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The Impulsive Character (Part Five)*

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CHAPTER SIX

Schizophrenic Projection and Hysterical Dissociation:

Some Observations

Our postulate of an isolated superego has doubly proven itself of heuristic value—for formulating the dynamics of schizophrenic projection and of hysterical dissociation, as well.

When our genital masochist learned of the death of the woman doctor who first treated her and who had become a total mother image to her, she experienced an acute hysterical psychotic break. She had auditory and visual hallucinations in which "Mami" would knock on her door at night and summon her to her grave. During a session, she saw "Mami" lying in her grave waving to her. She heard voices telling her not to masturbate—"Mami" wouldn't allow it. For hours she prayed tearfully before the dead woman's picture and saw it move. We have good ground for attributing these hallucinations to the same mechanism as operates in schizophrenic projection. The same process of projection occurs here as in the latter during a developmental stage of the ego. The ego ideal manifests itself externally (like the pursuer and critic in paranoid schizophrenia). Or, better put, it *reappears* in the external world and the process of introjection ceases. Thus, *most susceptible to the fate of paranoid shift from ego to outside world are those parts of the personality, those ego ideals, which once were not wholly fused with the total personality but remained estranged from it.* Nor is this assumption negated by the fact that the content of the pro-

*Translated by Barbara Goldenberg Koopman, M.D. from *Der triebhafte Charakter*, Int. Psychoanal. Verlag, 1925. Parts I through IV appeared in the last four issues of this journal.

jection—be it delusions of persecution or paranoid hallucination—is also the impulse (mainly homosexual) condemned by the ego ideal. The patient then behaves like an inn-keeper with two guests quarreling at his door—whatever happens, he must put up with the clamor at his door. The clinical manifestation of resistance likewise contains both—the repressor and the repressed.

We would thereby partly solve the problem so perpetually tied to Freud's hypothesis about paranoid projection in homosexuality: From the economic viewpoint, the process of projection was explained as an attempt at discharge: "I love him not—in fact I hate him because he is persecuting me."¹ But this economic interpretation failed to explain why the paranoid schizophrenic tries to relieve his impulses only through projection and not, for example, by evoking typical mechanisms of repression. We may now postulate that a defect within the ego facilitates projection and directs the forbidden impulse into this specific avenue of discharge. A defect in ego development such as incomplete fusion of the ego ideals *derived from the external world* would predispose toward psychotic projection *into the external world*. As to the nature of this defect and its timing for effecting such a tendency, we learn nothing from examining the paranoid forms of schizophrenia itself. The ambivalent nature of every persecution complex clearly points up the key role of ambivalence here. Merely the analysis of a paranoid neurotic character suggests the assumption of this fixation point. But if we are right about the genesis of this tendency, we have also gained some clues as to the time of the schizophrenic fixation—and we believe that an hypothesis is legitimate as long as it can explain data.

In one of his lectures, Schilder pointed out the loosening of the ego ideals in schizophrenia and used this, among other factors, to explain even the conscious awareness of symbolic meanings [which such cases show]. He also raised the question as to the timing of the schizophrenic fixation but did not answer it. One train of thought which runs parallel to this work and is intimately related to it raises the question as to the genesis of formal disturbances of psychic life: It starts by challenging the incorrect assumption that we would localize the schizophrenic fixation stage in the same manner as that of melancholia (oral sadistic), compulsion neurosis (anal sadistic), and hysteria (genital). In dealing with the question of schizophrenic fixation, we must first strongly em-

¹Freud, "Psychoanalytische Bemerkungen über einen autobiographisch beschriebenen Fall von Paranoia," *Ges. Schriften*, Bd. VIII. See also: Freud, "Über einige neurotische Mechanismen bei Eifersucht, Paranoia und Homosexualität," *Internat. Ztschr. f. PsA.*, Bd. VIII, 1922; *Ges. Schriften*, Bd. V.

phasize the formal disturbances which characterize it; secondly, we must not forget that schizophrenia can mimic all types of psychic illness (altered in form)—compulsion neurosis, hysteria, melancholia, hypochondria, etc.; thirdly, the assumption of a narcissistic fixation is much too broad to mean something specific. In the final analysis, it will involve a *certain stage within the narcissistic autoerotic phase of development*, presumably when the first bridge is thrown from the inchoate ego to the object [world],² the earliest identifications are formed,³ and the process of reality-testing is unfolding. The schizophrenic fixation must be sought in the stage of earliest object identification.

