many impulse-restrained compulsive neurotics.

3. Impulse denial is totally or virtually absent at the time of earliest development, owing to the fact that the child grows up without supervision. This can only result in uninhibited impulsivity. Since, sooner or later, the reactions of their expanding environment come into play, severe conflicts must of necessity arise. The first two possibilities we can verify analytically; the third we postulate in this extreme form. However, we are convinced that analytic investigation of criminals, prostitutes, etc., will bring such facts to light.

4. As to the fourth possibility, we see, finally, the typical configuration of the impulsive character, according to my experience. In part it dovetails with the third possibility. In the analysis of impulsive characters, we find with surprising regularity that an inordinate, unbridled impulse gratification was often met with a belated ruthless, traumatic frustration.

Thus, for example, one such patient of mine was raped by her father, yet beaten senseless if she had anything to do with playmates on the street. Another patient grew up entirely unsupervised, indulged in genital games at age three (perhaps even earlier), yet was brutally beaten by her mother who chanced to catch her at it. It commonly happens, for example, that children are strongly restricted in certain matters, but left entirely to themselves the rest of the time. Thus the father of a patient of mine insisted upon the children's eating everything, but ignored their masturbating and playing with dirt. Often, too, children undergo minimal supervision and consequently develop poor impulse repression. Then, one day, the whole thing becomes too much for the parents who now, suddenly—without warning and with great vehemence—"sing a different tune." We shall spare ourselves the listing of further possibilities. Every insightful educator will have more to say on the subject. Inconsistent upbringing, *i.e.,* faulty impulse denial focussed on a single detail, on the one hand, or sudden and belated inhibition, on the other—such is the common denominator in the genesis of the impulsive character.

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[6]Case 6, Reich: "Über Genitalität," *Int. Ztschr. f. PsA.,* Bd. X, 1924.

Conflict, born of ambivalence, here takes on quite characteristic forms. Constant hate and fear for the nurturer may predominate, together with unrestrained impulsivity, occasionally reinforced by stubbornness. Or, equally often, an intense, unsatisfied longing for love is opposed by a hatred of the same intensity. Varying factors determine whether the result of such a development takes a sadistic or masochistic form.The incapacity for love is always gross here and much more outspoken than in simple symptom neurosis. Allied to this is a strong craving for love.

In contrast to the ambivalence of the compulsive, there is the distinct difference that reaction formation is lacking, and sadistic impulses are more or less fully lived out. In the typical compulsion neurosis, the ambivalence is displaced, in a seemingly senseless way, to details and to a lack of concern. Occasionally, an impulsive will show such displacement, but, typically, the ambivalent relationship to the original objects or their corresponding substitutes remains persistently evident. In the impulsive character, the damage done by the nurturer's attitude is clearly manifest; in simple neurotics, such damage does occur occasionally, but, in most cases, this type of damage is not present or at least not more pronounced than in people who have remained healthy. The infantile experience of impulsive characters is riddled with severe traumas; symptom neurotics suffer none at all or, occasionally, only one. Typical experiences, such as healthy people undergo, like castration threats or primal scene, take on especially blatant forms in the impulsive character. This may be because the latter has suffered extreme cruelty for trivial offenses, experienced multiple seductions at the hands of the nurturers, or grew up in a sadistic environment. There are all gradations, ranging from the cultured person's unhappy marriage to the drunkard's brutal marital excesses. It is precisely this type of case which supports Freud's assumption that neurosis and pathological character formations are largely learned.[7] Clearly, an environment marked by scanty impulse control makes for poor ego ideal formation in the child; on the other hand, it allows the impulse frustration to be more brutal than necessary. Hence the typically acute and outspoken ambivalence of the impulsive, who could rightly say that he was not taught any differently. The unfeeling attitude of the nurturer is then reflected in the child's unfeeling attitude toward the environment. It would be quite incorrect to speak here of an absence of ego ideals. The impulse-negating ego ideal has been formed and is present, yet the impulse-

[7] "These crazy moods, attributed to nature, yet planted only by education . . ." writes Rousseau in his *Confessions* (*Ausgew. Werke,* Cotta, Bd. I, S. 51).

