CHAPTER EIGHT

PSYCHOPATHOLOGY

Psychoanalytic theories concerning mental disorders have changed and developed in the course of the past sixty years just as the theories of the drives and of the psychic apparatus have done. In this chapter we shall sketch this development from its origins to the present and discuss in a general way the fundamentals of the psychoanalytic theory of mental disorders as they exist at the present time.

When Freud first began to treat mentally sick patients, psychiatry was barely past its infancy. The diagnostic term, dementia praecox, had only just been introduced into the psychiatric literature; neurasthenia was the favorite label for most of the conditions which we should today call psychoneuroses; Charcot had recently succeeded in showing that hysterical symptoms could be removed or induced by hypnosis; and the neuropathic constitution was believed to be the prime cause of all mental sickness, ably abetted by the unnatural strains and tensions caused by the frenzied tempo of civilized, that is, of industrialized, urban life.

The reader will recall from Chapter I that the first condition to which Freud turned his attention was hysteria (Breuer and Freud, 1895). Following a suggestion of Breuer's, he treated several cases of hysteria by a modified form of hypnotic therapy which was called the cathartic method. On the basis of their combined experience he concluded that hysterical symptoms were caused by unconscious memories of events which had been accompanied by strong emotions that for one

reason or another could not be adequately expressed or discharged at the time the actual event had occurred. As long as the emotions were blocked from normal expression, the hysterical symptom would persist.

In essence, therefore, Freud's initial theory of hysteria was that the symptoms were the result of psychic traumata, presumably in individuals who were congenitally or hereditarily neuropathic. As he himself remarked (Freud, 1906), this was a purely psychological theory of etiology. On the other hand, as a result of his early experiences with another group of mentally ill patients, whom he diagnosed as neurasthenics, he evolved a quite different theory concerning the etiology of this condition, which he considered to be exclusively the consequence of unhygienic sexual practices (1895).

These practices were of two kinds and each kind, according to Freud, resulted in a different syndrome, or set of symptoms. Excessive masturbation or nocturnal emissions comprised the first group of pathogenic, sexual abnormalities. They produced symptoms of fatigue, listlessness, flatulence, constipation, headache, and dyspepsia. Freud proposed that the term "neurasthenia" be henceforth limited to this group of patients alone. The second type of sexual noxa was any sexual activity which produced a state of sexual excitement or stimulation without an adequate outlet or discharge, as, for example, coitus interruptus, or love making without sexual gratification. Such activities resulted in states of anxiety, most typically in the form of anxiety attacks, and Freud proposed that such patients be diagnosed as anxiety neurosis. He made it clear, even as late as 1906, that he considered the symptoms of neurasthenia and of anxiety neurosis to be consequences of the somatic effect of disturbances in sexual metabolism and that he believed the conditions themselves to be biochemical disturbances analogous to thyrotoxicosis and adreno-cortical deficiency. In order to emphasize their special character, he proposed that neurasthenia and anxiety neurosis be grouped

together as *actual* neuroses, as opposed to hysteria and obsessions, which he proposed be called *psycho*neuroses.

The reader will note that the classifications which Freud proposed were based primarily on etiology and not simply on symptomatology. Indeed, he specifically mentioned (Freud, 1898) that a case should be diagnosed as neurasthenia *only* when the typical symptoms were accompanied by a history of excessive masturbation or emissions, since without such a history they must be due to a different cause, as, for example, general paresis (syphilitic meningo-encephalitis) or hysteria. It is important to emphasize this fact for the reason that even today the usual psychiatric classifications of mental disorders which are not the consequence of disease or injury of the central nervous system is on the basis of their symptomatology. These are what are known as descriptive classifications and in psychiatry as in any other branch of medicine, descriptive classifications of diseases or disorders are of relatively little value, since proper treatment depends on a knowledge of the *cause* of the symptoms rather than of their nature, and the same symptoms in two different patients may have quite different causes. It is therefore worth while noting that from the very early years of his work with mentally ill patients Freud attempted to go beyond a purely descriptive classification and to set up categories of mental disorders which resembled one another in having a common cause, or, at the very least, a common, underlying, mental mechanism. Moreover, an interest in etiology and in psychopathology, rather than merely in descriptive symptomatology, has continued to characterize the psychoanalytic theory of mental disorders to the present time.

