TRANSLATOR'S INTRODUCTION

I. The Significance of Wilhelm Reich's *Der Triebhafte Charakter*

Wilhelm Reich's first book, *Der Triebhafte Charakter: Eine psychoanalytische Studie zur Pathologie des Ich*[1] [*The Impulsive Character: A Psychoanalytic Study of the Pathology of the Ego*] (1925), stands as a landmark in the history of psychoanalysis. It is the earliest systematic psychoanalytic exploration of character structure as a distinct psychological entity, and it makes the claim that every analytic treatment—regardless of presenting symptoms—must address the patient's total character if lasting change is to be achieved.

It is an important book for these reasons alone. But it is also the first book on any subject that uses the new concepts of psychic structure and function that Sigmund Freud had introduced in his book *The Ego and the Id*[2]. Freud acknowledged this in his letter to Reich accepting the manuscript for publication[3]. These theoretical tools were essential to Reich's understanding of character in this phase of his work; later on, as he writes in *The Function of the Orgasm*, he replaced Freud's concepts with his own 'functional theory of psychic structure'[4].

In *The Impulsive Character*, Reich provides a conceptual framework with which to understand a patient's character as an integral whole in a systematic and comprehensive way and to approach it through a psychological treatment. The investigations reported in this book were continued and linked to Reich's ongoing studies of the narcissistic defenses, or 'character armor'[5], as he came to call them, and of the concept of genitality[6]; the result of these inquiries is Reich's best-known

[1] Reich, W., *Der triebhafte Charakter. Eine psychoanalytische Studie zur Pathologie des Ich*, Neue Arbeiten der ärtzlichen Psychoanalyse, Vol. **IV** (ed. S. Freud), Internationaler Psychoanalytischer Verlag (hereafter IPV), 1925a. [Reich, W., *The Impulsive Character and Other Writings*, Koopman, B. (trans.), New American Library, 1974, pp. 1-81; Reich, W., *Early Writings,* Vol. I, Schmitz, P. (trans.), (1975), Orgonon Press, 2024, pp. 237-332].

[2] Freud, S., *The Ego and the Id*, (1923), *Revised Standard Edition* (hereafter *RSE*), Vol. **XIX**, 2024, pp. 10-53. This and all other references to Freud's work are to *The Revised Standard Edition of the Complete Psychological Works of Sigmund Freud*, Solms, M. (ed.), Strachey, J. (trans.), Rowan & Littlefield, 2024.

[3] Johler, B. (ed.): *Wilhelm Reich Revisited*, Turia+Kant, 2008, pp. 32-33.

[4] Reich, W., *The Function of the Orgasm*, Orgone Institute Press, 1942, p. 126.

[5] Reich, W., 'Zwei narzißtische Typen' ['Two Narcissistic Types'], *Internationale Zeitschrift für Psychoanalyse* (hereafter *IZP*), Vol. **8**, 1922, pp. 456-462; Reich, W. (1975), pp. 133-142. Reich introduced the concept of character as a defensive 'armor' ('Panzer') against feelings of anxiety in this paper.

[6] Reich, W., 'Über Genitalität vom Standpunkt der psychoanalytischen Prognose und Therapie' ['On Genitality: From the Standpoint of Psychoanalytic Prognosis and Therapy'], *IZP*, Vol. **10**, 1924, pp. 164-179: Reich, W. (1975), pp. 158-179; Reich, W., 'Weitere Bemerkungen über die therapeutische Bedeutung der Genitallibido: Nach einem Vortrag am VIII. Internationalen Psychoanalytischen Kongreß, Salzburg, April 1924' ['Further Remarks on the Therapeutic Significance of Genital Libido'], *IZP*, Vol **11**, 1925b, pp. 297-317; Reich, W. (1975), pp. 199-221. On the basis of experience with the

work, *Character Analysis*[7].

Reich systematically delineates three patterns of character development: the normal or healthy character; what Reich referred to as the 'impulse-inhibited character', i.e., the typical patient with neurotic symptoms; and a newly described category that he labels the 'triebhafte' (driven, instinctual, impulsive) character, which has a startling resemblance to our current concept of borderline personality organization. In fact, Reich's account of the impulsive character is the first published formulation of the currently accepted theory of the development, structure, and functioning of the borderline, anticipating by decades the work of Kernberg and others[8].

The book appeared at a time when psychoanalysts were just beginning to investigate the relationship of the enduring character of the patient to the more transitory symptoms that can develop, such as hysterical conversions or obsessional ruminations, which had been their focus hitherto. Historically, character traits had been seen as a matter of one's constitution or temperament[9]. Even Freud had viewed character traits as an expression of instinct or biology[10]. Karl Abraham had extended Freud's early study of the instinctual roots of character. He had a particular interest in the 'embryology' of the *libido* (sexual drive)[11], i.e., its developmental phases and their relation to particular character traits[12]—a perspective deeply influenced by his own early biological interests, evident in his medical dissertation on the embryology of the parakeet[13].

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psychoanalytic treatment of numerous patients, Reich argued in these two closely related papers that the prognosis of the treatment depended on the establishment of the capacity for genital orgasm.

[7] Reich, W., *Charakteranalyse,* Self-published, 1933; [Reich, W., *Character Analysis*, 3rd ed. (1949), Orgonon Press, 2024].

[8] Kernberg, O., *Borderline Conditions and Pathological Narcissism*, Aronson, 1975, pp. 3-47.

[9] See, e.g., Berrios, G., *The History of Mental Symptoms: Descriptive Psychopathology Since the Nineteenth Century*, Cambridge, 1996, pp. 419-442.

[10] Freud, S., "Character and Anal Erotism" (1908a), *RSE*, Vol. **IX**, 2024**,** pp.149-154,

[11] 'Libido' is a term denoting both sexual ties to another person and the energy of the sexual drive. See, e.g., Auchincloss, E., and Samberg, E., *Psychoanalytic Terms and Concepts*, Yale, 2012, pp. 137-139.

[12] Abraham, K., *Versuch einer Entwicklungsgeschichte der Libido auf Grund der Psychoanalyse seelischer Störungen* [*A Short Study of the Development of the Libido, Viewed in the Light of Mental Disorders*], IPV, 1924; in Abraham, K., *Selected Papers of Karl Abraham*, Hogarth, 1927, pp. 418-501.]

[13] Bentinck van Schoonheten, A., *Karl Abraham: Life and Work*, Karnac, 2016, p. 15.

Psychiatric authorities of the time, such as Kraepelin[14] and Bleuler[15] , had described certain enduring personality patterns — variously labeled the 'emotionally unstable', the 'born criminal', or 'pathological liars and swindlers', among other designations — that produced persistent, disruptive, and often antisocial behavior and yet did not fit any other defined mental disorder, whether a major psychosis, such as schizophrenia or manic-depression, or a relatively minor condition resulting in symptoms, such as hysteria or obsessive-compulsive disorder. Such personalities were labeled as 'psychopathic'; their condition was thought to be caused by mental 'degeneration'[16] and was felt to be essentially untreatable. *Reich played the central role in the shift from conceptualizing character as innate and unchangeable to viewing it as a psychological structure that could change and, when necessary, be treated.*

Historically, psychoanalysts had treated patients who could pay a fee to consult them in their private offices. Their symptoms, while troublesome certainly, for the most part did not require them to be hospitalized, and they lived bourgeois lives. The new category of patients, impulsive characters, had rarely been seen by analysts before. These were patients whom Reich had encountered at the Steinhof, Vienna's large public psychiatric facility where he was getting his postgraduate psychiatric training[17], and the Ambulatorium, the free psychoanalytic clinic established by the Vienna Psychoanalytic Society, where he was appointed to be the first assistant physician shortly after it opened[18].

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[14] Diefendorf, R., *Clinical Psychiatry: A Textbook for Students and Physicians Abstracted from Kraepelin's "Lehrbuch der Psychiatrie", 7th Edition*, Macmillan, 1912, pp. 515 ff.

[15] Bleuler, E., *Textbook of Psychiatry*, (trans.) Brill, A.A., Macmillan, 1924, pp. 569-592.

[16] Morel, B.A., *Traité des Dégénérescences Physiques, Intellectuelles, et Morales de l'Espèce Humaine et des Causes qui Produisent ces Variétés Maladives* [*Treatise on the Physical, Intellectual, and Moral Degeneracy of the Human Race and the Causes That Give Rise to These Pathological Variations*], Baillière, 1857, p. 48. Morel espoused a theory that exposure to toxins such as alcohol, opiates, tobacco, hashish, or heavy metals (e.g., lead or mercury), among many other substances, directly affected the 'transmission héréditaire' of the individual, leading to worsening mental degeneration in succeeding generations and eventually to the extinction of the race. The degeneration could take the form of developmental delay, major psychoses and mood disorders, addictions, neurotic symptoms, or maladaptive character traits. Morel's theory was remarkably influential, as is reflected in the fact that both Kraepelin and Bleuler refer to the role of degeneration in causing the development of 'psychopathic' characters, as noted here, and in the fact that even Freud made use of the concept early in his career. See, e.g., Freud, S., 'Hysteria' (1888), *RSE*, Vol **I**, 2024, p. 54, and *Three Essays on the Theory of Sexuality* (1905a), *RSE*, Vol **VII**, 2024, p. 208.)

[17] In October 1922 Reich began two years of postgraduate training in psychiatry and neurology under Prof. Julius Wagner-Jauregg at the Niederösterreichischen Landesheil- und Pflegeanstalt für Nerven- und Geisteskranke 'Am Steinhof' (Neuro-Psychiatric Asylum of Lower Austria 'On the Steinhof'), familiarly known as 'the Steinhof', a large public inpatient and outpatient facility located in suburban Vienna and closely affiliated with the University. See Reich, W. (1942), p. 41.

[18] In May 1922, two years after Eitingon and Abraham had established the first psychoanalytic Lehranstalt and Poliklinik (Teaching Institute and Treatment Center) under the auspices of the Berlin Psychoanalytic Society, the Vienna group opened their own free public Psychoanalytische Ambulatorium (outpatient clinic) under the direction of Dr. Eduard Hitschmann. Reich was promoted to deputy director in 1929. Hitschmann, E., 'Zehn Jahre Wiener Psychoanalytisches Ambulatorium (1922-1932): Zur Geschichte des Ambulatoriums', *IZP*, Vol. **XVIII**, 1932, p. 269.

These patients often presented with histories of severe trauma, physical and sexual abuse, neglect, poverty, parental alcoholism or addiction, illegitimacy, single-parent households, and exposure to criminal environments. Their symptomatology was dramatic, unrestrained, and frequently antisocial. Implicit in the book is that these patients were of a different social class from typical psychoanalytic patients, belonging to the urban and rural underclasses rather than to the bourgeoisie.

The Impulsive Character claims our interest today for several reasons. As a predecessor to Reich's *Character Analysis*, it sheds light on the latter book and helps us understand it better. As I will discuss below, the model of the structural development of the mind that is depicted is strikingly original and centers on a new model of the origin and development of the ego. This, in turn, depends fundamentally on yet another conceptual innovation of the book, that of internalized object relations. These advances remain highly relevant today and continue to shape current thought and practice. A new translation is offered now, a century after the *The Impulsive Character*'s first publication, because the book remains a greatly under-appreciated contribution to psychoanalytic theory and therapy, and it is hoped that a faithful translation and a psychoanalytic contextualization will help to remedy this circumstance.

The Impulsive Character marked the apogee of Wilhelm Reich's engagement with Sigmund Freud and his psychoanalytic movement. In no other publication is Reich's total identification with and commitment to Freudian concepts so evident. After its publication, however, Reich's interests and activities diverged more and more from those of Freud and psychoanalysis[19], eventually leading to his expulsion from the International Psychoanalytic Association (IPA) in 1934. Thus it was left to others, such as A. Freud, H. Hartmann, E. Jacobson, M. Klein and W.R.D. Fairbairn, to develop further the psychoanalytic innovations of the book. Of these, it is

[19] Two interests stand out: first, Reich's growing interest in leftist and anti-fascist political activism, and second, his conviction that the clinical significance of genitality was a central issue that Freud had discovered and that psychoanalysis was in the process of evading and abandoning.

the idea of internalized object relations that is perhaps most influential today.

II. Psychoanalysis in 1919

During the period of the First World War, Sigmund Freud had gone through a phase of summing up his psychoanalytic work of the previous 30 years[20]. This endeavor culminated in the publication of the metapsychological papers[21] and the *Introductory Lectures on Psychoanalysis*[22]; taken together, these volumes are as close to a textbook of psychoanalysis as Freud ever produced. The model of normal and pathological mental functioning they present is the so-called *topographical* model of the mind. The name derives from Freud's thesis that the characteristics of mental functions differ according to the place (*topos* in Greek) in the mind in which the functions take place: the unconscious, the preconscious, or the conscious[23]. This was the model of the mind confronting Reich when he first encountered psychoanalysis. As early as June 1919, he displayed his remarkable grasp of Freud's model in a paper on contemporary theories of drives presented to the Vienna Seminar for Sexology. The paper was written within a few months of his first encounter with psychoanalysis and was later augmented and published[24].