affirmative superego has also been acquired at the same time. If this were not the case, unbridled impulsivity without neurotic constructs would result, as occurs in many psychopaths who lack such structures. The omnipresent feeling of guilt, especially in the masochistic forms of the impulsive character, points to a strong position of the ego ideal; the strength of the ego ideal position must be paralyzed momentarily if the impulsivity is to be effectively unleashed in defiance of it. This pathogenic superego formation appears in all impulsive characters; it is mainly conditioned by outside forces and countered by an inner force. At the same time, a constitutional factor figures here: an abnormally early sexual readiness, which can regularly be documented, *i.e.,* an overly strong emphasis on all erogenous zones. I would emphasize that the genitality of such patients reaches full development at an abnormally early age. In healthy individuals and mild neurotics, sexual activity in early childhood is the rule; the genital phase seems to peak regularly around the fourth or fifth year of life. Often the genital phase unfolds in a situation of fully repressed impulsivity: Sexual and incest wishes never enter consciousness with full, sensual impact, but retain their full strength in the unconscious.

By contrast, impulsives have lived out their sexuality not only very early but also with fully conscious incest wishes. In this state of affairs, one libidinal phase does not free up another, as in symptom neurotics; instead, the partial impulses stay more or less juxtaposed and of equal weight. These are the patients who have a characteristic history of polymorphous perverse child's play. Owing to lack of supervision, such patients see and grasp far more of adult sexual life than do the simple neurotics. The latency period is activated minimally or not at all. If we consider the importance of the latency period in human ego development vis-à-vis sublimations and reaction formation, we can gauge the damage done here.[8] Puberty is ushered in with extreme breakthroughs of the sexual drive. Neither masturbation nor intercourse, which are taken up at a very early age, can afford relief, for the whole libidinal organization is torn apart by disappointment and guilt feelings.

The following case is very instructive in this regard. It illustrates such mechanisms as feelings of guilt, as well as the polymorphous perverse libidinal structure found in other types of impulsive characters, also. The latter I shall discuss in connection with a subsequent section on "isolation of the superego."

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[8]*Editorial note*: Reich subsequently changed his views on latency: If the oedipal conflict is decathected in childhood through *peer*-related sexual activity, there is no need for sexual repression in the so-called latency period.—BGK

The Question of "Borderline Cases"

We are dealing here with a compulsion neurosis, but the diagnosis of schizophrenia is very much in the forefront.

A nineteen-year-old patient sought analysis because of a tormenting idea which always appeared whenever she thought she had done something bad: The world ends; it is totally annihilated. Whenever she was supposed to work, she compulsively thought, "Why should I do all this if the world is going to end tomorrow anyway?" The next day she would be utterly amazed that the world was not yet destroyed. Along with this there was no trace of manifest anxiety. Instead, feelings of great sadness and desolation accompanied the fantasy of world disaster: "Everything is dead, extinct; I often marvel that people are still moving around." These states of depersonalization were always connected with the world extinction fantasy, but they also appeared on other occasions several times a day.

At first she did not experience the end-of-the-world fantasy as an illness. In the beginning, she maintained very firmly that she believed in the possibility of world annihilation. Sometimes the patient would look lost, interrupt her speech, and stare absentmindedly; sometimes her speech was circumstantial. The first impression was that of dementia praecox. The parents' observation that for days she was lost in dreams and unwilling to work bears this out.

Before continuing this history, we should like to mention that her older and prettier sister was well-adjusted and showed no neurotic manifestations, as far as was known. The father was a functioning and capable individual, with a violent temper—irascible, domineering, intelligent. The mother was reportedly healthy, but a person with somewhat limited spiritual horizons.