From about 1900 on, Freud's major clinical interest was in those mental disorders which he called the psychoneuroses and the other, so-called actual neuroses practically ceased to be objects of his study. However, in his monograph on anxiety (Freud, 1926) he reasserted his conviction that the classification of anxiety neurosis was a valid one (he did not mention

neurasthenia) and that it was caused by sexual excitement without adequate gratification. He no longer maintained that anxiety neurosis was essentially a biochemical, endocrine disturbance, though. Instead he attributed the appearance of anxiety, which constituted the principal symptom of the neurosis and which gave it its name, to a purely psychological mechanism. He assumed that the drive energies which should have been discharged in a sexual climax, but which were not so discharged, created a state of psychic tension which eventually became too great to be mastered by the ego, with the result that anxiety developed automatically, as we described in Chapter IV.

It is somewhat difficult to say what the consensus of psychoanalysts is today about neurasthenia and anxiety neurosis as Freud described them. They are discussed as genuine entities in the standard textbook on clinical psychoanalysis (Fenichel, 1946), yet they are rarely mentioned in the periodical literature of psychoanalysis and there have been no case reports since Freud's original description. It seems fair to say that in practice, at any rate, the category of the actual neuroses has ceased to be a significant part of psychoanalytic nosology.

The case is quite otherwise with respect to the category of the psychoneuroses. Freud's early theories concerning these disorders underwent a steady expansion and revision that continued over a period of some thirty years. These changes in theoretical formulation were always the result of fresh information concerning their psychopathology which resulted from the psychoanalytic treatment of patients, a method of treatment which, by its very nature, is at the same time the best method that has yet been devised for the observation of the functioning of the mind.

The changes and additions came thick and fast in the early years. The first was the recognition of the importance of psychic conflict in the production of psychoneurotic symptoms. The reader will recall that Freud's conclusion from his

work with Breuer was that hysterical symptoms and, we may add, obsessional ones as well, were caused by a forgotten event of the past whose concomitant emotion had never been adequately discharged. He soon added to this the formulation, based on further observation and reflection, that for any psychic event or experience to be pathogenic it must be repugnant to the individual's ego to such a degree that the ego tried to ward it off, or to defend itself against it (Freud, 1894 and 1896). The reader must realize that, although the words "ego" and "defend" or "defense" are the same *words* as those which Freud used thirty years later in formulating the structural hypothesis of the psychic apparatus, they meant something quite different in this early formulation. At that time, "ego" meant the conscious self and in particular the ethical and moral standards of the conscious self, while the word "defense" had rather the meaning of conscious repudiation than the very special significance that was assigned to it in the later theory and that we discussed in Chapter IV. Freud considered this formulation to hold good for cases of hysteria, obsessions, and, as he put it, for "many phobias," and he proposed therefore to group such cases together as "defense neuropsychoses." We can see here another instance of Freud's constant effort to establish an etiologically based system of classification rather than one which was based merely on the description of morbid mental symptoms. This tendency is particularly clear in the present instance, since at that time Freud believed some phobias, as, for example, agoraphobia, and some obsessions, as, for example, doubting mania, to be symptoms of anxiety neurosis proper and to be due, therefore, to the inadequate discharge of sexual excitement, with a resultant disturbance of the body's sexual metabolism, rather than to any purely psychological mechanism such as a defense against a repugnant experience.

The next addition to Freud's formulations concerning the psychopathology of the psychoneuroses was the result of his

experience that his pursuit of the forgotten, pathogenic event regularly led back to an event in the patient's *childhood* which concerned his *sexual* life (Freud, 1896, 1898). He therefore proposed the hypothesis that these mental illnesses were the psychic consequence of a sexual seduction in childhood by an adult or an older child. On the basis of his experience he further suggested that if the patient had taken an active role in the pathogenic, or, as it came to be called, the traumatic, sexual experience of childhood, his later, psychoneurotic symptomatology was obsessional. If, on the other hand, his role in the traumatic experience had been a passive one, his later symptoms were hysterical. It is this theory, which postulates a particular, psychically traumatic event of childhood as the usual cause of psychoneurotic symptoms in later life, that is so beloved by writers for Hollywood, Broadway, and the "best seller" lists. To be sure, in such fictional versions the additional, theoretical requirement that the traumatic experience be a sexual one is usually ignored, in deference to the several watchdogs of our public morals.