What follows in this section is a concise overview of this model and in the next section that of its successor, the so-called *structural* model, which are intended to establish a context for understanding Reich's achievement in *The Impulsive Character* and its reception.

The Drives and Defenses

Freud conceived of man as a creature motivated by two classes of instinctual drives, the sexual

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[20] Strachey, J., Editors' Introduction to Freud, S., *Introductory Lectures on Psychoanalysis (Parts I and II)* (1916-1917) (1964), *RSE,* Vol. **XV**, 2024, p. 5.

[21] Freud, S., *Papers on Metapsychology* (1915), *RSE*, Vol. **XIV**, 2024, pp. 103-180. This is a series of papers outlining some of the fundamental assumptions of psychoanalysis; the series includes papers on the psychoanalytic theory of instinct, of repression, and of the unconscious.

[22] *Freud, S., Introductory Lectures on Psychoanalysis (Parts I and II)* (1916-1917), *RSE*, Vol. **XV**, 2024; Freud, S., *Introductory Lectures on Psychoanalysis* (Part III) (1916-1917), *RSE*, Vol. **XVI**, 2024.

[23] Freud, S., *The Interpretation of Dreams* (1900), *RSE*, Vol. **V**, 2024, pp. 526-555. For example, the so-called *primary process* governs unconscious mental events, while the *secondary process* governs preconscious and conscious mental events. Preconscious mental events are those of which we are not immediately conscious when we are attending to something else but can readily become so. As an example, we may not be conscious of what is in the next room when we are engaged in work but can easily become so. Unconscious events require special techniques to be brought to consciousness.

[24] Reich, W., 'Trieb- und Libidobegriffe von Forel bis Jung' ['Drive and Libido Concepts from Forel to Jung'], *Zeitschrift für Sexualwissenschaft*, Vol. **IX**, 1922, pp. 17-19, 44-50, 75-85; Reich, W. (1975), pp. 86-124.

and the self-preservative[25]. The latter class is also known collectively as the ego-instincts[26]. The drives, in turn, are ruled by the pleasure-unpleasure principle, according to which thoughts and actions tend toward pleasurable experiences and away from unpleasurable experiences. Energy accumulates in the nervous system originating from stimuli received either from the external world or from within the body. A component of the latter stimulus corresponds to increasing drive needs, such as hunger or thirst. This accumulation of energy is perceived as an increase in tension that has the quality of unpleasure.

The accumulated energy is discharged in the form of mental processes and actions that are either self-preservative in aim (e.g., eating, drinking, staying warm or cool, as the case may be, or fight-or-flight activities) or sexual in aim. When there has been an appropriate *specific action*[27] corresponding to the particular drive need, e.g., eating a meal when one is hungry and drinking when one is thirsty, or a sexual experience after a period of abstinence, there is the discharge of the increased tension which is perceived as pleasurable, followed by relaxation. The mental apparatus can thus be viewed as acting like an electrical capacitor that accumulates, stores, and then discharges an energy charge. Charge regularly builds up, which feels unpleasurable; this is the motivation for thoughts and actions that will lead to the discharge of the tension via the appropriate specific action, which is felt as pleasurable and leads to relaxation.

In his *Three Essays on the Theory of Sexuality*[28], Freud describes the sexual drive as being present from earliest infancy, first in connection with the mouth and the activity of nursing, later focused on the anus and anal functions, and finally on the genital. These three anatomic structures are designated *erotogenic* zones because of the ready erotic sensations connected with

[25]Freud, S., *Beyond the Pleasure Principle* (1920b), *RSE*, Vol. **XVIII**, 2024, pp. 7-61. Only a year after Reich's first encounter with psychoanalysis, Freud radically revised his theory of drives by positing the existence of a 'death drive' as the source of human aggression. This theory was met with perplexity by the psychoanalytic community at the time, and was to have far-reaching consequences over the years, but is not immediately relevant to this discussion of *The Impulsive Character.*

[26]Freud, S. 'The Psycho-Analytic View of Psychogenic Disturbance of Vision' (1910c), *RSE*, Vol. **XI**, 2024, pp. 201-207, esp. 203 ff.

[27]Freud, S. 'Project for a Scientific Psychology' (1895), *RSE*, Vol. **I**, 2024, pp. 342-344. A specific action is an action that *satisfies* the specific drive need.

[28]Freud, S. (1905a), *RSE*, Vol **VII**, 2024, pp. 121-215.

their functioning. The child's psychological development is seen as consisting of three successive phases centered on the functioning of each of the different zones. For example, functioning during the oral phase is centered on nursing, or incorporating aspects of the external world in general, such as occurs in the psychological mechanism of *identification*, while that of the anal phase is focused on the development of feelings of activity and a growing mastery over one's body and the external world[29].

The sexual drive is connected initially with the self-preservative drive of obtaining nourishment, only later becoming independent and expressing itself as sensual sucking (i.e., the sucking of other objects than the breast for pleasure, such as the thumb or the big toe), or other masturbatory activity such as retaining and then passing stool in order to stimulate the anus, and, at about age four, stimulation of the genital. Freud referred to these separate drive expressions as Partialtriebe (literally, 'partial drives'), rendered in English as 'component instincts' by James Strachey, the most influential of his English translators. Freud's broadening of the concept of the sexual from the purely genital and the procreative to the so-called *pregenital* partial drives is one of his great contributions.

Associated with the genital phase of development (beginning at age three to five) is a period of intense love of the child for a parent, usually of the opposite sex, which Freud called the Oedipus complex, named after the drama *Oedipus Tyrannus* by Sophocles in which this constellation is clearly depicted[30]. This parent is the first love object, the earlier sexual activity being objectless or auto-erotic[31]. Envy, hate, and fear of the other parent, along with a wish to kill and replace him or her in the affections of the loved parent are also part of the constellation. The latter wish is associated with an intense fear of punishment which regularly takes the form of the *castration complex*. The castration complex is a universal fantasy existing in both boys and girls according to which the possibility exists that the phallus can be taken away from the child as a

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[29] Abraham, K. (1924); [in Abraham, K. (1927), pp. 422-433.]

[30] In the Oedipal, or *triangular*, situation, the child can be in love with either parent and experience the other parent as a hated rival. Freud termed love for the opposite-sexed parent as the *positive* Oedipus complex and that for the same-sexed parent as the *negative* Oedipus complex. Due to his assumption of man's *constitutional bisexuality*, Freud held that both complexes were simultaneously present in everyone, the intensities of each of which depending on the relative constitutional strengths of the two sexual strivings, heterosexual and homosexual. as well as on the child's experiences growing up. Only the simple positive Oedipus complex is discussed here for the sake of clarity.

[31] The topic of the pregenital attachment to part-objects is not directly pertinent to this discussion.

punishment. This is an outcome that arouses the most intense anxiety.

Freud stressed that for the child, what exists between it and the parent is a true love affair which, despite being associated with the most intense affects, is usually unconscious. The resolution of the Oedipus complex, discussed below, is a major task of the genital phase and marks the end of what Freud referred to as the *first sexual phase*[32]. It is associated with the introduction of the latency phase of childhood which corresponds roughly to the elementary and early middle school years.

The latency age child is relatively asexual; this is a time when the moderation of drive expression is instituted that permits the child to live in society. The pattern of the control of the drives that is established at this time is an important influence on an individual's mature character or personality.

The arrival of puberty signals the end of the latency period. The sexual organization reaches its adult form, with the genital assuming *primacy* over the other (pregenital) component instincts. The latter (e.g., touching, kissing) are incorporated into adult sexual life as elements of foreplay but always with the ultimate aim of genital union with an unambivalently loved person. Until the attainment of genital primacy, Freud considered the individual to be *polymorphously perverse*[33], that is, capable of the equal enjoyment of sexual pleasure arising from any erotogenic source.

Freud's theory assumes that control of both the self-preservative and sexual drives is a necessary part of normal growth and development. The expression of sexual component instincts, for example, must be restricted as to time and place in order for a person to exist normally in society. When it is not so restricted, the child is confronted with more or less severe punishment from care-givers. To avoid the punishment and the anxiety that attends it the child *represses* the offending impulses, and constructs *reaction formations* against them. These *defenses* are

[32]Freud, S. (1905a), p. 177.
[33]Ibid., pp. 169-170.

triggered by the self-preservative drive which is acting directly against the expression of the libidinal drive in order to avoid the pain and anxiety associated with an anticipated punishment. In repression, the wish is excluded from the conscious part of the mind by an unconscious mental *censor* acting in the service of the self-preservative drive, which shifts the wish to the unconscious. There it persists and continues to motivate the individual, though outside of his awareness. In reaction formation, the individual not only represses the awareness of wishes towards a desired object but also adopts an opposing attitude, such as hate feelings, towards the same object in order to strengthen the repressive force. This *conflict* between the libidinal and self-preservative drives is the paradigmatic example of *intrapsychic conflict* in Freud's topographic model.

Defense mechanisms such as repression and reaction formation merely keep anxiety-provoking wishes out of conscious awareness. There the wishes may dwindle away or, on the other hand, strengthen. If the latter is the case, they may get strong enough to overwhelm the defensive measures and begin to re-emerge into consciousness—a *return of the repressed*. Neurotic symptoms such as phobias, hysterical conversions, or obsessions and compulsions are defensive measures, each with its own psychic mechanism, that are triggered when an antecedent defense against drive expression, such as repression, begins to fail; they can thus be likened to emergency brakes. Symptoms are *compromise formations* in which the drive, no longer fully repressed, finds expression along with the defensive measure. Drive and defense are both partially expressed.

A hysterical conversion symptom such as a psychogenic seizure, for example, represents a compromise between the expression of the drive and a defense against it. The movements of the seizure might represent the disguised enactment of forbidden sexual wishes of which the individual remains unaware. Thus in one and the same event, the seizure, both a sexual drive wish and a defense against the full enactment and awareness of the wish are expressed, leading to a partial and disguised satisfaction of the unconscious wish in the form of the seizure. All neurotic symptoms employ this compromise mechanism. The work of defenses like repression or reaction formation is silent; but when, in the face of overwhelming drive pressures, they begin to fail, they produce 'noisy' symptoms that can interfere with normal life, motivating a person to

try to get help to remove them.

The conflict between drive and defense, between the unconscious and conscious parts of the mind, which is so characteristic of the topographic model has also been called the 'hydraulic model' of the mind. The instinctual drives are pictured as a stream of water that can overflow the damming up by repression and reaction formation, forcing the drives into other channels of expression, such as symptoms. In this way Freud was able to explain the formation and meaning of dreams, neurotic symptoms, and so-called Freudian slips (e.g., slips of the tongue or pen which betray an unconscious motive), as well as the mechanism of jokes.

Treatment and Resistance

Freud's model of the mind dictated treatment. If symptoms result from the failure of the repression of forbidden and anxiety-provoking wishes, treatment attempts to replace the inadequate repression of the wishes with a fully conscious awareness and *condemnation*, or rejection, of them. This provides the subject with the opportunity to select an alternative course of action. The psychoanalyst's *interpretation* of unconscious content is the technical measure that brings the material to consciousness. In an interpretation the unconscious meaning of symptomatic behavior is provided, in words, by the analyst. If the subject can assimilate the interpretation and acknowledge the unconscious content consciously, the failing defense mechanism is made unnecessary and the symptom dwindles away and disappears. Thus an automatic mental response, an unconscious defensive measure that is failing, is replaced by a conscious choice, thereby expanding the subject's agency.

This process is well illustrated by the fascinating case of 'Little Hans'[34]. Hans was a little boy who developed a phobia about horses: he was so afraid of seeing them in the street that he dreaded leaving his home. His father consulted Freud, who guided Hans' treatment by supplying his father with interpretations which he, in turn, made to Hans at opportune times in the course of

[34]See. Freud, S. 'Analysis of a Phobia in a Five-Year-Old Boy' (1909), *RSE*, Vol. **X**, 2024, pp. 5-113, esp. p. 110.

daily life. Freud understood Hans' phobia to be an attempted solution to his Oedipal conflict. Hans unconsciously feared that his father, in the symbolic form of the horses he encountered in the street which he thought would bite off his penis, wanted to castrate him as a punishment for his unconscious wish to replace his father in his mother's affections. These interpretations were made to Hans by his father over the course of a few weeks, in suitable terms that he was able to assimilate, and resulted in his full recovery. Hans visited Freud some 14 years later and confirmed that he had remained entirely well after the treatment.

Freud's earliest psychological treatment[35] of neurotic symptoms used hypnosis to try to circumvent the unconscious censor in order to bring the repressed material to consciousness. Hypnosis was eventually replaced by the method of *free association*[36]. The patient was asked to put into words everything that he was experiencing during the treatment session without consciously selecting or censoring the material, regardless of how 'unimportant or irrelevant or nonsensical,...embarrassing or distressing'[37] it might seem. The trend of associations, what was avoided, what was gravitated toward, gave indications to the analyst as to the functioning of the unconscious censor. The requirement to attempt, at least, to free associate became the *fundamental rule* of psychoanalysis.