The typically schizoid traits described above stood in sharp contrast to the patient's disposition, which bespoke an intense relationship to the outside world, especially towards the parents and sister; a relationship marked by stubbornness and spite. The patient felt extremely inferior and was unable to do anything, even though she was supposedly able to do everything. She would have liked to have learned every trade, understood mathematics, and grasped the construction of a machine, and she saw inability as "an oppression of the woman by the man." Whenever she saw a girl learning to ride a bicycle on the street, she had the compulsive thought that a man must be more adept, and she saw the learner's inability as an oppression. The inferiority feeling was very closely tied to conscious, self-tormenting tendencies. For example: She

learned how to cook and felt inferior; very often she did everything wrong consciously and deliberately, and her biggest delight was being scolded by her mother. She herself admitted that she did many things wrong in order to anger people and get reprimanded. She learned how to sew and purposely miscut material so that it had to be thrown out. In analysis, she was stubborn and unbudgeable, and after a few sessions asked why she didn't get thrown out. The world destruction fantasy always went hand in hand with the self-torment. But she even tormented others, especially her mother. She would purposely trip her to make her "fall and break her neck." She delighted in inventing cruel fantasies with both masochistic and sadistic goals. An example of the former: A sword is thrust up her vagina until it pierces the top of her head. Or she is made to walk barefoot and bleeding on a board spiked with nails.

The first fantasy related to her gonorrhea, which she pinpointed accurately as having occurred in her fourth year of life and which she presumably caught from a governess. She also dated the onset of her "craziness" from age four. For six years, she underwent special treatment, and the sword fantasy has a real basis in the pain she endured from dilatation of the cervix.

The second fantasy related to masturbation, which she had practiced continually since early childhood. It appeared at age four when her father yelled castration threats at her, tied her hands up all night, and inflicted other similar excesses.

Her sadistic fantasies can all be derived from the masochistic ones. Thus she told her mother: "Take a board, spike it with nails, and bash father's skull"; or, "Climb up on the window and throw yourself out. Meanwhile, if I happen to be eating, I shan't hinder you. I'll calmly finish eating and then go into the yard to have a look at your broken body." She perceived these outbursts as neither sick nor objectionable. She spoke them calmly without spontaneous feeling. On the other hand, she could throw herself on her mother's neck and kiss her.

It took long, hard effort in analysis to make the patient see that the world-collapse fantasy was related to her feelings of guilt, which actually stemmed from her sadistic impulses. The patient got special fun from "scratching" with fingers bent close to her mother's eyes, as if to blind her.

The patient felt oppressed by the father, but respected him because he was "smart" and the master of the house. The father, an evidently highly sadistic character, beat the children mercilessly (sometimes he even used switches) for the slightest infraction. Despite this, or, in keep-

ing with her masochistic attitude, because of this, she respected him. Indeed, she even adopted his attitude and treated the mother just like the father did. She broke dishes in anger and was sarcastic and cruel to the mother; at the same time, she gave her big rival, the prettier and preferred sister, all her love and admiration (later on, at least), just as the father did. The mother annoyed her "just by her mere presence." She seemed stupid, weak, overly permissive, and therefore unworthy of respect.

We can clearly see how the brutal fatherly ideal took over the patient's ego and how strong her father identification is. Next to this, at a deeper layer, lies the masochistic surrender to the father which runs parallel to the sadistic attitude toward the mother. Yet both sadistic and masochistic tendencies are fully conscious. Thus we see here the typical aspect of this case—precisely in the fact that such tendencies are fully conscious and not buried under the strongest repression in the manner of a simple compulsion neurotic. Our patient also failed to show the typical over-scrupulousness of the latter category; on the contrary, she was without qualms most of the time.

An analogy to the compulsive's over-scrupulousness is expressed by the central symptom, the world destruction fantasy, which corresponded to tremendous guilt feelings toward the mother (and later to broader and deeper determinants), but was associated with simple, trivial occurrences. But it was just this displacement of guilt feelings to trivial matters that made the manifest sadistic attitude possible. During analysis, this connection was correctly reestablished; but now the patient began to feel her sadistic attitude toward the mother as a compulsion. At this point, the impulsive, compulsive-neurotic character was transformed into a typical compulsive symptom.