Freud never abandoned the idea that the roots of any psychoneurosis of later life lie in a disturbance of the sexual life of childhood, and indeed this concept remains to this day the cornerstone of the psychoanalytic theory of these conditions. However, Freud was soon forced to recognize that in many instances the stories which his patients told him of having been sexually seduced in childhood were, in fact, fantasies rather than real memories, even though the patients themselves believed them to be true. This discovery was at first an overwhelming blow to Freud, who castigated himself as the credulous dupe of neuropathic patients and who, in his despair and shame, was nearly ready to abandon his psychoanalytic researches altogether and to return to the respectable fold of the local medical society from which those researches had ostracized him. It was one of the great triumphs of his life that his despair was short-lived, that he was able to re-examine his

data in the light of his new knowledge, and that instead of abandoning psychoanalysis he made an immense step forward by recognizing that, far from being limited in childhood to exceptional, traumatic events like seductions, sexual interests and activities are a normal part of human psychic life from earliest infancy on (Freud, 1905b). In a word, he formulated the theory of infantile sexuality which we discussed in Chapter II.

As a result of this discovery the importance of purely accidental, traumatic experiences in the etiology of the psychoneuroses was relatively diminished and the importance of the patient's sexual constitution and heredity as an etiological factor was relatively increased. Freud assumed, in fact, that constitutional and experiential factors both contributed to the etiology of the psychoneuroses and that in some cases the one was predominant and in some cases the other (Freud, 1906). This remained his view throughout his life and it is the opinion which is generally accepted by psychoanalysts today. We should add, however, that although psychoanalytic observations since 1906 have added greatly to our knowledge of those etiological factors which are experiential, the very nature of such observations has precluded their adding substantially to our knowledge of constitutional factors. Recent studies of child development (cf. Fries, 1953) have been aimed at elucidating the nature of such constitutional factors, but as yet they are hardly beyond the exploratory stage.

The discovery that infantile sexuality is a normal phenomenon also led to other new and interesting concepts. For one thing, it led to a narrowing of the gap between the normal and the psychoneurotic. For another, it gave rise to a formulation concerning the origins of the sexual perversions and their relation to both the normal and the psychoneurotic.

Freud's formulation was that in the course of development of the normal individual some of the components of infantile sexuality which we discussed in Chapter II were repressed,

while the remainder were integrated at puberty into adult sexuality under the primacy of the genitals. In the development of those individuals who later became psychoneurotic, the process of repression went too far. The excessive repression presumably created an unstable situation, so that in later life, as the result of some precipitating event, the repression failed and unwanted, infantile, sexual impulses escaped from repression, at least in part, and gave rise to psychoneurotic symptoms. Finally, in the development of those individuals who became sexual perverts, there was an abnormal persistence into adult life of some component of infantile sexuality, as, for example, exhibitionism or anal erotism. As a result, the pervert's adult sexual life was dominated by that particular component of infantile sexuality, instead of by the normal, genital wishes (Freud, 1905b and 1906).

The reader will note two points about these formulations. The first is that they already express the idea that repression is as characteristic of normal as of abnormal psychic development. This is an idea to which we referred repeatedly in Chapter IV, not only with respect to repression, but with respect to the other defense mechanisms of the ego as well. The second point is that the concept of a repressed impulse escaping from repression to create a psychoneurotic symptom is very similar to the concept which we discussed in Chapter VII of an impulse from the repressed during sleep escaping from the ego's defenses sufficiently to produce a manifest dream.

Freud, of course, was well aware of this similarity and in accordance with it he proposed the formulation that a psychoneurotic symptom, like a manifest dream, was a compromise formation between one or more repressed impulses and those forces of the personality which opposed the entrance of such impulses into conscious thought and behavior. The one difference was that the latent, instinctual wish of a dream might or might not be a sexual one, whereas the repressed impulses which produced neurotic symptoms were always sexual.

Freud was also able to show that psychoneurotic symptoms, like the elements of a manifest dream, had a meaning, that is to say, a latent or unconscious content. Such symptoms could be shown to be the disguised and distorted expressions of unconscious, sexual fantasies. This led to the formulation that a part or all of the sexual life of a psychoneurotic patient was expressed in his symptoms.