In 1919, psychoanalytic treatment took place six days a week for an hour. External stimuli, such as bright lights, noise, or even looking at the analyst, were minimized in order to facilitate the process. The patient lay on a couch and followed the fundamental rule—they free associated. Attending to the course of the associations, the analyst formed an impression of which thoughts, feelings, or wishes were being defended against and offered an interpretation—a verbal formulation—of what they were. When these interpretations were accepted, there could be gratifying results, as with Little Hans.

But what if a patient didn't associate, or didn't produce dreams? Or produced a chaotic profusion of associations? Reich describes his bewilderment with these technical questions during his early

[35]Breuer, J. & Freud, S., *Studies on Hysteria* (1895), *RSE*, Vol. **II**, 2024.
[36]Ibid. pp. 51, 57.
[37]Freud, S., 'Freud's Psychoanalytic Procedure' (1904), *RSE*, Vol. **VII**, 2024, pp.225.

experience as an analyst[38]. Without proffering more helpful advice, Freud stressed to Reich that the analyst needed to be patient and 'keep on analyzing'; he once insisted that Reich should not select the material to be analyzed, but rather was to depend on the order of associations that the patient provided to decide on what to focus in the session[39].

Freud had discovered very early[40] that patients tended to resist his efforts and interpretations in various ways—that is, they actively but unconsciously opposed his attempts to help them. For example, they might not seriously consider his interpretations, or they might censor associations, or lie. It's easy to see why this was happening—the self-preservative drive was expressing itself in the session by unconsciously preventing, in myriad ways, the anxiety-provoking material from being unearthed and confronted. That is, the repression of unconscious material, which is always operative, behaves in the therapy as a resistance to the aims of therapy. What on the surface might appear to be an analyst trying to help a patient is experienced by the patient, consciously or not, as an attack. The equilibrium that had existed, as unpleasurable as it might have been, is being disturbed by the analytic process. The patient experiences an anxiety-provoking feeling of loss of control that causes him, unconsciously, to tenaciously hold onto his existing defenses and ward off the efforts of the analyst.

One of Freud's great discoveries was his realization that resistance to the psychoanalytic treatment was organized around *transference*[41]. In transference, elements of the conflictual childhood relationships that have given rise to the symptoms are unconsciously transferred, or displaced, onto the analyst. The patient unconsciously begins to experience the analyst as the Oedipal father or mother, for example. The intense conflicts bound up with these relationships are then transferred to the analyst, and because the associated wishes are forbidden and anxiety-provoking (tabooed love for one parent and murderous hatred for the other), they are strongly repressed. The transference situation is thus a complicated situation of an intensely conflicted attachment which

[38]
[39] Reich, W. (1942), pp. 29-31.
Ibid, p. 142.
[40] Breuer, J., & Freud, S. (1895), 'The Psychotherapy of Hysteria', pp. 227-272, esp. pp. 239 ff.
[41] Freud, S., 'Fragment of an Analysis of a Case of Hysteria' (1905b), *RSE*, Vol. **VII**, 2024, pp. 7-108, esp.102-108.

is strongly repressed; in the therapy the strong repression motivates an intense resistance to the analyst's attempts to uncover the unconscious wishes and feelings.

Freud came to realize, however, that as inauspicious as the situation appeared, the transference was actually a most powerful therapeutic tool[42]. The intensity, immediacy, and incongruity of the wishes and affects that are transferred onto the analyst indicate to both patient and analyst that there are powerful unconscious forces at work that need to be explored despite the intense resistances. When they are analyzed, when the intense resistance is *worked through*[43] and overcome, the unconscious pathogenic conflicts are revealed and can be resolved. In short, the development of the transference heightens the conflict between drive and defense responsible for the symptoms and directs them onto the person of the analyst, who is then in the position of being able to analyze it in 'real time' and with all of its intensity in the analyst-patient relationship.

In 1919, it was already known that the treatment described here didn't always work; or it worked only partially, or temporarily. The symptoms of some patients actually began to worsen as they neared their treatment goals and the end of the treatment, a phenomenon which came to be known as the *negative therapeutic reaction*[44]. The focus of the treatment then shifted from uncovering unconscious material to understanding better the resistance to the uncovering of unconscious material, and the repressions that underlay it[45]. This was one of Freud's chief motivations for writing *The Ego and the Id*.

III. *The Ego and the Id* (1923)

Freud already knew in 1895 that repressed memories and the resistances to their being made conscious had a particular layering, or structure, in each patient that needed to be taken into

[42] Freud, S., 'Remembering, Repeating, and Working Through (Further Recommendations on the Technique of Psychoanalysis II)' (1914c), *RSE*, Vol. **XII**, 2024, pp. 151-153.

[43] In a psychoanalytic treatment, 'working through' is the process of overcoming a resistance, thereby making unconscious material conscious, by progressively uncovering the unconscious roots of the resistance by means of interpretation, usually of the transference. See, e.g., Laplanche, J. and Pontalis, J. B.. *The Language of Psycho-Analysis*, Norton, 1973, pp. 488-489.

[44] Freud, S. (1923), p. 44.

[45] Freud had already announced in 1910 that the focus of treatment should be the resolution of the resistances rather than the direct interpretation of repressed material. This shift in technique was to be only very slowly accepted by the psychoanalytic community. See Freud, S., 'The Future Prospects of Psychoanalytic Therapy' (1910b), *RSE*, Vol. **XI**, 2024, p. 132.

account in the treatment[46]. Later, Freud described three examples of character types he had encountered as a clinician, the character traits of which functioned as resistances to the therapy[47]. The efforts in therapy of those 'wrecked by success' or those who were 'criminals from a sense of guilt' were undermined by their intense unconscious guilt; 'the exceptions' felt, due to a history of adversity, that they didn't have to follow rules in life that everyone else did, for example, the fundamental rule in therapy. The concepts of a systematic 'structure of resistances' and of enduring character traits functioning as chronic resistances in therapy represented crucial early milestones in psychoanalytic theory.

These ideas reflected the beginning of a shift away from the topographical model—which organized mental functioning according to regions of consciousness (unconscious, preconscious, conscious)—toward a new framework focused on enduring psychic structures or agencies, *id*, *ego*, and *superego*, and their dynamic interactions, which came to be known as the structural theory. This emerging perspective reached its full elaboration in *The Ego and the Id*. There, Freud reconceptualized psychic conflict not merely in terms of repressed content striving to become conscious, but as ongoing tensions among relatively autonomous mental structures, each with its own functions, origins, and modes of operation.

Before going any further into this topic, however, the concept of *narcissism*, which is an essential component of Freud's argument in *The Ego and the Id* must be discussed. Freud introduced his theory of narcissism in 1914[48]. He proposed that a normal *narcissistic stage* be added to the stages of libidinal development, between the stages of auto-erotism and object-love. With the concept of narcissism he tried to explain such clinical phenomena as the megalomania and loss of interest in the external world of the schizophrenic; the relative lack of interest in the external world of the neurotic or the physically ill preoccupied with their symptoms; the inaccessibility of certain patients to analytic treatment; or the normal child with age-appropriate magical thinking.

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[46]Breuer, J. & Freud, S. (1895), pp. 256 ff.
[47]Freud, S., 'Some Character Types Met with in Psychoanalytic Work' (1916), *RSE*, Vol. **XIV**, 2024, pp. 315-336.
[48]Freud, S., 'On Narcissism: An Introduction' (1914a), *RSE*, Vol. **XIV**, 2024, pp. 63-89.

In each of these settings, Freud proposed that libido had been withdrawn from objects in the external world back into the ego[49] from whence it had come, as an amoeba withdraws its pseudopodia back into its body. The increase in libido in the ego at the expense of libido invested in objects, that is, the increase in *narcissistic* (or *ego) libido* at the expense of *object libido*, corresponded to an increase in a person's self-esteem, self-interest and, if the increase was sufficiently great, to their grandiosity and the overestimation of their abilities and value.

In the earliest stages of psychological development there is no distinction between self (ego) and outer world. Freud theorized that in this undifferentiated stage of ego development the ego experienced feelings of omnipotence and enormous self-esteem. It was 'possessed of every perfection of value'[50], as Freud says. As it develops, the ego comes to recognize its true weakness and powerlessness, which is anxiety-provoking and a profound blow to its self-regard. Gradually, a standard develops in the child, consisting of its moral and cultural values, which Freud calls the ego ideal (or ideal ego—the terms appear to be interchangeable). *The ego ideal becomes the reservoir, or inheritor, in the mind of the original narcissistic feelings of perfection.*

When the child behaves according to the values in the ego ideal, the ego is rewarded with its love, resulting in a rise in its libidinal investment and thus self-esteem. In this way the ego recovers some of the profound loss of self-esteem it experienced in early development. When the child doesn't behave according to the values of the ego ideal, the ego is punished by a withholding of its love, and feels shame and guilt in consequence. The ego ideal thus functions as an overseer of one's behavior: it rewards behavior that meets its standards and punishes it when it falls short. Of particular note, the ego can avoid future punishment by repressing unacceptable drive impulses at the instigation of the ego ideal.

In *Group Psychology and the Analysis of the Ego*[51], Freud used the concept of a shared ego-ideal with a leader to explain the behavior of members of both enduring groups, such as religious denominations or armies, and that of transitory mobs.

[49] The word 'ego' in 'On Narcissism' is used to denote the self; in *The Ego and the Id* it has a more specialized meaning.

[50] Ibid., p. 81.

[51] *Freud, S., Group Psychology and the Analysis of the Ego* (1921), *RSE*, Vol. **XVIII**, 2024, pp. 67-133.

The Ego and the Id synthesizes elements of the topographic model with new insights into the mechanisms of defensive operations, marking a shift away from a solitary focus on what was being defended against. Instead of just an unconscious and conscious part of the mind, the mind is now conceived of as being composed of three entities, defined by their functions, in mutual interaction. The id is the agency of the drives; the superego[52] originates in the ego but develops into an independent agency which monitors the activities of the ego, instigates repression and other defensive measures by the ego, and rewards and punishes it in accordance with an internal set of standards, just as the activity of the ego-ideal was depicted in 'On Narcissism'. In *The Ego and the Id*, Freud compares the functioning of the superego to the colloquial notion of the *conscience*.

The ego is the seat of perception; consciousness; thought, judgment, and action; and is the initiator of the defenses. It acts as the executive organ of the mind, guiding behavior by means of a mediation between id impulses, superego injunctions, and the pressures of external reality.

One of the most consequential parts of *The Ego and the Id* is Freud's account of the origins of the superego. The superego is formed, according to Freud, by a process of identification that resolves the Oedipus complex and ushers in the latency phase of development. The intense object relationship with the parents of the Oedipal phase is usually replaced with an identification with the parent of the same sex and a diminution of the positive feelings toward the opposite-sexed parent[53]. Intense rivalry with the same-sexed parent is replaced by an identification, in which 'the object [the rivaled parent] is set up in the ego'[54]; an intense and erotically-charged love of the opposite-sexed parent is replaced by mere affection.

Thus in the resolution of the simple positive Oedipus complex, the object relationship with the

[52]Freud, S. (1923), pp. 24-34; the term 'superego' is introduced in this book as another term for the ego-ideal. Both of these terms experienced enormous development and elaboration in the ensuing decades, resulting in specialized roles for each in the monitoring and sanctioning of behavior.

[53]As before, only the simple positive Oedipus complex is discussed,

[54]Ibid., p. 29.

parent of the same sex is replaced, in part, by a relationship between different parts of the ego: the superego, or ego ideal, formed on the basis of an identification with the person and values of the parent of the same sex, stands in relationship to the rest of the ego as an internal object functioning as a critical agency. This model of the establishment of the superego is the prototype for all later theorizing about the establishment of internal objects by the so-called object relational school of psychoanalysis[55].

Without going into detail, Freud indicates in *The Ego and the Id* that in the course of development there is the potential for multiple object choices to be made, leading to multiple identifications that can lead, in turn, to conflicts within the ego. This can lead to the fragmentation ('Aufsplitterung') of the ego itself[56]. In an elegant and much-quoted formulation, Freud states that 'the character of the ego is a precipitate of abandoned object cathexes and contains the history of those object choices'[57].

In the simpler topographic model of conflict, treatment was a matter of interpreting either unconscious content or the resistance to uncovering the unconscious content. With the introduction of the superego as a moral agency that monitors and sanctions thoughts, feelings, wishes, and actions—essentially an elaboration of the 'censor' of the earlier model—one component of resistance, at least, could be identified and targeted in the treatment: an unconscious feeling of guilt. Guilt, culpability, blameworthiness, the unconscious sense that neurotic suffering was just punishment for past sins, was identified as a powerful force that motivated resistance to the treatment. If the guilt could be analyzed—interpreted and made conscious—that could lead to a previously resistant patient permitting himself to be helped by the treatment, thus enlarging the population that could be successfully treated.