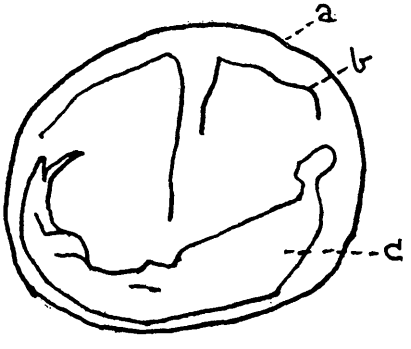
The typical case of compulsion neurosis presents with an undisguised compulsive thought or impulse, and the guilt feeling is directly related to the symptom. In the sharp separation between sadistic impulse and guilt feeling, we see one of the typical mechanisms of the impulsive character. As further evidence, we note the following: In the hyperscrupulous compulsive who has completely repressed his sadistic impulses, guilt feelings are connected to trivial events, just as they are in the impulsive.

Later on, we shall have to deal more exactly with the key question concerning the impulsive character—what makes the separation of guilt feelings from manifest sadism possible?

I should like to present briefly the libidinal aspects of our case, whose sexuality is unrepressed to an extreme degree.

The patient masturbates almost every day without orgastic sensation and with abundant masochistic fantasies. There is no intercourse. In this respect, we label her libidinal structure as totally polymorphous perverse. One masturbatory fantasy is that she and her father would eat stuffed vaginas that had previously been cut out and filled with dirt. We have, therefore, components from all three libidinal levels: eating (oral); vaginas (genital); dirt-filled (anal); and the whole thing is experienced masochistically (she is forced to do it). Manifest coital fantasies of a normal nature play a minimal role. The oral component of this fantasy has its special history. During childhood, she and her sister suffered from eating disturbances. To combat this, the family doctor (!!) recommended they be forced to eat by any means available; should they regurgitate, they should be forced to eat the vomitus also. This happened repeatedly. How understandable that repression and sublimation of oral and anal tendencies failed, so that the patient was still eating dirt and vaginal secretions in her seventh and eighth years of life. At the time of the analysis, the patient used to take great pleasure in smearing vaginal secretions between her fingers.

Fantasies of the womb also loomed large in this patient's symptomatology, along with the libidinal development. A vivid visual image went hand in hand with the world destruction fantasy, which in the final analysis was a temporary regression to the womb, dictated by feelings of guilt: The patient sees herself lying in a "globe." The drawing is from the patient herself: a) represents the globe; b) are the eyelids which "like shelves line the interior and run to the body"; c) represents herself. We do not hesitate to take this for a womb situation.[9]



[9]I should only like to call attention to the strange position of the shelves. It is totally reminiscent of the development of the amniotic membrane. I am avoiding any attempt at interpretation but would like to point out that the patient, as far as we know, had never seen a picture of the embryonic set-up and that this fantasy had existed since early childhood.

We may better understand the libidinal structure of such patients if we compare it to that of a classical case of hysteria and compulsion neurosis, respectively. In the analysis of a pure anxiety hysteria, we find a repressed genital libido as the central pathogenic factor. Moreover, even if a different libidinal component emerges as a symptom or in the course of a depth analysis, we still have no reason to doubt that the main fixation in pure anxiety hysteria is at the genital stage. Hysteria, according to Freud, is an illness of the genital phase. This is true even in a conversion hysteria of an oral type—a case of hysterical vomiting for example—where we find a central oral fixation in the libidinal pattern. Analyzing the total personality of the hysterical character, and the meaning and cause of the oral symptom soon tells us that the oral zone has acquired a genital meaning ("displacement upwards"), as Freud and Ferenczi pointed out. In a classic compulsive, whether he shows sadistic impulses or cleaning rituals based on anal eroticism, the pregenital anal-sadistic fixation always occupies the central position (Freud); it gives rise to the symptoms, and it gives the compulsive character his specific stamp (over-conscientiousness, orderliness, etc., as reaction formations against repressed sadism and anality). In melancholia, the oral fixation is central, as Abraham conclusively demonstrated—a fact which every analytically trained clinician can easily prove for himself. In the mixed forms of compulsion neurosis and hysteria, a depth analysis can, without difficulty, reduce the various symptoms and character traits to their corresponding fixation points. True, there is still a myriad of unsolved, crucial problems centering around the developmental thrust from the anal sadistic to the genital stage—which really has to do with the problem of specific etiology. Nevertheless, in the milder and purer forms of hysteria and compulsion neurosis, we do delineate circumscribed fixations and developmental blocks of a portion of the personality with more or less sharply defined libidinal positions. In the extreme impulsive character, such as our case, we can never make such an evaluation. If we try to relate a host of attitudes and symptoms to a genital or anal fixation, we must ascribe to the oral fixation as important a role. Even with extensive analysis, we cannot find a common fixation point at a given stage of libidinal development, but, rather, a more or less equal juxtaposition of all known partial impulses in combinations and permutations which cannot be sorted out most of the time. We get the impression—to use a drastic expression—of a bull unleashed in the china shop of infantile development.