So far we have traced the development of Freud's ideas concerning mental disorders up to 1906. Such was the genius of the man and such the fruitfulness of the psychoanalytic method, which he had devised and which he used as a technique of investigation, that his theories at that time already contained all of the major elements of our present-day formulations, either fully developed or in the bud. As we have seen, he began his studies with the concepts that were current in the psychiatric thought of the time, according to which mental disorders were diseases of the mind which had nothing in common with normal mental functioning, that were classified on a descriptive, symptomatic basis, and whose causes were either frankly admitted to be unknown or were attributed to such vague and general factors as the tensions of modern living, mental strain or fatigue, and a neuropathic constitution. By 1906 he had succeeded in understanding the psychological processes underlying many mental disorders to a degree which was sufficient to permit him to classify them on the basis of their psychology, or, if you will, of their psychopathology, rather than of their symptomatology. Moreover, he had recognized that there is not a wide gulf between the normal and the psychoneurotic, but that, on the contrary, the psychological differences between them are ones of degree rather than of kind. Finally, he had made a beginning toward a psychological understanding of characterological disturbances, as exemplified by the sexual perversions, and had realized that these psychic disorders, too, were related to the normal, rather than sharply and qualitatively distinct from it.

The studies of Freud which followed 1906, as well as the later studies of others, served essentially to add to and revise his theories of that time concerning the psychopathology of mental disorders with respect to many important details. They did not, however, lead to changes in principle or in fundamental orientation. Analysts today still direct their attention to the psychological causes of a symptom rather than to the symptom itself, they still think of these causes in terms of psychic conflict between instinctual and anti-instinctual forces, and they still view the phenomena of human mental functioning and behavior as ranging from the normal to the pathological in much the same way as the spectrum of an incandescent solid ranges from red to violet, with no sharp line separating one color from the next. Indeed, we know today that some, at least, of what Freud called psychoneurotic conflicts and symptoms are present in every so-called normal individual. Psychic "normality" can only be defined arbitrarily in relative and quantitative terms. Finally, and in particular, analysts still look to infancy and childhood for the events and experiences which are either directly responsible for mental disorders in later life or at the least cooperate in their development.

In terms of modern psychoanalytic theory, what we refer to clinically as *mental disorders can best be understood and formulated as evidences of malfunctioning of the psychic apparatus to various degrees and in various ways*. As usual, we can best orient ourselves if we adopt a genetic, or developmental approach.

From what we have said in Chapters II-V it is clear that there are many possibilities for trouble in the course of the early years of childhood, when the various parts or functions of the psychic apparatus are actually in the process of developing. For example, if the infant is deprived of normal, physical handling and stimulation by a maternal figure during the first year of life, many of its ego functions will fail to develop

properly and its capacity to relate to and deal with its external environment may be impaired to such an extent as to make it feeble-minded (Spitz, 1945). Then, too, even after the first year of life the development of necessary ego functions may be marred by a failure to develop the necessary identifications, owing either to excessive frustration or to overindulgence, with the result that the ego is unable to perform to best advantage its essential task of mediating between the id and the environment with all that this implies in the way of controlling and neutralizing the drives, on the one hand, and of exploiting to the full the opportunities for pleasure which the environment can afford, on the other.

If we look at the same difficulties from the point of view of the drives, we can readily understand that they must be suitably controlled, but not excessively so. Too little control of the drives will result in an individual who is unfit or unable to be a member of the society to which man ordinarily belongs. On the other hand, excessive suppression of the drives will lead to results that in their way are just as undesirable. If the sexual drive is suppressed too much and particularly if this happens too early, the result is likely to be an individual whose capacity for enjoyment is seriously impaired. If the aggressive drive is the one which is unduly controlled, then the individual will be unable to hold his own in what we consider to be normal competition with his fellows. In addition, because the aggression which cannot be expressed toward others so often turns against the self, he may become more or less overtly self-destructive.

It is also possible for the normal processes of superego formation to go awry. That is to say, the complex, psychological revolution which puts an end to the oedipal period may miscarry in some way, and in consequence the superego may be overly harsh, unduly lenient, or an inconsistent mixture of the two.

In fact all of these possibilities are real ones which do occur.