The Ego and the Id outlined the tripartite structure of the mind. It portrayed the agencies and delineated some aspects of their interaction, but did not discuss their development. *The Impulsive*

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[55] See, e.g., Fairbairn, W.R.D., 'Endopsychic Structure Considered in Terms of Object-Relations', *International Journal of Psychoanalysis* (hereafter *IJP*), Vol. **25**, 1944, pp. 70-92.

[56] Freud, S. (1923), p. 26.

[57] Ibid., p. 25. 'Cathexis' is a neologism devised by Strachey as the English translation of the German word 'Besetzung'. The latter is the noun form of 'besetzen', meaning to 'occupy' or 'fill'. Cathexis means the libidinal attachment to or investment in someone or something.

Character was to provide that discussion.

IV. *The Impulsive Character*

The Impulsive Character, written in 1924, presented a new and highly condensed synthesis of the normal and abnormal development of the ego and its character in light of the structural ideas that Freud had first presented publicly at the 7th International Psychoanalytic Congress held in Berlin in 1922, which Reich had attended, and which were later published in 1923 in *The Ego and the Id*. At the same time, Reich attempted to present a formulation of the specific ego pathology of a class of patients he called 'impulsive characters'—patients who were on the borderline between symptom neuroses and psychosis. Given the extreme density and technical rigor of Reich's argument, what follows is a synopsis.

Introduction (pp. 5-13)

Reich begins by stating that a systematic and general theory of ego development and pathology, parallel to Freud's theory of sexuality and the development of the id, did not exist. Implicitly, his book represents a first attempt at developing one.

The definitive treatment of the patient with neurotic symptoms depends on treating the 'basis of the neurotic reaction', i.e., the *character* within which the neurotic reaction (symptom) develops, so that symptoms cannot recur. The character is announced in the forms of the patient's actions and *behavior*—the *way* that a patient lives his life. In the psychoanalytic treatment this is revealed and made accessible to the treatment in the form of the resistance to the treatment. Reich refers to this as the *formal* element of character, as opposed to the content. The latter refers to the unconscious fantasies, such as incestuous fantasies, that are presumed to be universally present but are lived out or expressed differently—that is, have different forms—according to one's character. Thus, the same Oedipal conflict is expressed differently in a hysterical than in an obsessional character. Reich's appreciation of the importance of the formal element of character

was first emphasized in his paper on narcissistic types[58] and was to be greatly elaborated on in *Character Analysis*.

Reich goes on to state that 'the characterological understanding of the personality is based on identification'. He then summarizes parts of Freud's argument in *The Ego and the Id*. The character of the ego is the result of identifications that have taken the place of intense object relationships with the child's primary care-givers, which are usually the parents. The superego (ego ideal) is the result of a particularly important set of identifications which establishes an individual's 'thou shalts' and 'thou shalt nots', i.e., his or her moral compass.

Reich then argues that both normal and pathological ego development depend on *the structure and qualities of the ego-ideal (superego)* that develops which, in turn, depends on

> 1) which attitudes of the parental personality the child incorporates [by identification] into its ego ideal as a) affirming or b) prohibiting elements; 2) whether the ego ideal formation of the boy is predominantly based on the father or mother (vice-versa for girls), and how the model for the ego ideal was created; 3) in which *stage of libidinal development* an effective identification develops and the interaction of libidinal and ego development at the different stages; 4) whether or not the demands of the ego ideal are realized [i.e.,met by the developing ego]; 5) the influence of the original pleasure ego[59] in future ego development.[60]

In the model outlined above, a systematic approach is brought to the assessment of the developing structure and contents of the ego-ideal. Which parent is responsible for the important positive (approving) and negative (disapproving) demands incorporated into the ego ideal? In which libidinal stage do the important identifications constituting the ego-ideal take place? This is important because Reich felt that, e.g., for a boy a maternal identification in the anal or phallic stage led to different outcomes in character development. How accepting was the existing pleasure ego of the externally imposed demands? How well did the developing ego meet the demands of the ego ideal? It was well known that where the ego falls short there is the potential for significant anxiety and depression due to punishment emanating from the ego ideal. Finally, in Reich's model the simultaneous interactions of all three agencies, the id, the ego-ideal, and the ego, are all being considered in the process of the formation of the character of the ego.

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[58] Reich, W. (1922).

[59] Reich is referring here to the earliest and most primitive form of the ego, which is driven solely by the pleasure principle. See Freud, S. 'Formulations on the Two Principles of Mental Functioning' (1911a), *RSE*, Vol. **XII**, 2024, pp. 219 ff..

[60] Reich, W. (1925a), p. 11.

Reich then states that he proposes to study ego development in a particular group of patients, 'those under the sway of their uninhibited drives', which he, 'like Alexander[61], call[s]' 'impulsive characters', 'those whom exhibit gross defects of ego structure— those people who remain in constant battle with the external world and thus look as if they have never progressed beyond the first stages of identification or of superego formation. The typical neurotics [i.e., patients with neurotic symptoms] under the sway of the repetition compulsion[62], the antisocial, the occasional criminal— people who systematically blight and destroy their own existence, and whose egos remain completely infantile'. The reason for studying this group is that they reveal the mechanisms of early ego and superego development in a particularly clear way.

Observations on the Neurotic and Impulsive Characters (pp. 14-27)

Reich states that '"the neurotic character", the "impulsive character", "psychopathy"' is viewed by clinical psychiatry as on the borderline between health and psychosis, by Alexander as on the borderline between health and neurosis, and by himself ('with reference to specific dynamic mechanisms') as on the borderline between symptom neurosis and psychosis.

The apparent paradox that the impulsive characters represented to Reich is that despite their seemingly uninhibited drive expression they still had a profusion of neurotic symptoms. It would seem that the way they lived their lives would obviate the need for repression and subsequent symptom formation, but clearly that was not the case. The focus of Reich's study then becomes 'the process which determines the defective defense, the defective *mechanism* of repression, which permits actions to the impulsive which never gain access to motility in a simple symptom neurotic'.

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[61] See Alexander, F., 'The Castration Complex in the Formation of Character' (1922), *IJP*, Vol. **4**, 1923, pp. 11-42. Alexander argues in this important paper that unconscious conflicts that result in the formation of symptoms, e.g., those involved with the castration complex, can also be expressed in the form of enduring character traits in the absence of symptoms. His argument is illustrated with the report of a patient he treated in psychoanalysis in whom new symptoms appeared during the treatment when certain masochistic behaviors were given up—that is, there was a dynamic equilibrium between character trait and symptom formation. He coined the term 'treibhafte Charaktere' to denote this group of patients.

[62] See Freud, S. (1914c), p.148-149. The repetition compulsion refers to the tendency of the neurotic to relive, or repeat, childhood conflicts rather than remember them. Analytic treatment enables remembering, which obviates the repetition.

In addition to the flamboyance of his patients' symptomatology, vividly described on page 17, Reich adds that, by comparison with Alexander's case, 'our cases show the same 'daemonic trait' [of the repetition or 'fate' compulsion], but what is impulsively enacted and experienced [unlike in Alexander's case] is primitive and pervaded by undisguised masochistic, sadistic, anal, oral, and similar drives'.

Reich then poses three questions that his book will address:

> *1.)* What are the dynamic similarities and differences between the impulsive character and the simple transference neuroses? *2.)* Is there a specific defect in the mechanism of repression in the impulsive character? And closely connected to this question, *3.)* if there are such specific defects of repression, are they related to the defects in schizophrenia? Here we are approaching the view of general psychiatry that 'psychopaths', to some extent, are at an 'early stage of psychosis proper' (*Kraepelin*[63]), and especially of schizophrenia, or at least have a very close relationship to the latter.[64]

Reich then provisionally defines a person's character as 'the specific mode of expression of his mental attitude to the environment'. Further, '*neurotic* characters impress us as those characters exhibiting more or less gross deviations from reality-oriented sexual and cultural strivings, and from the ability to adapt socially'. Neurotic symptoms are the result of a fixation of a part of the personality [thus, id *and* ego], while the neurotic character reflects the disturbance to the total personality created by the fixation. Thus, 'a fixation (and the psychic conflict associated with it) *always simultaneously* has two aspects: the *neurotic symptom* specifically corresponding to the fixation (e.g., hysterical vomiting as the expression of an oral-genital fixation) and the *neurotic character* corresponding to the disturbance created in the total personality by the fixation of a portion of it'; thus, 'we have to assume...that even the most inconsequential fixations do not leave the rest of the personality untouched. Every neurotic symptom is based on a neurotic character'. Finally, 'the expression '*impulsive character*'...can only refer to a particular form of the neurotic character, namely, *a disturbance of the total personality*, which is recognizable by more or less *uninhibited behavior*'.

The enactments of these patients are diffuse, ego-syntonic[65], and responsive to environmental cues

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[63] Kraepelin, E., *Einführung in die psychiatrische Klinik*, 3rd ed., [*Lectures on Clinical Psychiatry*], Barth, 1916.
[64] Reich, W. (1925a), p. 19.
[65] A symptom or impulse is ego-syntonic if it is accepted as being in harmony with the rest of the self, and ego-dystonic if it is perceived as intrusive or alien.

and thus easily rationalized, in contrast to the actions of the compulsion neurotic which are usually rather stereotyped, ego-dystonic, and senseless (e.g., compulsive handwashing) . Some could periodically develop schizoid (psychotic-like) qualities such as marked grandiosity, ideas of reference, ideas of persecution, and periods of depersonalization. They were distinguished from frank schizophrenia by the presence of 'an intense and lively relationship with the external world' and the presence of intact reality testing and ego boundaries, which, nonetheless, could blur in the presence of strong affect. Undisguised perversions, usually sado-masochistic, were almost always present .

Ambivalence[66] **and Superego Formation in the Impulse-inhibited Character** (pp. 28-54)
Before addressing the development and dynamics of the impulsive character, Reich considers these issues in what he terms the 'impulse-inhibited' character, by which he means the character of the typical person who develops neurotic symptoms.

Reich begins with some general comments regarding the vicissitudes of normal drive development in relation to superego formation . The entire section rewards careful study, but a brief excerpt sets the stage:

> *Freud* has taught us that everything that we call culture and civilization is based primarily on the suppression of drives [Triebunterdrückung] and secondarily on their sublimation[67]. A pure drive-ego is born into a world of severe restrictions and restraints to which it must adapt by abandoning most of its claims for immediate gratification in exchange for partial gratification at a much later time. This adaptation takes place gradually in more or less sharply circumscribed phases, but not automatically as growth in the embryo does. The 'psychic embryo' needs clear reference points in its immediate environment, usually represented by the first care-givers, who are the objects of the first instinctual demands. They are not only the first drive-gratifying objects, especially in infancy, but also play the decisive role of frustrating the drives, which represents the earliest and most significant restrictions. [68]

Drives are never extinguished, but 'evolve and shift...their aims and pathways', and experience

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[66] *Ambivalence* refers to when a subject both loves and hates the same person.
[67] See Freud, S. (1905a), pp. 158-159, *Sublimation* is the redirection of a sexual drive to a non-sexual aim, and is one of the most important developmental achievements.
[68] Reich, W. (1925a), p.28.

four types of vicissitudes. First, frustration of a drive, eg, suckling, leads to a **splitting-off a portion of the drive in an unchanged form**, important in later sexual fore-pleasure. Second, 'more or less energetic **reaction formations**' against the drive are established, eg, disgust as a reaction against anal tendencies. Third, the drives experience **sublimation**, eg, cleanliness as a sublimation of anal drives. Fourth, 'every erotic drive serves to **establish [object] relationships with care-givers**' [my emphases].

The latter is decisive in helping a child give up immediate pleasures, for, e.g., 'mother's sake':

> 'If the child renounces a certain type of pleasure for the mother's love, it has taken ownership of one of the mother's demands and we have before us a case of the most primitive *identification*. But it is an identification that still retains a great deal of object love, without which it would not be sustainable.'[69]

These early identifications, which Reich refers to as 'superego precursors'[70], help pave the way for the definitive identifications that help resolve the Oedipal phase, the outcome of which is normally the formation of the mature superego, and is described as follows:

> The situation seems to be that the primitive drive ego is held in check by an agency that *Freud* calls the ego ideal or superego. Its sources are the abandoned object cathexes and it comprises all of the demands which the parents or other care-givers have placed on the drive ego. The parents are ultimately given up as objects, and retained as the superego by means of identification. At the same time the object relationships are desexualized. The instinctual force used by this new authoritative agency to hold the drive ego in check, in other words, to do the work of repression, is sadism in its sublimated form of moral 'masochism', that is, masochism disconnected from its erotic component (the masochistic perversion).[71]

The real ego originates in the realization of—that is, the meeting of— the demands of the superego, through the process of identification, hence the capital importance of the development and the contents of the ego-ideal. Crucially, Reich is also asserting that ego and superego develop in interaction, and that there are pre-Oedipal superego precursors that decisively influence ego development.