Our case shows a lasting, marked ambivalence toward the father and mother, which is especially expressed in the cruel words and deeds

toward the mother. Her superego is totally oriented toward the male. She admires her strong, rough father and acts just like the father toward the "dumb" weak mother. The identification is fully conscious. The inferiority feelings, so prominent in her complaints, hark back totally to the father identification and to the envy towards the sister who is her father's favorite.

Analysis revealed the following about the father: He had almost certainly inflicted severe damage with his sadistic attitude; he had provided the model for the sadistic ego ideal; but, most of all, he was very likely a party to the defective impulse repression. He had approached the children with unveiled sexual intent; indeed, I strongly suspected that he had given the patient gonorrhea when I learned that he himself had suffered from chronic gonorrhea. The patient herself dated the onset of her illness to around the fourth year of life, the exact time of the gonorrhea infection, and she always felt immensely shy toward the father: She was always fantasizing being "raped" by the father.

The father is also implicated in the poor control of anal impulses. He forced the children to eat vomitus, thus fostering coprophilic tendencies which at any rate were present to begin with.[10] It is understandable that anal repression was defective. He beat the children mercilessly for the slightest transgression but felt completely free himself in anal matters. One might object that the older sister remained healthy despite growing up in the same environment. To this we counter the fact that she was always held up as a model to the younger sister and was favored and over-esteemed in every way, a factor which was surely weighty enough to turn the scales. Moreover, we really do not know anything about the sister's libidinal vicissitudes or what had really promoted the favorable outcome. She hated the parents as much as the sister did, but opportunely freed herself from home.

The case shows pronounced schizophrenic mechanisms side by side with classical compulsive mechanisms. Many readers will make a diagnosis of schizophrenia. The major compulsive symptom, the rumination about the end of the world, is schizophrenic both in content and in the way it is perceived. The patient tends toward autism. The absence of repression, the conscious awareness of the sexual wishes, bespeak schizophrenia; yet, all the grosser dissociations of affect and confusion are lacking for a strict diagnosis, nor are there hallucinations or delusions. Although we do not expect to make a diagnosis, it is still not unproductive to ask whether we are dealing here with a schizophrenia or a com-

[10]The fantasy of the dirt-filled vaginas.

pulsion neurosis. Only future developments will tell. If we apply Bleuler's[11] broader concept of schizophrenia here, we shall tend toward a diagnosis of latent schizophrenia with compulsive symptoms. At the same time, we must rule out dementia praecox, according to Kraepelin's narrower definition,[12] but we can consider the patient a kind of "psychopath" which, as Kraepelin notes, is an early precursor of true psychosis. In the final analysis, we see that the whole question becomes a struggle over terminology.

The question of borderline cases warrants considerable discussion, since most patients with this clinical picture show not only various schizophrenic symptoms but also an oscillation of their libidinal structure back and forth between autism and object cathexis. In almost all severe cases of impulsive character, we must raise the question as to whether a schizophrenic process exists.

From the psychoanalytic standpoint, we can approach this question only in the dynamic context of a libidinal position. Even in psychoanalysis we speak of "latent schizophrenia"; but this does not imply the actual existence of a schizophrenic position that is merely covered over by transference-neurotic symptoms and attitudes. Such an assumption would diametrically oppose the libidinal-dynamic principles we have come to understand. It would impart a static quality to an area we see as purely dynamic. In the absence of typical schizophrenic symptoms like stupor, delusions, word salad, or hallucinations, we cannot say there is a schizophrenia present, nor can we talk about latent schizophrenia. But, in keeping with the above, we must always remember that what we are talking about is a greater tendency toward the schizophrenic withdrawal of libido from the outside world. There is often a deterioration from an overly strong narcissistic position to a "latent" schizophrenia. On the other hand, there are neurotics who could never be called schizophrenic, yet who show a narcissistic position matching in intensity that of the schizophrenic.