Of course, in our outline of them we have been overly schematic. For example, if the drives are too little controlled, this naturally means that there are corresponding deficiencies in the functions of the ego and superego. On the other hand, if control of the drives is too rigid, then presumably the ego is too fearful and the superego too harsh.

As we said in Chapter III, many of the ego's interests, that is, many of the activities it chooses as outlets for drive energy and sources of pleasure, are selected on the basis of identification. However, there is another factor which may sometimes be of even greater importance than identification in the selection of a particular activity of this sort. The choice in such cases is determined primarily by an instinctual conflict. Thus, for example, a child's interest in modeling or painting may be determined by a particularly urgent conflict over the desire to smear with feces rather than by the need or desire to identify with a painter. Similarly, scientific curiosity may derive from an intense, sexual curiosity in early childhood, and so on.

The two examples which we have just given are ones that we naturally consider to be favorable as far as the individual's development is concerned. They are examples of that outcome of instinctual conflict which we discussed in Chapter IV under the heading of sublimation. However, it may happen that an instinctual conflict is resolved, or at least stilled, by a restriction or inhibition of ego activity rather than by an enlargement of it such as is found in sublimation. A simple example of this is furnished by the inability of an otherwise bright child to learn arithmetic, because to do so would have been to compete with an older sibling who was gifted in that particular direction. The self-imposed inhibition on his own intellectual activity protected him from some of the painful feelings arising from his jealous rivalry with his brother.

Such restrictions of ego interests or activities may be of little consequence in an individual's life, or they may, on the other hand, be extremely deleterious. It is not rare, for example, that

an individual unconsciously shuns success in his life work as resolutely as the child in our last example shunned arithmetic and for essentially the same reason, that is, to put an end once and for all to an instinctual conflict that would otherwise be intensely unpleasurable. In addition, severe ego restrictions often serve to satisfy a superego demand for punishment or penance. Moreover, to complicate matters even further, not all ego restrictions which arise from instinctual conflicts get the child into trouble with his environment, as an inability to do arithmetic would be likely to do. For instance, a small child's exemplary behavior may be a self-imposed, desperate attempt to win love from his surroundings rather than to continue to suffer the unpleasure of being in violent conflict with them. Is this good or bad for the child and how does it differ from "normal" good behavior?

The same sorts of questions arise in connection with the regressions and fixations that may occur either in the sphere of the ego or of the id or of both. For example, in a particular individual the resolution of the oedipus complex may be accomplished only at the expense of a partial regression of his instinctual life to an anal level, with the result, let us say, that he remains for the rest of his life with an unusually great interest in his own anal processes and products as well as a tendency to collect and hoard whatever he can lay his hands on. As we said in Chapter II, such instinctual regressions usually proceed to a previous fixation point and we believe that the fixation actually facilitates the regression. In our example, we have assumed that the subject's anality was regressive. In another case it might instead be due to a fixation, with essentially the same end result. As another example, this time in the sphere of the ego, there may be a partial regression, as a result of the oedipal conflicts, of the ego's relationship to objects, so that thereafter the objects of his environment are important to him only in so far as they gratify his desires with the result that no object has any permanent or very lasting cathexis. In this

example as in our first one, the same result may in another case be the consequence rather of fixation than of regression.

Such ego restrictions, as well as such fixations and regressions of both the ego and the id as those which we have just described, produce character traits which we shall tend to call normal if they do not interfere unduly with the individual's capacity for pleasure and his ability to avoid severe conflicts with his environment, while we shall tend to call them abnormal if they do interfere with pleasure to a great extent and do bring him into severe conflict with his environment. Here again we must emphasize that there is no sharp dividing line between the normal and the abnormal. The distinction is purely a pragmatic one and the choice of where to make it is necessarily an arbitrary decision. For instance, we consider that the formation of the superego is a normal consequence of the severe, instinctual conflicts of the oedipal phase, yet it is certainly accurate to characterize one aspect of superego formation as a permanent imposition of certain inhibitions or restrictions on both ego and id in order to put an end to the danger situation arising from the oedipal conflicts.