A major challenge for the growing child is that, after puberty, an initially drive-negative superego

[69] Ibid., p.30.
[70] Ibid., p.32, 'primitive Vorstufe des Über-Ich'.
[71] Ibid., pp. 31-32.

must begin to include some drive-positive content—e.g., approval of sexual activity—if future neurotic illness is to be avoided. In this connection, Reich argues for leniency in regard to childhood masturbation .

The process of ego development is then spelled out in healthy boys and girls. The key elements of this process are first, that *libidinally,* there is a strong phallic position in the boy, while the girl has renounced the wish for a penis[72], and secondly, that the superego in both the boy and girl is to an extent *drive-affirmative*:

> 'The only *negative superego formation at the genital stage* is the incest prohibition. This negative superego demand rarely comes into consideration in genitally satisfied people, because, as well as being suppressed, the incest wish itself is diminished. The remaining negative ego ideals are based on pregenital libido insofar as it presses for its original satisfactions. Insofar as pregenital libido is sublimated, the negative ego ideals blend with the positive ego ideals of the genital stage to create a harmonious, purposeful, fully reality-oriented personality. In summary, these antitheses: health-illness, reality principle-pleasure principle are paralleled by these: genital-pregenital, positive superego-negative superego, sublimation-reaction formation'[73].

The remainder of the chapter focuses on what Reich calls 'sexual misidentification' [geschlechtliche Fehlidentifizierung]. Identifications occur in the context of drive frustration and the hate (thus ambivalence) that ensues, and are an attempt to resolve the intrapsychic conflict that results. The 'masculinity' and 'femininity' complexes of women and men, respectively, are founded on disappointments in the *parent of the opposite sex* in both cases, which lead to identifications with them instead of with the same-sex parent, whose 'mere existence' is sufficient to generate frustration and identification in the typical Oedipal scenario.

More generally, *'superego formation is based mainly on the parent towards whom there* [*is*] *the greatest ambivalence*, in other words, on the parent who was the source of the most important frustrations...This leads to the development of acute ambivalence toward the parent of the

[72]Reich is emphasizing here that healthy development for both the boy and the girl depends on each of them securely reaching the genital stage of libidinal development.

[73]Ibid., p. 43.

opposite sex, which leads in turn to a subsequent withdrawal of object libido and the introjection of the object, and finally to a pathological identification'.

Erotic predispositions also play a part in respect of a readiness to identify with a frustrating parent, e.g., 'a strong anal disposition in a boy will tend to keep him in the anal stage and encourage an intense identification with the mother'.

Reich describes two types of sexual misidentification in both men and women, each depending on the vicissitudes of inborn disposition and the experiences of frustration at the hands of parents. There is vivid case material on pages 49-50.

Reich summarizes this chapter in his usual pithy way:

> 'Pathological identifications, persisting [i.e., unresolved] Oedipal or other conflicts, and the influences of particular experiences on erotic dispositions can so shape the character of a person that the ability to deal with reality and enjoy life suffers, with or without the formation of neurotic symptoms. We believe we have shown that the realization of certain ego ideal demands is what creates the neurotic character: the individual identifies with the demands of care-givers, which firmly establishes the ego ideals in the personality; the ego, in turn, 'identifies' with the ego ideal, realizing its demands in the process'[74].

Ambivalence and Ego Formation in the Impulsive Character (pp. 55-78)

Since frustration and ambivalence are normal experiences, indeed, are necessary aspects of normal development, what is it that makes them pathogenic?

> 'It seems that it depends on the form and strength of the instinctual gratifications and frustrations, the stage in which they occur, and the attitude of the child toward the caregiver at the time in question.'[75]

Thus, it is the *juxtaposition* and degree of drive gratification and drive frustration which determines the pathogenicity of ambivalence. Reich presents four possible permutations of drive gratification and frustration: 1) partial gratification and stepwise and gradual frustration, leading to repression of the drives; this is the normal or healthy scenario; 2) wholesale frustration at every stage of development, leading to a total lack of initiative or to the compulsion neurotic in the most

[74] Ibid., p. 54.
[75] Ibid., p. 58.

favorable case; 3) total absence of frustration, leading to severe impulsivity (in the sense we have been discussing it); and finally, 4) untrammeled gratification met with traumatic and belated frustration.

While Reich did not have observational data to support the existence of the third scenario, he felt it would be forthcoming one day. *The fourth scenario results in the impulsive character*. It is important to note that there is also a sociological subtext here: the last two categories of patients were more likely to be observed among the proletarian and urban indigents attending the psychoanalytic Ambulatorium and Wagner-Jauregg's clinic, while the first two categories were more likely to be seen among the bourgeois patients consulting psychoanalysts in their private offices.

Reich points out that a period of gratification followed by sudden, harsh, frustration leads to a characteristic expression of ambivalence. *Strongly drive-denying and drive-affirming ego ideals, or superego precursors, are simultaneously established*, in contrast to the impulse-inhibited character, where the *drive-denying ego ideal dominates early,* and only changes with puberty.

Because of early neglect and parental acquiescence, *reaction formation and repressions do not have an opportunity to be established, indeed, then become impossible.* Belated and harsh frustration then leads to attitudes of chronic hate and fear accompanied by intense guilt. There is an inability to love in the presence of a strong craving for it in the context of a childhood experience of many traumata, including sexual and physical abuse. These patients tend to have no latency, or only an abbreviated one, and begin a sexual life very early. There is a polymorphously perverse libidinal organization in the presence of conscious incest wishes.

A discussion of such a 'Grenzfall'—a borderline case— between psychosis and symptom neurosis illustrating many of these features follows (pp. 64-72).

The remainder of the chapter argues that there is no difference in principle between schizophrenia and the transference neuroses; they both lie on a spectrum, which might help to explain the coexistence of psychotic and symptom neurotic manifestations in this class of impulsives who are 'borderline cases'.

Isolation of the Superego (pp. 79-106)

Reich presents his formulation of the dynamic structure of the impulsive character in this chapter. Like the phenomenological description of this category of patients, it is strikingly novel.

His explanation is organized around the presentation of a case of 'genital masochism and a completely infantile character'. At the time of the case report, the patient was a 26-year-old woman who had been in six-day-a-week analysis with Reich at the Ambulatorium for 18 months, and who had presented with chronic sexual excitement that couldn't be satisfied, in the presence of vaginal anesthesia. She was only able to achieve orgasm by masturbating with a knife handle to the point of bleeding, accompanied by masochistic fantasies. During masturbation, she fantasized that her genital was a little girl, whom she addressed as 'Lotte', telling her that she was 'a little whore', among other things, who deserved to die for her sexual depravity. In fact, her method of masturbation was to lead to uterine flexion and prolapse.

Reich eventually understood that during masturbation, the patient's genital represented her enduring pleasure ego, while her admonitions and criticisms—the voice of her superego—had been taken over wholesale from her harsh mother. Masturbation was thus a compromise formation in which the pleasure demands of the pleasure ego and the demands for punishment, internalized (by identification) en bloc from her mother, were both met.

It was the huge contrast between an impotent and very undeveloped ego, on one hand, and a harsh and powerful maternally-derived superego, on the other, both starkly displayed in the patient's masturbation, that distinguished this patient's psychic structure from that of the usual impulse-inhibited patient:

> The most striking feature of our case is the enormous contrast that exists between the ego and the ego ideal: the superego consists entirely of maternal dictates, while the ego, strictly separated from the superego, is infantile, impotent, and permeated by incest

> wishes. Normally, the child's ego adapts to the external world by incorporating parts of it in the form of a superego, which in turn initiates the processes of reaction formation and sublimation. A child's development consists of a gradual and stepwise incorporation of the real external world in the form of superego demands which *have the closest connection to the existing ego*. As they are assimilated, partly changed, into the structure of the ego, a vigorous drive ego is forced to modify itself, which it does entirely by means of compromise formations. In the analysis of the healthy or of those with mild neurotic disturbances, it is usually impossible to trace ego ideal formation back to particular identifications, and to the degree that it is possible, one encounters the ego ideal in the most manifold and complicated relationships with, or better, soldered connections to, the sexual and other ego components of the personality. The further we pursue a comparison of the normal with the severely pathological, the clearer it becomes that we are confronted in the latter with an *isolated superego* and in the former with an *ego ideal which is organically fused to the rest of the developed personality*.[76]

And further:

> *This isolation is tantamount to a repression*. The prohibition then behaves impulsively as if it were a repressed sexual wish: due to successful identification it strives to prevail; it is inhibited in this by negativistic attitudes originating in the pleasure ego. Consequently, the prohibition is not organically incorporated into the total personality. It follows that there must be conflicts within the ego which resemble in every respect conflicts between sexual wishes and the repressive forces of the ego.[77]

Thus, in Reich's impulsives, the superego itself behaves more like a hostile and punitive drive (analogous to the libido, but opposite in quality) that the ego must then defend itself against than like a smoothly calibrated moral regulator of behavior; 'Structurally, we are dealing with an impulsive character whenever the superego is isolated or separated from the ego rather than being 'organically' fused with it as it is in the impulse-inhibited neuroses'. The isolated, or split off, superego becomes a driving force for self-punishment rather than an instigator of repression, as it is in the impulse-inhibited.

Reich's compressed account of the development and functioning of the split-off superego in this section contains two theoretical innovations that remain valued elements of contemporary psychoanalytic thought. *One is his description of the essential role of the splitting of the ego[78] in*

[76]Ibid., pp.85-86.
[77]Ibid., p.87.
[78]Recall that the ego-ideal or superego originates as a part of the ego that identifies with the demands of the care-givers and then functions as a separate psychic agency with which the ego can be in harmony or in conflict.

the pathogenesis of borderline personality organization, and the other is his description of the dynamics of his patient's masturbation practices and fantasies in terms of internalized object relations. One example of the latter was the intensely punitive ego-ideal representing an identification with the hated mother.

A chart summarizes some of the important structural and dynamic differences discussed hitherto between the impulsive character and its direct opposite, the compulsion neurotic:

Compulsion neurosis	***Impulsive character***
1) manifest ambivalence	*1)* manifest ambivalence
2) reactive transformation of the ambivalence	*2)* no reactive transformation, or hate predominates
3) strict superego integrated into the ego	*3)* isolated superego
4) strong repression and reaction formation	*4)* defective repression
5) sadistic impulses linked with guilt	*5)* sadistic impulses without guilt
6) character is overly conscientious; ascetic ideologies	*6)* character is without a conscience; manifest sexuality with accompanying guilt anchored in neurotic symptoms or totally repressed
7) the ego submits to the superego	*7)* the ego sits ambivalently between the pleasure ego and the superego; in actuality has allegiance to both the pleasure ego and the superego

In the structure of the impulsive character *both* the libidinal drive and the punishment for the expression of the drive are lived out in a relatively uninhibited and relentless way.

Reich suggests in passing that the psychic mechanism for the production of *perversions*, the subject of an important contemporaneous article by Hanns Sachs[79], might involve the split psychic structure he hypothesizes as causing the clinical picture of the impulsive. Fifteen years later, one

[79]Sachs, H.,'Zur Genese der Perversionen' ['On the Genesis of the Perversions'], *IZP*, Vol. **IX**, 1923, pp. 172-182. In perversion, full genital primacy has not been achieved—there is a continuing expression of the partial drives of childhood, e.g., voyeurism , exhibitionism.

of Freud's last published papers postulated this very mechanism[80].

Finally, Reich proposes that the phenomenon of the isolated superego is *a normal developmental stage* that impulsive characters get fixated in and others grow out of, according to the following schema of ego development:

> '*1) The stage of the primitive pleasure ego*: unambiguous rejection of restriction.
>
> *2) The stage of manifestly ambivalent object cathexis*, or, from the standpoint of the superego, the *ambivalent response to the superego*. Fixation at this stage results in the permanent establishment of an *isolated superego* and the disposition to uninhibited impulsivity in the sense we have been discussing it.
>
> *3)* The stage of *the reactive transformation of the ambivalence*: the ego identifies with the restricting care-giver (*realization of the caregiver's demands on an ambivalent basis*). This is the stage at which sexual misidentification occurs. There is a disposition to compulsion neurosis if this process occurs during the anal-sadistic phase and a disposition to hysteria if it occurs in the genital stage.
>
> *4) The stage of (relatively) ambivalence-free ego structure.* However little we may yet know of its genesis and dynamics, analytic experience tells us that this reality-oriented position of the ego cannot exist without drive-affirming elements in the ego ideal, that is, without the possibility of an orderly libido economy.'[81]

Comments on Schizophrenic Projection and the Hysterical Split (pp. 107-114)

In this section Reich uses his concept of the isolated, or split off, superego to illustrate the dynamics behind two other clinical manifestations, namely, psychotic projection and hysterical dissociation. In each circumstance, the isolated position of the superego facilitates the development of the phenomenon in question. He summarizes his brief discussion as follows:

> 'The ego in the *schizophrenic* who is delusional and hallucinating has disintegrated due to conflict; the pressure of the conflict is relieved by way of the *delusional projection* of the ego ideal along with the forbidden id strivings.