Hysterical dissociation of the personality is another way in which the ego can escape the role of mediator between superego and primitive tendencies (in contrast to the superego's discharge through psychotic projection)—*double conscience* of Janet. Here there is no projection, no expulsion of the ego's enemies (which is, after all, a definite though always unsuccessful decision); rather, *the ego identifies first with one opponent and then another*. Thus, *during masturbation*, our nymphomaniac patient totally identified with the punitive mother, a maneuver we must construe as a special kind of hysterical "state of emergency," while her pleasure ego identified with her genital. *Outside of this emergency state*, she plays the role of the small child towards all persons in

²After I completed this manuscript, a paper by T. H. Van der Hoop appeared, entitled "Über die Projektion und ihre Inhalte" (*Int. Ztschr. f. PsA.*, X, 1924). The author arrives at conclusions similar to mine by viewing the essential process of projection from a different angle (p. 288): "Psychologically speaking, schizophrenia should be regarded as an intense state of introversion, marked by an ever-increasing process of regression which follows an infantile archaic phase of development; in the latter, there is minimal or no differentiation between subject and object, and, for this reason, the process of projection can manifest with an inordinately powerful influence." However, intense introversion is not an adequate explanation, because introversion itself is only a sequel of fixation at this phase.

³To avoid misinterpreting the expression "earliest identification," which we purposely chose, bear in mind that, like Freud, we must distinguish between two phases of identification: 1. According to *Group Psychology and Analysis of the Ego*, there is the identification which precedes all clear, unequivocal, object choice (narcissistic identification) and 2. there is that identification which follows the stage of object formation and leads to the final construction of the ego ideal through renunciation of objects or their incorporation as the superego (*The Ego and the Id*). There is a discrepancy between the theories set forth in *The Ego and the Id* and those in *Group Psychology*, the former presupposing a stage of narcissistic identification as a forerunner to the stage of object choice, and the latter postulating identification as a form of object cathexis. This discrepancy is only a seeming one, since [the processes of] pre- and post-object-libidinal identification are very closely allied. Freud (*Group Psychology*, p. 69) observes, "Identification is the earliest and most primordial form of emotional development" and (in *The Ego and the Id*, p. 36), "However, the object choices pertaining to the first sexual stage and corresponding to the father and mother are, in the normal course of events, apparently incorporated into such identification, and thereby appear to reinforce the primary identifications."

any way suitable to her purpose: She tries to cling to the doctor, the nurse, etc., but becomes very stubborn and temperamental when rebuffed. She involves herself in countless, always incest-tinged relationships and seeks in the male the father with the long penis. But if coitus occurs, the figure of the threatening mother intervenes, sometimes in the form of voices calling her a "dirty whore," and sometimes in the figure of the devil condemning her.

A female hysteric with twilight states (to be discussed elsewhere in detail), who finally wound up with a permanently split personality, gave me the idea that the dissociation is an attempt at restitution. I was also persuaded of this on the basis of two other cases. In the prepsychotic twilight state, the patient relived an otherwise forgotten sexual assault by a teacher; at the same time, she masturbated on her breasts and dressed in her prettiest clothes though normally she dressed very simply. Thus, in the twilight states, her ego surrendered to the forbidden drives, which were fully repressed in the waking state, and accommodated them by bringing them to motor discharge. In the normal waking state, the ego subjugated itself to the severe, motherly superego which had preached abstinence. In her second year of life, she had already suffered frustration of genital masturbation by her mother. It seems typical for such cases that the ego oscillates between the pole of the superego taboos and that of the impulses.

The ego serves two hostile masters; it loves both and would follow both. But the conflict is not solved through a compromise symptom [formation] as in the symptom neuroses; rather, the one is not allowed to know of the other's existence (dissociation into two states of consciousness). Even this case showed a clear-cut, sharp ambivalence towards the mother since early childhood, which we shall not elaborate any further. We only wish to mention that the positive tendency toward the mother was based upon an intense oral tie and longing for the womb, while the negative sprang primarily from the genital frustration, which was experienced as extreme castration. Therefore, this case resembles our nymphomaniac patient, with one great difference—she never experienced full impulse gratification in early childhood. The culmination of the ego's ambivalence towards its ideal finally occurred through the patient's allowing the ego to die ("I have kissed Eva S., *i.e.* myself, to death; I am not Eva S.; I am nameless"), and indeed what ego she had was identified with the pleasure ego. Stubbornness towards the mother dominated the child's attitude from the very beginning. Even at this point, we must note the tendency toward dissociation in a defective incorporation of the forbidding motherly ideal. The ambiva-

lence is fully contained in the expression "kissed to death." The expulsion of the depressive, prepsychotic personality, with insight into the illness, at first triggered a hypomanic reaction. The patient lost her symptoms (insomnia and hysterical gastritis) and felt well.