From a purely theoretical point of view we could avoid the accusation of arbitrariness simply by considering all of the possibilities that we have discussed in the last several paragraphs as different ways in which the psychic apparatus may develop and function, without attempting to characterize any as either normal or abnormal. However, the clinician, who is consulted by persons in distress or in serious conflict with their environment, must risk being called arbitrary and must make a division somewhere between what he considers to be normal and not a reason for either concern or treatment and what he considers to be pathological and worthy of both concern and treatment. As we have already said, the distinction between what is normal and what is pathological among the patterns of development and functioning of the psychic apparatus which we have been discussing in the past few pages tends to be

made on the basis of how much the individual's capacity for pleasure is restricted and how seriously impaired is his ability to adapt to his environment. As for terminology, when a pattern of psychic functioning of the sort we have been discussing is considered to be abnormal, it is usually labeled a character disorder or a character neurosis in clinical parlance. Such a label, then, ordinarily refers to a type of functioning of the psychic apparatus which is considered to be sufficiently disadvantageous to the individual to be called pathological, but which represents, nevertheless, a relatively fixed and stable equilibrium within the psyche which developed, as any intrapsychic equilibrium must do, from the interaction between the various forces within the psyche and those influencing it from without during the course of growth.

The various, so-called character disorders, or character neuroses vary considerably in their responsiveness to treatment. In general, the younger the patient and the more discomfort he suffers from his particular character trait or character structure, the more likely is therapy to be effective. We must confess, however, that we have as yet no very precise or very reliable prognostic criteria for such cases.

We come now to the type of disturbance of functioning of the psychic apparatus with which Freud became familiar as a result of his early studies of hysteria and the other "defense neuropsychoses." In such disturbances the following sequence of events occurs. First comes a conflict between ego and id during early childhood, characteristically during the oedipal or preoedipal phase. This conflict is solved by the ego in the sense that the ego is able to set up some stable and effective method of checking the dangerous drive derivatives in question. The method is usually a complex one, involving both defenses and ego alterations such as identifications, restrictions, sublimations, and, perhaps, regression. Whatever the method, it works satisfactorily for a longer or shorter period of time until some subsequent event, or series of events, destroys the

equilibrium and makes the ego apparatus unable any longer to control the drives effectively. Whether the precipitating circumstances act by reinforcing and strengthening the drives or by weakening the ego is of no consequence as far as we know. What is important is that the ego be *relatively* weakened sufficiently to impair its ability to control the drives. When this happens, the drives, or, to be more exact, their derivatives, threaten to irrupt into consciousness and to be translated directly into overt behavior despite the ego's efforts to contain them. An acute conflict thus arises between ego and id with the ego at a relative disadvantage and a compromise formation results of the sort with which we are familiar from Chapter VII. This compromise is called a psychoneurotic symptom. It is also frequently called a neurotic symptom, even by Freud himself in his later writings, despite the fact that it has nothing to do with his concept of the actual neuroses, corresponding instead to what he called the psychoneuroses.

In the type of psychic malfunctioning which we have just described, then, there is a failure of the ego's defenses, whatever the precipitating reasons, as a result of which the ego can no longer adequately control id impulses which had previously been effectively mastered by the ego. A compromise formation results which unconsciously expresses both the drive derivative and the ego's reaction of defense and of fear or guilt to the danger which is represented by the partial breakthrough of the drives. Such a compromise formation is called a neurotic or a psychoneurotic symptom and, as Freud pointed out many years ago, it is highly analogous to a manifest dream or dream element.

A few examples may help to illustrate what we mean. Let us take first a case of vomiting in a young woman. On analysis it developed that the patient had an unconscious, repressed wish to be impregnated by her father. The wish and the countercathexis against it originated during the oedipal period of the patient's life. The relatively stable solution which she was

able to achieve for this and other oedipal conflicts in childhood functioned satisfactorily until her parents divorced and her father remarried when she was in her twenties. These events reactivated her oedipal conflicts and disturbed the intrapsychic equilibrium which had been established years before with the result that the forces of her ego could no longer control her oedipal wishes adequately. In this case, one of the compromise formations that resulted was the symptom of vomiting. The symptom represented unconsciously the gratification of the repressed, oedipal wish to be impregnated by father, as though the patient were demonstrating by her vomiting, "See, I'm a pregnant woman with morning sickness." At the same time the suffering caused by the vomiting and the anxiety which accompanied it were the expression of the ego's unconscious fear and guilt, which were associated with the wish in question. In addition, the ego was able to maintain a sufficient degree of repression so that the infantile content of the wish did not become conscious. The patient had no conscious knowledge of the fact that her vomiting was part of a fantasy of being pregnant, much less of having been made pregnant by her father. In other words, the dysfunction of the psychic apparatus which gave rise to the symptom of vomiting afforded a discharge of the drive energy with which the wish was cathected, but a discharge which was substantially distorted and disguised by the defensive operations of the ego and which gave rise to unpleasure rather than to pleasure. We should add that psychoneurotic symptoms are commonly "overdetermined," that is, that they ordinarily stem from more than one such unconscious conflict between id and ego. In the present case, for example, the wish expressed by the fantasy, "Mother is dead or gone and I have taken her place," as well as the guilt and fear arising from it, also contributed to the symptom which we have described.