[80] Freud, S. 'Die Ichspaltung im Abwehrvorgang' (1938) ['Splitting of the Ego in the Process of Defense'], *IZP & Imago,* Vol. **25**, 1940, pp. 241-4; Freud, S., *RSE*, Vol. **XXIII**, 2024, pp. 249-252.

[81] Reich, W. (1925a), pp. 104-105.

> The ego in *hysteria with a splitting of the personality*[82] attempts to resolve conflict by *successively taking sides* with each party to the conflict while simultaneously being amnestic about the other party.
>
> The ego in the *impulsive character simultaneously sides* with both opponents; conflicts are occasionally resolved by means of schizophrenic projection and hysterical splitting.
>
> In contrast to the disintegration of the ego found in the foregoing clinical syndromes, the ego (that is, ego + superego) of the *impulse-inhibited character* or the *symptom neurotic*, as the case may be, is coherent and integrated.'[83]

Therapeutic Difficulties (pp. 115-127)

Reich begins by pointing out that the scope of psychoanalytic treatment had been widening since the very beginning, such that even some schizophrenics might be treatable some day.

In the typical symptom neurotic with an intact ego, the analyst can count on the patient's cooperation in confronting the warded off impulses: 'This is certainly not the case in the impulsive character. Even his ego [i.e., not just his id] has remained more or less infantile'. This fact leads to all the difficulties associated with treating the impulsive character.

First, Reich discusses the problem of lack of insight into illness. This is usually not a problem in transference neurosis—the neurotic's symptoms are ordinarily ego-dystonic and he is motivated to get help because he has been unable to remedy them on his own. Insight into illness can only exist when the ego and the superego are allied in successfully rejecting impulsive behaviors. 'But if the superego is of a type that is aligned with a pathological attitude, if it remains isolated, or if the symptom lacks the character of the irrational or absurd [i.e., if the symptoms are ego-syntonic] then insight is also lacking'.

Insight develops in these patients when their ego ideals begin to change via an identification with the ego ideal of the analyst. Here, one is reminded of Strachey's 'The Nature of the Therapeutic

[82] Reich is referring here to the phenomenon of multiple personality, such as had been described by Janet and other members of the French school of psychiatry. See Janet, P., *The Major Symptoms of Hysteria*, 2nd ed., Macmillan, 1924, pp. 66-92.

[83] Reich, W. (1925a)., pp. 113-114.

Action of Psycho-Analysis' (1934)[84], in which a similar argument is advanced. According to Reich, this process 'is carried out by way of an analysis of the object relations which underlie [the pathological ego ideal]'. As insight develops, what had been impulsive acts disconnected from guilt become compulsions associated with guilt. Indeed, the guilt can become so intense as to provoke suicidal crises.

Reich then discusses how the impulsive's tendency to enact in both hateful and erotic ways presents severe, even insuperable, technical challenges. He stresses the importance of working in the transference to deal with these challenges: 'The only thing that works is *daily* discussion of the transference...'.

A final section argues that 'non-analytic' limit-setting and educational measures are almost always necessary in the treatment of these patients, especially at the beginning, and that a definitive treatment of such patients could require an inpatient setting—something that then, as now, was essentially unavailable.

V. Summary

The Impulsive Character is a work of remarkable originality, articulating for the first time a series of ideas that would come to hold lasting significance for psychoanalytic theory and practice. The originality of the ideas, combined with their highly compressed presentation, goes a long way toward explaining why the book has remained under-appreciated and insufficiently understood. Here I will summarize only the most important contributions of the work.

To begin with, the book is a tour de force of synthesis. It concisely summarizes elements of the topographic model, integrates it with Freud's new structural model of the psychic apparatus, presents a new theory of the development of psychic structure, delineates a new psychopathological entity (the impulsive, or borderline, character), proposes the 'isolation of the

[84]Strachey, J., 'The Nature of the Therapeutic Action of Psycho-Analysis', *IJP*, Vol. **15**, 1934, pp. 127-159,

superego' as both the structural basis of the clinical picture of the impulsive character and as a normal developmental phase, outlines a novel treatment approach to the impulsive (and, by implication, the impulse-inhibited neurotic as well), and reviews the psychiatric literature, recent and historic, on the topics of discussion[85].

Reich asserts, for the first time, the pre-eminence of the ego and its structure in psychoanalytic therapy: every therapy that attempts to treat a neurotic symptom must treat the underlying ego—the matrix of the symptoms—for every neurotic symptom is based on a neurotic character (of the ego). The neurotic character itself must therefore be the focus of treatment. Successful treatment of the character, however, depends on a theory of character development and functioning, just as the successful treatment of physical illness depends on an understanding of anatomy and physiology. No such theory or account of the normal and pathological development and functioning of the psychic structures—the id, ego, and superego—existed when Reich began writing *The Impulsive Character*. That was missing from *The Ego and the Id*; Reich had to produce one and this book is the result of that endeavor: *thus was born the field of ego psychology, as Freud himself acknowledged.*

The innovations of Freud's *The Ego and the Id* furnished Reich with a toolbox with which to construct such a theory. Reich's efforts are thus a continuation of Freud's inaugural efforts at a comprehensive theory of the psyche in structural terms, now extended from an explanation of symptoms to a theory of the formation of the structure—the character—of the ego. It is important to highlight that implicitly Reich viewed character development as fundamentally a matter of psychology and not biology as psychiatric authorities such as Kraepelin and Bleuler believed. In principle, therefore, characters that developed in a pathological direction could be treated psychologically.

As he states at the beginning of the book, Reich accepted Freud's theory of the libido, located in the id, and its development. His theories of ego and superego development are a complement to Freud's libido theory. There exists in early development a pleasure ego

[85] Reich, Helene Deutsch, Ludwig Jekels, and Paul Schilder, were among the very few psychoanalysts in Vienna with formal training in psychiatry. See Reich, W., *Reich Speaks of Freud*, Farrar, Straus, and Giroux, 1967, pp. 41-42.

aimed solely at the immediate satisfaction of the demands of the drives. This pleasure ego encounters frustrations at the hands of care-givers who impose restrictions of this satisfaction in the form of, e.g., limitations of the times and quantities of feedings, punishments for complaining or crying, time limitations of enjoyable activities, enforcement of time alone, prohibition of masturbation, requirements regarding the time and place of urinating and defecating, etc.—all the 'thou shalts' and 'thou shalt nots' of infancy and childhood.

The child hates, consciously or unconsciously, the limitations so imposed and the care-givers who are limiting him, but also loves and needs them. This simultaneous love and hate, or ambivalence, is a decisive factor in the development of the individual. The experience of ambivalence is extremely anxiety-provoking for the young child, and is dealt with—'resolved'—by identifying with the frustrators. In identification the intensity of the relationship with the caregiver is diminished to a certain extent as the child sets up the demands of the external authority within his own ego, making it a part of himself in the form of an ego-ideal, or superego, precursor. When the child behaves according to the demands of the ego-ideal, it rewards the ego with its approval, which is experienced by the child as a pleasurable feeling of increased self-esteem, and when it doesn't, the ego-ideal punishes the ego, which is experienced as intensely unpleasurable feelings of blameworthiness, shame, and guilt. The developing ego is thus spurred to identify with—to form its character on—the template of the ego-ideal, which it largely accomplishes by instituting repressions and reaction formations.

External frustration and the ambivalence it engenders thus emerge as the most important factors in character development because they determine with which parent and with which parental values the child identifies. These, in turn, determine the content and qualities of the child's ego-ideal. It was Freud[86] who first suggested that identification is one way of dealing with ambivalence, and further, that identifications are key to character formation[87]. Reich took those ideas further and developed the first model of character development. The ego develops by identifying with the ego

[86] Freud, S. 'Mourning and Melancholia' (1916-1917), *RSE*, Vol. **XIV**, 2024, pp. 217-231.
[87] Freud, S. (1923). p. 24.

ideal; the latter, in turn, develops from an identification with the most frustrating, the most hated, the most ambivalently-held, parent. The quantitative factor of ambivalence is decisive and it is dealt with by identification.

The capital importance to the development of the superego of identification with the most frustrating parent, first identified by Reich, has been echoed in the later psychoanalytic literature, but always without attribution. In his well-known paper on the 'confusion of tongues' between children and their parents, Sandor Ferenczi[88] was later to discuss this theme, coining the phrase *identification with the aggressor* (Identifizierung mit dem Angreifer). Anna Freud, in turn, referred to a similar phenomenon in child development in her *The Ego and Mechanisms of Defense*[89]. Joseph Sandler's influential 'On the Concept of the Superego'[90] also echoes this theme.

In healthy development the demands of the ego-ideal are imposed in a gradual way, which mirrors the gradual way in which attuned parents impose their demands on the child. This gives the immature ego an opportunity to progressively develop the repressions and reaction formations necessary to control the drive expressions which have met with parental disapproval and to foster behaviors of which they approve. As Reich puts it, in this setting the ego-ideal and ego are 'soldered' ('verlötet') together, so that the ego-ideal has a continuous effect on the developing ego. It ceaselessly imposes its demands, thus enabling the ego to incrementally develop the repressions and reaction formations necessary for social life.

In the impulsive character, however, demands are suddenly, harshly, peremptorily, and inconsistently imposed after a period of drive gratification. In this setting, there is a drive-positive component in the ego-ideal which is a consequence of the period of drive gratification which was not condemned initially by the care-givers. Reich gives several examples of such a circumstance

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[88] Ferenczi, S., 'Sprachverwirrung zwischen den Erwachsenen und dem Kind (Die Sprache der Zärtlichkeit und der Leidenschaft)' ['Confusion of Tongues between Adults and the Child: The Language of Tenderness and of Passion'], *IZP*, Vol. **XIX**, 1933, pp. 5-15.

[89] Freud, A., *The Ego and the Mechanisms of Defense* (1936), rev. ed. (trans., Baines, C.), International Universities Press (hereafter IUP), 1966, pp. 109-121.

[90] Sandler, J., 'On the Concept of the Superego', *The Psychoanalytic Study of the Child*, Vol. **11**, 1960, pp. 128-162, esp. pp. 155 ff.

in the book, e.g., neglected children who were allowed to openly masturbate, engage in sexual play with siblings, play with their feces, etc., who then were suddenly and harshly prohibited from these activities. In this context, the ego has experienced a period of relatively unrestrained drive satisfaction which it is not willing to give up, and there has been no need for the establishment of repressions and reaction formations since there were no demands for the latter forthcoming from the ego-ideal. The sudden imposition of harsh restrictions on drive satisfactions that had been previously tolerated leads to sudden intense frustration of the ego and intense hatred of the frustrators.

The ambivalence that results, however, is dealt with differently than in the healthy person or the impulse-inhibited neurotic. There is an identification with the drive-negative demands of the hated parent, but, due to the fact that the ego does not want to give up the pleasures to which it has already grown accustomed, and due to the intensity of the hatred toward the frustrators, the ego-ideal which develops is not 'soldered' to the rest of the ego. Rather, it exists in isolation and split off from it. In this setting the weak ego is temporarily able to repress the activity of the ego-ideal and continues to act irresistibly and impulsively in the direction of various drive gratifications. The ego-ideal eventually breaks through the ego's weak repressions and acts equally impulsively in the direction of self-punishments for the prohibited drive expressions. There is less opportunity in this context for the development of necessary repressions and reaction formations. Those that are established are apt to fail intermittently, yielding the clinical picture of unrestrained and uninhibited impulsive behaviors in the presence of more or less frequent neurotic symptom formation.

Reich's model of the development of psychic structure leaves room for the possibility of multiple identifications leading to the formation of multiple early, or precursor, ego-ideal formations in interaction with other ego elements, such as the remnant of the early pleasure ego and the rudimentary and weak mature ego which is developing. *This is the earliest model of the contributions of internalized object relations to development*. Long before the term became

widespread, Reich showed that the mind is not just a container of drives and defenses, but an inner stage on which relationships continue: the ego now interacts with the internalized parental figures that have been taken in as the superego (ego ideal) elements, of which there can be more than one. In normal development, this internal relationship is relatively harmonious and integrated ("soldered" together). In pathology — especially in the impulsive character — the relationship is split, hostile, and poorly coordinated.

Reich illustrates this beautifully with his clinical example of the patient who masturbates in a painful, self-tormenting way: the patient's genital, Lotte, representing the remnant of the original pleasure-ego, seeks sexual gratification, while an internal sadistic voice (the harsh internalized mother, now part of the split-off ego-ideal) simultaneously punishes her for it by way of masturbating in a way that caused her to have a prolapsed uterus. The masturbation scene is no longer a solitary act; it is an internal drama between two parts of the self that were once two people in the external world.

It is important to note that Reich's model claims that the qualities and functioning of the superego, that is, its harshness or moderation, as well as the process of superego development itself are strongly influenced by the qualities of the child's parenting. Moderate and consistent limit setting by parents results in a moderate and integrated superego, while harsh and inconsistent parenting result in an excessively punitive superego. In the case of the impulsive or borderline patient, they result in a split off and primitive superego precursor that no longer functions as a regulator of behavior, but as an aggressive force attacking the weak ego.