To what degree does a schizophrenic's narcissistic position differ from that of a "narcissistic," inaccessible transference-neurotic's? This is still a question without a satisfactory solution. And it is not our purpose to deal with it here. However, analytic research of "borderline" cases like our patient warns against the assumption of a "ready-made" schizophrenia, as it were, which subsequently "becomes manifest."

I treated a forty-year-old female psychopath who, from earliest childhood and particularly since puberty, presented the clinical picture of

[11] "Gruppe der Schizophrenien," in Aschaffenburg, *Handb. d. Psychiatrie,* 1911.
[12] *Klinische Psychiatrie.*

"latent" schizophrenia. She was a complaining patient, who thought she was pursued by fate and maltreated by everybody. She also suffered from states which differed little from catatonic stupors, in addition to phobias, compulsive rumination and impulses, and conversion symptoms. At the psychiatric observation ward, where she had been a number of times, she was diagnosed once as a psychopath, another time as a compulsive, and finally as a paraphrenic, without any appreciable change in the clinical picture since puberty. There are some typical compulsives who, owing to their cyclic depressions, belong in the group of cyclothymic disorders and seem to be totally excluded from a schizophrenic diagnosis. Again, there are others who show a special relationship to schizophrenia (our patient, for example). The whole problem becomes clearer if we free ourselves from the prejudice (still held even in analytic circles) that schizophrenia, owing to its organic nature, is a basically different illness from the rest of the "psychogenic" neuroses. (Jaspers[13] speaks of a "schizophrenic process.") Even Schilder[14] still holds to this. In psychiatric literature, we often do not see the connection between the outbreak of a psychosis and the actual history, because we are trapped by the prejudice of a ready-made, organically preformed psychosis. Hartmann[15] had occasion to observe two sisters who became schizophrenic at the same time, coinciding with their father's death. How can this be compatible with the idea of a preformed psychosis?

There are two theories in particular concerning this question: One postulates that schizophrenia is caused by internal secretions; the other assumes that schizophrenia is constitutional, especially since Kretschmer's work.[16] Of course, Freud has always thought about an internal secretory process even in the etiology of transference neurosis, and his whole theory of "erogenous zones," so central to his theory of the neuroses, is based upon this assumption ("sexual hormones"). However, according to this schema, transference neurosis would not differ basically from schizophrenia. Even the assumption of a specific constitution, Kretschmer's "schizoid group" for example, does not contradict a psychogenetic viewpoint. The schizoid group covers a much broader territory than the realm of schizophrenia. Compulsives, and, in particular, hysterics also belong here. Likewise, the finding of pathological changes

[13] *Psychopathologie,* Berlin, 1920.

[14] *Seele und Leben,* Berlin, 1923.

[15] "Ein Betrag zur Lehre von den reaktiven Psychosen," *Monatsschr. f. Psychiatrie u. Neur.* Bd. 57, 1924.

[16] *Körperbau und Charakter,* Berlin, 1922.

in the cerebral cortices of old, burned-out schizophrenics does not contradict our view. In the first place, we do not know what kind of changes (cytoarchitectural perhaps) may occur even in hysterics and compulsives. Thus far, none has been found. Moreover, the rarity and sparsity of such findings is markedly disproportionate to the high incidence of schizophrenia—even if we do not consider whether such changes in the burned-out dementias represent atrophy from lack of activity. If this is so, the transformation of a compulsion neurosis into a schizophrenic disorder remains a problem; we think it would be of utmost help not to erect a wall between these illnesses. The relationship between them is all too obvious.[17]

During the analysis of an impulsive character, we can observe transitory delusions *in statu nascendi*; moreover, we see how an irresistible impulse, normally not felt as a compulsion, is transformed into a compulsive act. At this point, the content remains and only the form is changed. During analysis, in conjunction with a homosexual transference which became acute, one of my erthrophobes developed a fully systematized delusion of persecution of five days' duration. He was presumably an Aryan, I was a Jew and therefore wanted to hurt him; he felt I was watching him and he was afraid of me. I was a sensuous pig, I had sensuous lips, and I looked at him sensuously. All he had done was to project on to me his homosexual wishes, which had just come up in analysis. When this phase passed, he realized the connection of the wishes to himself and he would reproach himself for being lasciv-