Another example is that of a young man with the following symptom. Whenever he left the house, he had to make sure

that all of the floor and table lamps had been disconnected. The frightening fantasy that served as a rationalization for this behavior was that if the lamps were not disconnected, there might be a short circuit while no one was home and the house might burn down. Here again the original conflict was an oedipal one. However, in this case the solution of the oedipal conflict was never a very stable one and the ego's defenses and regulatory mechanisms failed with the onset of the psychic storms of puberty, so that compromise formations, or psychoneurotic symptoms, were conspicuous in his psychic functioning from that time forward.

In the course of analysis it appeared that this young man's symptom had the following unconscious or latent content. Unconsciously the patient wished to take his father's place with his mother. In his unconscious fantasy this would be accomplished in the following way: the house would burn down, his father would be crushed by the loss of the house, would take to drink, and would be unable to work, so that the patient would have to take his place as the head of the house. In this case the irruption of the id wish is represented by two facts: (1) the frequent preoccupation with that part of the fantasy of displacing his father which was permitted to remain conscious, that is, that the house would burn down, and (2) the fact that in his rounds before leaving the house the patient would plug the lamps *in* as well as unplug them, thus expressing his desire to *make* the house burn down, despite his conscious preoccupation with the necessity for preventing this disaster. On the other hand, the ego's part in the symptom is equally clear: undoing, repression, anxiety, and guilt.

A third example is that of a young man with a pathological fear of cancer. Here again the infantile conflict was an oedipal one, while the precipitating factor was the patient's successful completion of professional school and the early prospect of marriage, both of which meant to him unconsciously the grati-

fication of dangerous, oedipal fantasies. The patient's symptom expressed the unconscious, oedipal fantasy of being a woman and being loved and impregnated by his father. The expectation or fear of being mortally ill, which formed the one part of his symptom, symbolized the fantasy of being castrated and hence female, while the idea that something was growing inside his body, which formed the remainder of his symptom, expressed the fantasy that he had been impregnated and that a baby was growing inside him. At the same time, of course, the ego's reaction to these unconscious wishes produced the repression of the infantile content of the fantasy, since the patient was quite unconscious of any desire to be a woman or to have a baby by his father, and was also responsible for the fear which accompanied the symptom itself.

Freud coined two terms in connection with the formation of psychoneurotic symptoms. They are, respectively, the primary and secondary gain of illness, or of symptom formation. Let us see now what Freud meant by saying that an actual gain or advantage somehow accrued to the individual as a result of symptom formation.

Freud considered that the primary gain of this process consisted of an abolition or a diminution of fear or guilt. This may seem a strange thing to say in view of the fact that anxiety so frequently accompanies neurotic symptoms and may indeed be such a prominent part of them, but the paradox is more apparent than it is real. Freud conceived of it in this way. The relative weakness of the ego threatens to permit the irruption into consciousness of the full, infantile content of the id impulse. If it occurred, this would be accompanied by the full, infantile guilt and terror that originally were produced by the impulse in question. By permitting a partial, disguised emergence of the drive derivative via the compromise formation which we call a psychoneurotic symptom, the ego is able to avoid some or all of the unpleasure which would otherwise develop. Here we see how similar a psychoneurotic

symptom is to that other compromise formation which we called a manifest dream. In the manifest dream the ego is likewise unable to avoid the emergence into consciousness of an impulse from the repressed, but by permitting the impulse a fantasied gratification or discharge which is adequately disguised and distorted, the ego can avoid the unpleasure of experiencing anxiety or of being awakened.