Freud had long considered the Oedipus complex to be 'the *nuclear complex* of every neurosis'[91], meaning that it was always the final and most important cause of a neurosis. Shortly before the publication of *The Impulsive Character*, Otto Rank[92] had argued for the importance of the trauma of birth, certainly a pre-Oedipal influence, as the main determinant of later neurotic symptoms. This was a theory which Freud was explicitly to reject[93]. *The Impulsive Character is the first*

[91] Freud, S., *Five Lectures on Psychoanalysis*, (1910a), Vol. **XI**, 2024, p. 45.

[92] See Rank, O., *The Trauma of Birth*, Harcourt, Brace, 1929 [anon. trans. of *Das Trauma der Geburt*, IPV, 1924], pp. 58 and 194.

[93] Freud, S., *Inhibitions, Symptoms, and Anxiety* (1926), Vol. **XX**, 2024, pp. 120 ff.

psychoanalytic publication to provide a model for a pre-Oedipal contribution to character formation and to assert that the pre-Oedipal experiences are the most important contributors to it:

> [T]oday we can safely assert that the experiences of the first two years of life are the most decisive of a person's life. The child enters the critical phase of the Oedipal era with character attitudes and traits which are already beginning to mature, if not irreversibly. The Oedipus complex is like a lens that refracts the drives. The drives give the experiences of the Oedipus phase a specific imprint and on the other hand are extensively modified by it.[94]

Melanie Klein, an important contributor to the object relations school of psychoanalysis, for example, refers to Reich's model in her influential *The Psychoanalysis of Children*[95].

Reich's model of stages of ego and superego development is the first such model developed[96]. He proposes that a stage of an isolated superego (along with the intense affects attending its isolation) is the earliest stage of superego development, and is a normal stage of development that healthy people and impulse-inhibited neurotics pass through on the way to the development, with the resolution of the Oedipus complex, of the mature superego, but in which impulsive characters remain fixated. Whether an individual becomes an impulsive character, an impulse-inhibited neurotic (e.g., a hysteric or compulsion neurotic), or is healthy depends on the intensity of his ambivalence towards his childhood care-givers and the libidinal phase in which the ambivalence manifests. This is a schema that can be tested empirically, and is thus a contribution to the problem of the 'choice of neurosis', that is, the issue of what determines the development of a specific pathological picture in a patient, which was an abiding interest of Freud's.

Reich's comments on the therapy of the impulsive are of great interest. Since the pathological mechanism is proposed to be the pathological functioning of a harsh and unintegrated superego, Reich proposes that the remedy must be an analysis in the transference of the object relations

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[94]Reich, W. (1925a), p. 55.

[95]Klein, M., *The Psychoanalysis of Children*, Hogarth, 1932, p.198.

[96]See, however, Ferenczi, S., 'Stages in the Development of the Sense of Reality' (1913), in Ferenczi, S., *First Contributions to Psycho-Analysis*, Hogarth, 1952, pp. 213-239. In this important early paper, Ferenczi focuses on the developmental stages of a restricted ego-function, that of reality testing, rather than on the whole ego as a structure.

underlying it. In this process, the patient begins to develop a new superego based on an identification with the superego of the analyst. *This is one of the earliest formulations*[97] *of this process, and the first that describes a mechanism for the salutary effects of the interaction between the superegos of analyst and patient*. As well, it is the first that argues for the routine necessity of a didactic or psycho-educational element to the analytic treatment of a patient group—what Freud referred to as an 'alloy[ing of] the pure gold of analysis freely with the copper of direct suggestion'[98].

It is important to note that the years between 1919, when Reich first encountered psychoanalysis, and 1924, when *The Impulsive Character* was written, were a time of unusual dynamism in psychoanalytic theory. During those few years the topographical model of 1919 was augmented by the structural model of 1923, which in turn was enhanced by the object relational dimension that Reich brought to his theory of the development of psychic structure in *The Impulsive Character*. These theoretical shifts were paralleled by shifts in psychoanalytic technique.

The technical shift from the interpretation of repressed content to the interpretation of resistance had already occurred during the era of the topographical model. The advent of the structural model facilitated a focus on what lay behind the resistances, and especially on the phenomenon of unconscious guilt. *Reich's theory shed light on another source of resistance, that is, on the highly ambivalent object relations that underlie the identifications that structure character pathologically*. The analysis of specific early object relations, especially those of the pre-Oedipal period, could now be added to the interpretation of unconscious content (including unconscious guilt) and unconscious resistance as a technical measure[99].

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[97] See Sachs, H., 'Metapsychological Points of View in Technique and Theory' (1924), *IJP*, **6**, pp. 5-12, 1925. Sachs' article touches on the issue of the patient's identification with the ego-ideal of the analyst as an element of the psychoanalytic cure. The article is a report of a talk given by Sachs at the 8th International Psychoanalytic Congress which Reich attended, and can justifiably claim priority.

[98] Freud, S., 'Lines of Advance in Psycho-Analytic Therapy' (1919 [1918]), *RSE*, Vol. **XVII**, 2024, p. 161.

[99] See, however, Freud, S. (1923), p. 45 footnote, and Kris, A., 'Freud's Treatment of a Narcissistic Patient', *IJP,* Vol. **75**, 1994, pp. 649-664. Freud's long footnote foreshadows the importance to the treatment of some patients of the analysis of the early object relations that lie behind unconscious guilt, that is, the importance of the analysis of the object relations that give rise to what Reich termed 'superego precursors'. What Freud refers to in the footnote as a sporadic measure Reich makes a consistent and regular feature of the treatment of the impulsive or borderline. Kris' paper gives some of the historical background to this important footnote, which involves Freud's treatment of a patient who may have had a mild form of borderline pathology.

These evolving technical approaches greatly increased the scope of patients who could be treated psychoanalytically. In addition to the impulsive, or borderline, characters that are a main focus of the book, Reich's theory of the development of psychic structure suggests a new way to approach the treatment of children, perversion, hysterical dissociation and multiple personality, and even some psychotic states.

As to the impact that Reich's object relational approach had on psychoanalytic technique, suffice it to say that there was no immediate effect. On the other hand, object relations theory is now one of the main psychoanalytic schools in the world[100].

In 1918, Freud had called for the democratization of psychoanalysis—'for treating a considerable mass of the population'[101]—and had begun an examination of what that would entail for a treatment that had started with six day a week sessions for a few mostly bourgeois patients. *The Impulsive Character is the first serious response to this call*. It deals with the diagnosis and treatment of a vastly expanded patient population, many members of which were indigent or naïve to psychoanalysis, living in the urban, post-World War I conditions of a greatly diminished and economically ruined Red Vienna[102].

Freud's model of superego formation and Reich's theory of ego and superego development together introduced a socio-political dimension into psychoanalytic thought. Because specific parenting practices can foster either healthy development or neurotic and impulsive character structures, child-rearing becomes a legitimate concern of public health. The same applies to economic conditions that impair parents' ability to function effectively. Between 1927 and 1934, therefore, Reich worked to prevent and treat neurosis on a mass scale rather than through individual therapy alone—an effort that first led him to the Austrian Social Democratic Party and

[100] See, e.g., Greenberg, J., Mitchell, S., *Object Relations in Psychoanalytic Theory*, Harvard, 1983.
[101] Freud, S. (1919 [1918]), p. 160.
[102] Gruber, H., *Red Vienna: Experiments in Working Class Culture 1919-1934*, Oxford UP, 1991.

later to both the Austrian and German Communist Parties. Although he eventually abandoned direct political activism, e.g., the establishment of free public sex-counseling centers for young workers, Reich's theory of ego and superego development was the first in psychoanalysis to provide a systematic framework for addressing the problem of neurosis as a remediable public health problem rather than as a fundamentally untreatable matter of one's constitution[103].

VI. Conclusion

On December 14, 1924, Sigmund Freud met with one of his colleagues of longest-standing, Paul Federn[104], to address an issue related to the internal politics of the Vienna Psychoanalytic Society. The board of the Society had elected Reich vice-president, but Federn, who had been Reich's analyst[105], wanted to replace Reich with his favored candidate, Ludwig Jekels, and evidently needed Freud's support to override the result of the election. In the event, he was able to get it. Later that day, Freud wrote Federn a letter which I quote in full:

> Shortly after you left, I read a manuscript by Dr. Reich that he had sent me that forenoon, and I found it to be so content-rich and valuable that I felt regret to have to deny him a recognition of his efforts. In this mood, it occurred to me that our decision to propose Dr. Ludwig Jekels as vice-president is invalid because both of us have no right to arbitrarily revoke a decision that has been made in the board meeting. In that light fades what you have told me of personal animosity against Dr. Reich. Satisfied with having found this formal reason, I therefore ask you to abide by the official proposal that had been made in the committee and to drop the substitution of Dr. Jekels. I am sorry to have to contradict myself so soon, but I hope you agree that this decision is the only correct one. (Signed) Freud.[106]

Freud wrote Federn again the next day, December 15, 1924:

> I am very sorry, but I cannot help you out of the predicament you have brought upon yourself. You should have raised your objections to Dr. Reich at the board meeting, not afterwards. Seeking approval from the various board members shortly before the meeting and under the impression that I had some motive to oppose it is clearly inadmissible.[107]

[103] Reich, W., *People in Trouble*, Orgone Institute Press, 1953; Fallend, K., Nitzschke, B. (eds), *Der 'Fall' Wilhelm Reich*: *Beiträge zum Verhältnisse von Psychoanalyse und Politik* [*The 'Case' of Wilhelm Reich: Essays on the Relationship of Psychoanalysis and Politics*], 2nd ed., Psychosozial Verlag, 2002; Peglau, A., *Unpolitische Wissenschaft?: Wilhelm Reich und die Psychoanalyse im Nationalsozialismus* [*Apolitical Science?: Wilhelm Reich and Psychoanalysis under National Socialism*], 2nd ed., Psychosozial Verlag, 2015

[104] See Mühlleitner, E., *Biographisches Lexikon der Psychoanalyse*, edition Diskord, 1992, pp. 90-92. Federn, an internist, had been an associate of Freud's since 1903, and was designated by Freud as his personal successor after he was diagnosed with oral cancer in 1923.

[105] Sharaf, M., *Fury on Earth*, St. Martin's, 1985, p.82.

[106] David Schulson Autographs Catalogue, no date. This translation is from the catalogue. Interestingly, Federn was able to get his way in the end.

[107] Fallend, K., *Wilhelm Reich in Wien: Psychoanalyse und Politik*, Geyer-Edition, 1988, p. 197. This is my translation of an excerpt of the letter.

The manuscript that so impressed Freud was *The Impulsive Character*. This is known because Freud wrote the following letter to Reich on December 14:

> Dear Herr Doctor!
>
> I immediately read the manuscript you sent to me and am pleased to inform you that nothing stands in the way of its acceptance and publication. I would suggest that the first parts lack clarity and contain an excess of unanswered questions. We well know what is unknown to all of us, and it is of little benefit to compile a list of these problems as long as we can't solve them. The last two parts, however, contain much of value, are clear, and I trust, are also correct. They confirm the expectation I once expressed that the relationship between the ego and superego will become an area of research of similar importance to that of the relationship between the person (ego + superego) and the object, ***which is all that we have studied hitherto***. Whether the expressions 'impulsive character' and 'isolated superego' will prove to be useful in the end, I leave aside. In any case, your work is an important advance in the knowledge of those forms of disease which probably culminate in moral insanity [sic]. [My emphasis]
>
> Warmly,
> Freud[108]

These letters are quoted because they demonstrate that Freud valued *The Impulsive Character* and its author sufficiently as to be willing to disappoint and put in an embarrassing position one of his oldest and most trusted colleagues.

The reception by the rest of the psychoanalytic community was more muted. Otto Fenichel's lengthy and mixed but predominantly positive review of the book appeared almost immediately[109]. He demonstrates a good understanding of the arguments of the book and praises the clinical description of the isolated superego. For the most part, his criticisms seem to focus on what he considered to be Reich's terminological looseness. He is quite critical of Reich's use of the term 'repression of the superego' to explain the periodic breakthrough of impulsive drive-gratifying behaviors, feeling that repression of an entire psychic agency is impossible and an illogical concept in the structural model. In fairness, however, Reich was attempting to explain, for the first time,

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[108] Johler, B. (2008), op.cit. My translation and emphasis.
[109] Fenichel, O., 'Reich, W., *Der Triebhafte Charakter*, 1925', *IZP*, Vol. **XI**, 1925, pp. 381-387.

the mechanism behind the alternating appearance of comprehensive mental states that exhibit very different qualities for which the term 'repression' was inadequate. In ordinary repression, it is a case of rather restricted and selective content being excluded from consciousness rather than a total mental state. This difference is acknowledged today with the terms 'splitting' and 'repression' respectively[110]. Clearly, this was a distinction that Fenichel did not appreciate, possibly because he did not have clinical experience with this patient population.