In the psychotic phase, the patient told me she now knew much more about Eva S. than the latter would have known during her lifetime. What it was she did not wish to tell me. But we understand that she was now allowed to know more about the repressed material; after all, she had the delusion that it belonged not to her but to Eva S., whom she had "kissed to death."

The tendency toward schizophrenic and hysterical dissociation can thus be traced back to a faulty merging of the accepted ego ideals and the pleasure ego. Still unanswered is the question as to how the two forms of dissociation differ.

We may roughly summarize the above as follows:

In schizophrenia of the delusional and hallucinating variety, there is a conflict and a disintegration within the ego. The former is disposed of through discharge by way of psychotic projection of the ego ideal along with the tabooed id striving.

In hysterical dissociation, the ego tries to solve its conflict by *successively* siding with each master.

In the impulsive character, there is a *simultaneous* siding with both; sometimes conflicts are solved through a type of schizophrenic projection or hysterical dissociation.

These clinical pictures with their ego dissociation stand in contrast to the impulse-inhibited character neurotics and to the symptom neurotics with their firmly molded ego (ego plus superego).

However, we do not mean to imply that there are no ego conflicts in the impulse-inhibited neurotic. Such conflicts are surely present, for example, between opposing ego identifications. It all depends upon whether there is a weakening of the common united defense which they maintain against the repressor, a defense which is quite compatible with the existing ego conflict.

CHAPTER SEVEN

Therapeutic Pitfalls

Since its existence, psychoanalytic treatment has been ever widening its horizons in the realm of psychic illness. In the beginning, it was suitable only for curing hysteria; soon it drew even compulsion neurosis into its domain and proved to be the most adequate treatment modality

for this ailment. Freud and Abraham had already attempted the treatment of melancholia and related cyclic states. The results are not definitive as yet. The same holds true for attempts with cases of incipient schizophrenia. Psychoanalytic literature shows no indication of potential or actual success in this regard,⁴ but, here and there in analytic circles, they say we should not reject *a priori* the possibility of analytically influencing this severe form of mental illness. First, we must determine the exact conditions under which we can exert an influence in the future, for it is a basic tenet of psychoanalysis that we can change only what we understand.

However, in advanced, institutionalized cases of schizophrenia, these conditions will scarcely be found. At first, only incipient cases will qualify for this treatment, or at least those cases which are not full-blown but show, nevertheless, typical schizophrenic mechanisms coupled with a strong transference neurosis; that is, cases like our patient with the world destruction fantasies. Since the schizophrenic is presently unreachable—not only because he cannot establish a transference, but also because the ego ideal breaks down—the analysis of the impulsive character may well afford the opportunity to clarify the requisites of treatment and its pitfalls, to the extent that they typify them.

"Within man hides a child who wants to play." With these words, Nietzsche anticipated Freud's classical formulation of the neurotic conflict. In analysis, we appeal to the "man" while proceeding to tame the "child," the unconscious, the infantile, the opponent of reality-testing. Our therapeutic efforts fail if the man refuses to combat the child; we succeed if we can win over the man and motivate him to deal with the child—either to retrain it or allow it some measure of controlled freedom. In the transference neuroses, the major part of the personality quickly allies with us and becomes identified with our therapeutic endeavors. Not so the impulsive character. Even his ego has stayed more or less infantile. From this difference in psychological makeup come all the pitfalls of treating these patients analytically.