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[17]The discussion of the etiology of schizophrenia has been well organized by Wilmann, who put the psychoanalytic viewpoint in proper perspective. ("Die Schizophrenie," *Ztschr. f. d. ges. Neur. u. Psych.,* 78. Bd., 4 u. 5. H., "Vortäge zur Schizophreniefrage.") Collected here is all the pertinent literature.

All the cases of impulsives with strong asocial trends, whom I studied analytically and observed personally, had this in common: Since early childhood, their activities were unrestrained. Gerstmann and Kauders published some interesting cases who, following an encephalitic illness, and, during a post-encephalitic condition bordering on hyperkinesia, developed a dyssocial, impulsive state. ("Über psychopathieähnliche Zustandsbilder bei Jugendlichen," *Archiv f. Psychiatrie,* 1924.) The analyst should not disregard such facts. The cases cited were not, of course, fully examined with regard to their premorbid personality; in particular, the libidinal transformations are not discussed. Therefore, further conclusions are not permissible. We would just like to point out that Schilder and others have repeatedly discussed the problem as to what extent brain disease triggers psychogenic processes. The fact that a disease of the midbrain or basal ganglia "begets" a dyssocial reaction is as incontrovertible as the fact that paresis "produces" delusions. Certainly a somatic process can occasionally encroach upon psychic causality. ("Cortex—Stammganglien: Psyche—Neurose," *Ztschr, f. d. ges. Neur. u. Psychiatrie,* Bd. 74, 1922, and "Über den Wirkungswert psychischer Erlebnisse und über die Vielheit der Quellgebiete der psychischen Energie," *Arch. f. Psych.,* 1923. Also, *"Seele und Lebe,"* Berlin, 1923.)

ious and having intercourse with his eyes, etc. As H. Deutsch[18] has stressed, excessive neurotic distrust, especially in compulsives, stems from the fact that their own repressed sadistic tendencies are projected on to others. We know the role played by distrust in cases of paranoia.

A patient whom we shall discuss later on—in whose case schizophrenia could not be totally ruled out—developed acute transient auditory and visual hallucinations during analysis. She had learned of the death of a loved one and wished to deny it. During a session, she heard this person cry out and pound on the door and saw her standing clearly in front of her. A strong denial of the experienced loss—the wish that the deceased would live—was fulfilled through hallucinations.

In all such cases, a transient clouding of reality-testing occurs, which enables the patient to experience delusionally the content of her experience. Cases of the type we just discussed are especially prone to transient clouding of reality-testing. This undoubtedly has to do with an acute withdrawal of cathexis, with narcissistic regression. When the ego is flooded by narcissistic libido, this must have a distinct effect upon that part of consciousness which receives perceptual stimuli and controls reality-testing. (The *Wahrnehmungssystem* of Freud.)

It appears that the road connecting the "narcissistic reservoir" to the object-libidinal position is far broader in such cases than in the simple transference neurotic. The roughest assumption we can make is that the "breadth" of communication between ego and outside world implements this great tendency toward regression. The libido of such patients is in a perpetual state of oscillation: At the slightest denial or disappointment on the part of reality, an acute withdrawal of cathexis ensues. Freud has already clarified the difference between this and the libidinal regression of simple transference neurotics who have no schizophrenic mechanisms: After a disappointment, the neurotic withdraws libido from real objects and recathects fantasied objects with it. The schizophrenic, or the neurotic with schizophrenic mechanisms like our main case, deflects the withdrawn libido into the ego and even renounces cathexis of the fantasy. This is how the cathecting of a fantasy with object libido serves as a protection against narcissistic regression. A broader regressive pathway to autism, no matter what its nature and origin, will unfavorably balance the outcome against the cathexis of the fantasy.

(To be continued in the next issue of this journal.)

[18] "Psychologie des Misstrauens," *Imago, VII,* 1921.