As seen from the side of the id, therefore, a psychoneurotic symptom is a substitute gratification for otherwise repressed wishes. As seen from the side of the ego, it is an irruption into consciousness of dangerous and unwanted wishes whose gratification can be only partly checked or prevented, but it is at least preferable to and less unpleasurable than the emergence of those wishes in their original form.

The secondary gain is merely a special case of the ceaseless efforts of the ego to exploit the possibilities for pleasurable gratification which are available to it. Once a symptom has been formed, the ego may discover that there are advantages which the symptom brings with it. To take an extreme example, the combat soldier in wartime who develops an anxiety state has a realistic advantage over his fellows: he is evacuated to the rear, where the danger of being killed is less. To be sure, such an example is not the best, though so obvious on the surface, since the development of the anxiety state itself may be unconsciously influenced by the knowledge that it will lead to removal to safety. However, there are many cases in which there is no question of such a possibility and in which the neurosis comes to have a certain value to the individual only after its development.

From the point of view of the theory of psychoneurotic symptoms the secondary gain is not nearly as important as the primary gain. From the point of view of their treatment, however, it may be very important, since a high degree of secondary gain may result in the fact that the patient unconsciously prefers to keep his neurosis rather than to lose it, since his

symptoms have become valuable to him. The treatment of severe obesity, for example, is always a difficult matter, but it becomes impossible if the patient is a fat lady in a circus, who makes her living from her illness.

In the examples which we gave of the formation of psychoneurotic symptoms we did not include one which illustrated the possibility, which we have mentioned earlier, that one of the ego's defenses may be a regression, both of the ego functions and of the drives. Once again, from a theoretical point of view, regression is but one of the many defensive maneuvers which the ego may employ. However, from the point of view of its practical consequences, it is a particularly serious one. The greater the degree of regression, by and large, the more serious is the symptomatology which results, the poorer is the outlook for successful treatment, and the greater is the likelihood that the patient will require hospital care.

Another point which we wish to make about the type of malfunctioning which may result from a failure of the ego's defenses is this. Those malfunctionings which we speak of as psychoneurotic symptoms are ordinarily those which are felt by the individual's ego to be alien to it, unpleasurable, or both. The young man who had to check all the lamps before he could leave the house, for instance, didn't *want* to do so. On the contrary, he couldn't help himself. He *had* to check them. His symptom, in other words, was perceived as alien by his ego and at the same time as unpleasant. On the other hand, the young woman who vomited did not feel her symptom as alien to herself. There was no question in her mind that it was *her* stomach that felt sick, just as would have been the case if her nausea had been due to an acute infection. However, her symptom was distinctly unpleasant.

Now there are compromise formations which result from a failure to establish or maintain a stable method of controlling the drives owing to a relative weakness of the ego which are neither ego alien nor unpleasurable. The most severe and obvious of these are many cases of sexual perversion and addiction. Two observations are in order about such cases. In the first place, they are obviously intermediate between what we have chosen to call character disorders and what we have chosen to call psychoneurotic symptoms and cannot be sharply differentiated from either. In the second place, the instinctual gratifications which constitute the perversion or addiction as the case may be are used by the ego in a defensive way to keep in check other drive derivatives whose emergence and gratification is too dangerous to the ego to be permitted. These compromise formations, from the point of view of the ego, are examples of the use of one drive derivative to help in the control of another and in this sense they are similar to the defense mechanism of reaction formation, which we discussed in Chapter IV. The reader will note that this represents a considerable emendation of Freud's original statement that a sexual perversion is the reverse of a neurosis, to which we referred earlier in the present chapter (Freud, 1905b).

It would be beyond the scope of our presentation to discuss in detail what specific, intrapsychic conflicts and compromise formations give rise to the variety of symptoms which are clinically referred to as hysterical, obsessional, phobic, manic-depressive, schizophrenic, perverse, and so forth. It has been our aim rather to give to the reader some understanding of the general, fundamental, theoretical formulations which are common to all of these clinical subdivisions, or which may be used for the purpose of making broad, psychopathological distinctions among them. Above all, we have tried to make clear the fact that there is no sharp or indisputable distinction to be made between what we consider normal and what we consider pathological in the realm of mental functioning. What we call normal and what we call pathological are to be understood as the consequence of differences in the functioning of the psychic apparatus from individual to individual—differences which are of degree rather than of kind.