A first typical problem to confront us is the deficient or absent insight into illness. With the symptom neurotic, an awareness of illness brings him to analysis, and, before any transference takes place, he is generally committed to opening up to the analyst; the impulsive, however, is mainly without insight into his most basic disturbances. Even in the transference neurotic, insight at first pertains only to the trouble-

⁴Some time ago, Walder made a gratifying effort to clarify the theoretical prerequisites for affecting schizophrenia: "Über Mechanismen und Beeinflussungsmöglichkeiten der Psychosen," *Internat. Ztschr. f. PsA.*, Bd. X, 1924.

some symptoms; neurotic character traits are mostly not in awareness. But the symptoms provide welcome *entrées* into the pathological material, and the gaining of further insight is not too arduous. With impulsive characters, it is different. Their attitude is mainly suspicious. Sometimes they cannot be moved to talk at all. It may happen that we win the patient's trust at the first interview by taking his side right at the outset and never preaching to him or mouthing his opponent's view; in that case, we may quickly determine whether the lack of insight goes very deep, as in overt schizophrenia, for example, or whether a sharp current conflict has pushed the patient into maintaining his homeostasis with hysterical attacks, crying fits, convulsive sobbing, paroxysms of rage, and the like. Since the patient's opponent is not necessarily a more insightful or flexible individual, but rather represents the view of the husband or father who rears her—severely neurotic himself most of the time—we have the groundwork laid for the rationale of her condition and it would be a lost labor to fight against it. Mainly a change of environment, such as separation from the opponent, makes analysis possible, but this is usually very hard to come by especially amongst the poor. Insight into pathological phenomena, whether neurotic symptoms or character traits, can exist only when the ego allies with the superego, which sharply and successfully denies the impulse. But if the superego allies with the pathological attitude, or remains isolated, or if the symptom does not appear absurd or irrational to the patient, insight is lacking. Thus our patient with the world destruction fantasy was totally unaware of her attitude towards her mother, because her superego was borrowed from her father, who behaved in the same way. The superego of our genital masochist remained isolated from the reality ego ("You must die from masturbation"); therefore insight was lacking here also. Indeed, we occasionally find absence of insight even in patients with circumscribed hysterical symptoms. Thus, a patient with hysterical vomiting, who was involved at the time in severe battles with her brother's wife, thought it entirely normal to throw up after getting upset.

The acquisition of insight comes about in diverse ways. One typical possibility is that a strong transference may lead to identification with the analyst and through this the poorly understood impulsive impulse is converted into a typical compulsive act. In the case of the genital masochist, whenever the most deeply repressed hatred of the mother became conscious, compliance with the mother's invective was lost during masturbation: The impulse to masturbate now appeared as a typical compulsive symptom laden with guilt feelings, self-condemnation, and

anxiety attacks whenever she tried to suppress masturbation. In this phase, the punitive actions and invective against the genital stopped; she masturbated with heterosexual fantasies of coitus and corresponding feelings of guilt. The old ego ideal effected the condemnation in a new form.

The attitude change toward the symptom became even clearer in the patient with the world destruction fantasy: Because of unhappy experiences in similar cases, I bent over backwards not to remind her by my attitude of her father or mother, which meant I refrained from every verbot and every active intervention into her commissions and omissions. Had I done otherwise, I would have immediately reinforced an *insuperable* acute ambivalence towards myself. In the beginning, I confined myself, without further analysis (which, by the way was quite impossible), to making clear to her that her actions were all acts of revenge: She had had to suffer greatly from her parents; her older (prettier) sister was preferred to her, and now she was trying to turn the house upside down out of revenge. I held that she was entirely right but that she would destroy herself by fulfilling that right. At first, she presented the strongest defense reactions against me, but gradually the positive transference gained the upper hand to such an extent that she agreed to have a try at behaving herself at home. This she did only by dint of an incredible self-discipline—the mere attempt was taken as [a sign of] progress. After fourteen days, she flared up again. I now explained to her that her parents would forbid analysis if she would not keep quiet. (This assumption was justified.) By now, the transference was so strong that she feared termination of the analysis. *Only at this juncture did she feel the sadistic impulses towards her mother as a compulsion, a painful realization for her.* She started to see the futility of her attitude. Her guilt feelings, which were tied to the world destruction fantasies, she now correctly related to her sadistic impulses. The situation became critical when her outer-directed sadistic urges were checked and turned against the self: She wanted to commit suicide.

This critical change at the emergence of insight appears to be typical in such cases. I had a similar experience in two other cases, also. *The patient gains insight into his aggressive actions toward the environment by rightly relating them to his guilt feelings, which are always stirring around somewhere at the same time; at this point, suicidal impulses break through.* Our patient verbalized the following: "I realize that I wanted to get my parents' attention and concern by acting crazy. I feel so inferior (the rivalry with the older sister, existing since childhood); if this is taken from me, what do I have left?" These secondary gains

of illness she could not relinquish for a long time.

The change in the ego ideal ensues in the course of the analysis of the basic object relations. If the original object is devalued—which is partly possible through intellectual working out but mainly through a new relationship to the doctor—the old superego loses its dynamic footing. The acquisition of insight occurs more or less typically in the following stages:

1. *Stage of absent insight*: The pathological reactions are compatible with the effective superego, or isolation of the superego from the ego allows the full surrender of the latter to the impulsive strivings.

2. *Stage of the growing, positive transference*: The patient makes the doctor a libidinal object. Already, through this process, the old ideal is pushed down a step; any narcissistic libido connected to it is changed into object libido. The new object, the doctor, can provide the basis of new superego formation inasmuch as he stands for the reality principle and interprets the heretofore unperceived attitude as running counter to reality.

3. *Phase of effective insight*: A portion of the new—and, by the way, incestuously-cathected—object, the doctor, is introjected and becomes the new ego ideal; the old is renounced along with its source. Only now can regular analysis begin.

In the first phase, such patients transfer their attitudes and aggressive feelings immediately to the analytic situation; but hate, distrust, and ambivalence especially threaten to make every attempt at analysis an illusion. Distrust and ambivalence are also typical attributes of the compulsive. But, in the latter case, they operate only in connection with the analyst's rejection and are generally susceptible to analysis. In the impulsive character, they take effect through actions. The doctor becomes a bitterly hated enemy, and serious intent to kill him is present. The patient discussed in chapter five planned exactly how she would waylay me on the street and shoot me down. She had even been to a gun shop to buy a revolver.

Where the actions are dictated not by hatred, but by a longing for love, they likewise show all the hallmarks of a defective ego ideal. The love is frankly demanded; no insight comes from the analyst's attempts to remind the patient of the transference nature of the love. Only a struggle could keep our nymphomaniac patient from undressing or masturbating during a session. Another patient very quickly developed the unshakeable hope that the doctor would start an affair with her. After an explicit indication that this could never happen, she broke off

analysis. One patient, who frankly demanded homosexual intercourse with me, became enraged at my rejection, kicked and thrashed about, and could hardly be quieted down. Such forms of transference are obviously inconceivable in transference neuroses and only become manifest as intimations of a tender nature; sensuous wishes must be teased out of the dreams or they are forthwith repudiated as soon as they have reached full consciousness.

Since such patients are generally involved in severe acute conflicts with parents or parent surrogates and since they are generally people who have suffered severe repeated disappointments, they compulsively try to carry the conflict even into analysis. Insofar as neurotics live out this repetition compulsion in analysis within reasonable limits, one can even spare them disappointments. One can be more friendly and helpful, as they are used to it from their environment. But how can disappointment be avoided if the patient creates situations which must evoke the most emphatic rejections? The nymphomaniac cited so often as an example was brilliant at provoking me to severity. She would often declare she did not want to stop the session. Kindly urging was of no avail here. Only after being told she would be thrown out would she leave, crying, and often yelling, that we were mean to her, nobody loved her, we were insulting her, and so on. In this way, she would live out the rejection in masochistic fashion and would masturbate with corresponding fantasies. Another patient came to realize after many months of difficult work that her only reason for coming late and behaving badly was her wish to have me beat her; she later frankly declared that she always knew this but wanted to test my patience just as she had done with her father. But his beating she had experienced as pleasurable.

Wherever there are criminal impulses, strictest verbots with threats of breaking off analysis must be invoked. One must generally work with a much stronger transference than usual if the aim is to curb the acting out. Especially with masochistic patients, this Scylla stands face to face with the Charybdis of producing a fixation that often cannot be dissolved. According to my experience so far, in extreme cases we cannot even come close [to dissolving such a fixation]. We can counter this only somewhat through daily discussion of the transference, with heavy emphasis upon the hopelessness of gratification of the desires.⁵ In milder cases, the transition into the aforementioned third phase

⁵As to current attempts at dealing with this enormous masochistic fixation through a systematic breaking off of treatment ("weaning by the doctor"), we cannot yet comment on account of insufficient results.

comes about rather easily. In patients who remain strongly infantile, one of the biggest obstacles is getting them to do the analytic work of association. They cannot or will not understand what is asked of them.⁶ The work of association is also hampered by the constant acting out. But if we do get them to associate, to produce ideas and flashes, and even if the memory work gets under way, we hit upon a new obstacle.

For example: After more than a year of analytic labor, we succeeded in making the nymphomaniac patient capable of work. A six-week vacation break had a salutary effect by effecting a partial weaning from the doctor. The acting out abated, and the memory work on repressed material proceeded fairly well for three weeks. The patient recalled incest wishes from her third and fourth year of life, which had hitherto been fully buried. Shortly thereafter, her father, an 80-year-old with senile dementia, came to Vienna. The patient grew nervous, had intensified guilt feelings and fantasized having intercourse with him. No matter how strong the fantasy, the following occurs typically, to a lesser degree, in the pronounced impulsive character: The tabooed wishes are not condemned after reaching consciousness, as occurs regularly in neurotics; they press for discharge. How far this prevails depends upon the amount of reinforcement of the ego ideal which could be evoked until then. Our theorem would read, therefore: In cases involving a defect in the ego ideal, ego analysis is a must, above all. But in practice it is always more complicated, no matter how high-sounding and logical the theorems obtained in this way.

First of all, it so happens that currently we do not know what the so-called ego analysis should look like, and we doubt whether it should even be separated from the rest of analysis.⁷ [We wonder] whether it would not entail [using] the most blunt persuasion without regard to causal factors and associations. Without kindly encouragement and persuasion, at least in the beginning, one can never manage in such cases. One must, *lege artis*, educate the patient to prepare him for the analysis. But we would only founder into deepest misunderstanding and only document our thorough ignorance of psychodynamics if we were to keep this introductory phase separate and were to counterpose it to analysis under the label of "psychagogy." One could object that, as we ourselves admit, the uncovering of repressed impulses in such cases

⁶The way in which some intellectually defective impulsives lose their "weakness" after ego integration leads us to conjecture that even intellectual defects may be psychogenic.

⁷The theoretical components of "ego analysis," such as the analysis of identifications, particularly of the superego and narcissism, etc., are even empirically feasible. Yet, at the same time, they are not separable in practice from the analysis of libido transference. Above all, libido transference is also the vehicle of ego analysis.

would lead to a push for motor discharge and that therefore analysis would be contraindicated. Even we ourselves would gladly opt for pure education if we could only be sure it could achieve what analysis cannot. The educational successes with antisocial subjects reported by Aichorn are indeed outstanding; however, in the first place, his antisocials are not entirely identical to our impulsive characters, even though they show many similarities. And secondly, no doctor, nor even institution, can afford the smashing up of all the furniture for the sake of the abreactions. Thirdly, everyone who has had to deal with such patients will admit that they are especially noteworthy for their inability to accept persuasion for any length of time (stubbornness). Therefore we maintain that educational intervention is always necessary to make possible an ensuing analysis. The question of how to avoid the pitfall of impulse breakthroughs must be left open. Our experience is insufficient for a satisfactory solution. In general there is only one rule to follow: Uncover the unconscious very carefully and slowly; indeed, slow down the process at times, particularly when schizophrenic mechanisms play a role.

Unfortunately, the only feasible way to get at socially dangerous impulsivity is blocked today: psychoanalytic treatment in an institution. With few exceptions, mental hospitals are only custodial in nature, for the protection of society. The patient himself is entirely secondary. If we follow the fate of such hospitalized patients, we can discern the following pattern: The patient is at first confined because of a suicide attempt; he is discharged but returns sooner or later and gradually develops a peculiar tie to the hospital. Each time the impulses grow more threatening, more dangerous, until finally one suicide attempt is successful, or the patient remains permanently hospitalized as a "psychopath" or a schizophrenic.

Psychoanalysis was able to show how extensively environmental factors, financial misery, parental ignorance and brutality, and surely even predisposition transform children into antisocial, sick, distorted human beings. Humanity protects itself from them by locking them up—which always makes for deterioration under today's conditions. But if the "conscience of humanity should awaken one day" and wish to right the many wrongs done to these patients by so many of its representatives, surely psychoanalysis will be called to the front lines to collaborate in their liberation from neurotic misery—in a setting far more propitious than today's conditions.