Edward Glover's[111] review, on the other hand, was more negative. Glover had exhibited an early interest in the development of the ego and character, and had clearly been influenced by Abraham's libidinal theories of character[112]. He focuses on the phenomenological differences between the impulse-inhibited and impulsive character types and finds so much overlap as to conclude that the distinction is not a clinically useful one. He, like Fenichel, takes issue with the concept of 'repression of the superego'. Curiously, neither in his review nor in another contemporaneous paper[113] does Glover examine in any depth the structural model of development that was of so much interest to Freud. It is tempting to conclude that Glover was not interested in or possibly missed some essential points of the book.

It is a remarkable fact that these were the only two reviews that appeared at the time of the publication of *The Impulsive Character*. A search of the Psychoanalytic Electronic Publishing online database[114] for the period of the century after the publication of *The Impulsive Character* reveals a total of 66 citations, 37 of which occurred within the first 15 years. Reich himself accounted for 14 of these, followed by Fenichel, with eight. The remainder of the citations before 1940 were by such authors as Alexander[115], Edith Jacobson[116], M. Searl[117], Melanie Klein[118], and Hans Zulliger[119], among others. Of the authors mentioned here, only Fenichel, Klein, and Searl

[110]Kernberg, O. (1975), pp. 13, 28-33.
[111]Glover, E., '*Der Triebhafte Charakter*', *British Journal of Medical Psychology*, Vol. **5**, 1925, pp. 359-361.
[112]Glover, E., *On the Early Development of Mind*, IUP, 1954.
[113]Glover, E., 'The Neurotic Character', *British Journal of Medical Psychology*, Vol. **5**, 1925, pp. 279-297.
[114]Search of pep-web.org, using search term Der Triebhafte Charakter. December 28, 2025. Perfunctory citations, such as publication announcements, are not counted in my report of this search.
[115]Alexander, F., 'The Neurotic Character', *IJP*, Vol. **11**, 1930, pp. 292-311.
[116]Jacobssohn, E., 'Beitrag zur asozialen Charakterbildung', *IZP*, Vol. **16**, 1930, pp.210-235.
[117]Searl, M., 'Infantile Ideals', *IJP*, Vol. **17**, 1936, pp. 17-39.
[118]Klein, M. (1932)
[119]Zulliger, H., 'Ùber Hochstapler und Verwahrloste: Berichte und Gedanken zur Erörtung des narzißtisch-triebhaften Charakters, *Zeitschrift fűr psychoanalytische Pädagogik*, Vol. **9**, 1935, pp. 149-168.

seem to have addressed Reich's structural argument.

In more recent years, on the other hand, some authors[120] have expressed more discerning and favorable opinions of the book, and a recent psychological study[121] found empirical support for Reich's clinical description of the impulsive character.

In light of the many contributions of *The Impulsive Character*, the question arises as to why they did not receive more acknowledgment. A couple of reasons seem likely. It is a very dense and very technical presentation that is itself based on Freud's novel theorizing in *The Ego and the Id*. As Arlow and Brenner observed, it took decades for the structural model per se to be assimilated by the psychoanalytic community[122]. To understand Reich's innovations, based on the new theory, would be an even harder task. *Put simply, it is likely that The Impulsive Character was not understood by most readers when it was first published*. This explanation is supported by a reading of the reviews and citations that appeared in the 15 years after the book's publication. However, I think another contributory reason is suggested by Freud's own theory of group psychology.

I would suggest that the ego-ideals of most psychoanalytic readers identified with the ego-ideal of Sigmund Freud, the undisputed and charismatic leader of psychoanalysis. As Reich's interests diverged more and more from those of Freud and mainstream psychoanalysis, I believe that Freud increasingly saw him as an apostate whose innovations he viewed with skepticism and suspicion. Like Jung and Adler before him, Reich was once a favorite of Freud's who was later ostracized by him[123]. The members of the psychoanalytic movement likewise distanced Reich in various ways — not least by denying him the recognition his brilliant creativity deserved. This identification

[120] See, e.g., Mack, J. (ed.), *Borderline States in Psychiatry*, Grune & Stratton, 1975, pp. 5-7; Hoevels, F., *Wilhelm Reichs Beitrag zur Psychoanalyse*, Ahriman Verlag, 2001.

[121] Perry, J., Körner, A., 'Impulsive Phenomena, The Impulsive Character (Der Triebhafte Charakter) and DSM Personality Disorders', *Journal of Personality Disorders*, Vol. **25**, 2011, pp. 586–606.

[122] Arlow, J., Brenner, C., *Psychoanalytic Concepts and the Structural Theory*, IUP, 1964, p. 1.

[123] See Fallend, K. (1988); Rubin, L. 'Wilhelm Reich and Anna Freud: His Expulsion from Psychoanalysis', *International Forum of Psychoanalysis*, Vol. **12**, 2003, pp. 109–117; and Steiner, R., 'It is a New Kind of Diaspora...', *International Review of Psychoanalysis*, Vol. **16**, 1989, pp. 35-79.

helps explain the appalling treatment Reich received from organized psychoanalysis in the years leading up to his expulsion from the IPA in 1934. Moreover, it has long obscured — and continues to obscure — psychoanalysis's fundamental debt to him.

Wilhelm Reich's experience with psychoanalysis was only the first instance of what was to become a pattern for him: he entered a field, made fundamental contributions to it, and then moved on, motivated by his vision of what he called functionalism[124]. Refusing to be hemmed in by the artificial boundaries of specialized fields, he forged his own pioneering path.

[124]Reich, W., *Ether, God, and Devil*, Orgone Institute Press, 1949.

Der triebhafte Charakter : eine psychoanalytische Studie zur Pathologie des Ich (1925)

[The Impulsive Character: A Psychoanalytic Study of the Pathology of the Ego]

Wilhelm Reich, M.D.

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Introduction

There is presently no theory of character on a psychoanalytic basis that is even remotely systematic. It is in the nature of the psychoanalytic method of research that individual phenomena are investigated first, whether in a psychoanalytic treatment or in the field of psychopathology as a whole. The results of individual studies can only later be synthesized into a valid general theory. A psychoanalytic theory of character presupposes a precise knowledge of the finest details of the mechanisms of mental development; this is a requirement still far from being fulfilled. Even if the theory of sexual development seems to be well established in its essentials, it nevertheless does not suffice for a characterological understanding of the personality. Those who have followed the development of psychoanalysis closely, especially in the relevant writings of Freud, and who have grasped the nature of the analytic experience as both analyst and patient, understand that ego dynamics are harder to grasp than sexual ones.

Psychoanalysis has emphasized, as Freud repeatedly also has both in his fundamental works and more recently in *The Ego and the Id* [125], that it must zealously avoid presenting the patient with ready-made formulations {6} of his personality. Fundamentally oriented to a genetic view of the mind—a psychic embryology so to speak— psychoanalysis must take the longer and more difficult path of a detailed investigation of the individual patient. This has decisively influenced therapy: to treat analytically means first of all to recognize and understand developmental defects, and as much as possible to make use of that understanding to undo them. So it is that contemporary therapy is as incomplete as its theory. The ideal precondition of psychoanalytic therapy would be *the complete genetic understanding of the character of the patient* .

Psychoanalysis has been more than a merely symptomatic treatment for a long time now, and has been consistently evolving into a therapy of the character. This technical change can be

[125] Freud, S. (1923).

attributed to Freud's first realization that what is essential in the analytic work does not consist of guessing the unconscious meaning of a symptom and communicating it to the patient, but in detecting and removing resistances[126]. Two fundamental elements are regularly expressed in a resistance: first, every resistance contains a repressed content corresponding to a specific analytic situation, and at the same time a repressing component which does the work of defense. Second, apart from these specific elements, or rather, contents, every resistance also expresses a specific *form* of resistance; every resistance gets its specific character, so to speak, from the total personality. An incestuous transference resistance has the same content in compulsion neurosis as in hysteria, but totally different forms, {7} corresponding to the compulsion neurotic and hysterical characters respectively. Knowledge of the unconscious content probably suffices for carrying out the most urgent analytic work. At first, the way, *how* the personality of the patient declares itself in his resistances is unimportant. But if one has gone beyond the viewpoint of pure symptom analysis, if one recognizes that it is not the analytic resolution of the symptom but the resolution of the basis of the neurotic reaction, that is, of the neurotic character, on which real cure—i.e., rendering the patient unable to relapse—depends, then one must also replace symptom analysis with character analysis. But despite this, character analysis has only recently been placed in the foreground of analytic work. And this has not even taken place explicitly[127]. Ferenczi and Rank[128]particularly emphasize the importance of the analysis of neurotic acting out. They criticize the methods of symptom analysis, or as the case may be, complex analysis, which have been used almost exclusively up till now; but with their emphasis on grasping the patient primarily through his actions, they give rise to the impression that they are putting aside the memory work to which Freud has always given first place therapeutically. Now it is certainly the case that the analysis of neurotic actions gives one the best access to the patient, certainly in far greater measure than in 'memory analysis', because it is precisely in actions that a patient's total behavior and quirks of character are expressed most clearly. But analyzing action *without* attending to the associated memories or *without* {8} an analytic reconstruction of the causes of the action is

[126] Freud, S., 'On the History of the Psychoanalytic Movement (1914b), *RSE*, Vol. **XIV**, 2024, pp. 5-58. [This citation appears to be erroneous. It seems likely that Reich meant to refer to 'The Future Prospects of Psycho Analytic Therapy' (1910b), p. 132, where Freud expresses this ideas almost verbatim.]

[127] Abraham, K., *Psychoanalytische Studien zur Charakterbildung* [*Psychoanalytic Studies on Character Formation*], IPV , 1925, p. 64. [in Abraham, K. (1927), pp. 370-417.] Abraham's extremely enlightening study, in which 'character analysis' is clearly considered to be essential, was published while this book was in press.

[128] Ferenczi , S., Rank, O., *Entwicklungsziele der Psychoanalyse* [*The Development of Psychoanalysis*], IPV , 1923.

very poorly suited to a genetic understanding of the patient; on the other hand, experience shows that patients who do not act out tend to be unaffected by even the deepest memory work.

Freud's conception of the 'anal-erotic character'[129], fruitfully augmented by Jones[130]and Abraham[131], represented the first fragments of a psychoanalytic characterology . Here it was shown for the first time that primitive drive energies take part in the formation of character traits: parsimony, orderliness, pedantry, excessive cleanliness, obstinacy, etc., were seen to be the direct derivatives of anal eroticism, and not neurotic compromise formations. Today, the question of how it is that primitive drive energies sometimes result in neurotic symptoms and sometimes in character traits is still an open one. For example, we know that urethral erotic drive energies sometimes result in the neurotic symptoms of premature ejaculation (Abraham[132]) and enuresis (Freud[133], Sadger[134] , Stekel[135]), and sometimes in the character trait of envy. The same goes for the role of sadism in the compulsive character, which is characterologically far clearer to us than, for example, the hysterical character. The problem of why the universal fact of the compulsion to repeat[136] only dominates certain cases in the form of character traits, that is, as the compulsion to re-experience certain situations over and over again, while in other cases it doesn't seem to play the role its {9} biological nature would assign it is equally mysterious. There are neurotic characters without neurotic symptoms, and there are symptom neuroses in which the character, the total personality, does not seem essentially pathological.

All of these problems belong to the field of psychoanalytic characterology , whose

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[129]Freud, S. (1908a).

[130]Jones, E.,'Über analerotische Charakterzüge ['On Anal Erotic Character Traits'], *IZP* , Vol. **V**, 1919, pp. 69-92.

[131]Abraham, K., 'Ergänzungen zur Lehre vom Analcharakter' ['Supplement to the Theory of the Anal Character'], *IZP*, Vol. **IX**, 1923, pp. 27-47. See also the recently published monograph, l.c., p. 7 [Abraham, K. (1927), pp. 370-392.]

[132][See Abraham, K., 'Ejaculatio Praecox' (1917), in Abraham, K. (1927), pp. 280-299.]

[133][Freud, S. (1905a), p. 168-169.]

[134][Sadger, I., 'Über Urethralerotik', *Jahrbuch für psychoanalytische und psychopathologische Forschung*, Vol. **II**, 1910, pp. 409–450.]

[135][Stekel, W. *Peculiarities of Behavior*, Vol. 2, Liveright, 1924, p. 126.]

[136]Freud, S. (1920b), p. 36.

methodological foundation must be a *comparative* analytic psychology, analogous to comparative embryology.

No matter how great the scientific satisfaction of medical analysts with their ability to understand symptoms, to trace back individual character traits to their sources and to practice a causal therapy, one could never deceive oneself about the lack of a systematic characterology, which was never so intensely felt as when therapeutic experience began to show the overwhelming importance of character analysis.

We find the foundation of a comprehensive psychoanalytic theory of character in Freud's *The Ego and the Id.* The characterological understanding of the personality is based on identification:

> '[T]he character of the ego is a precipitate of abandoned object cathexes...[W]e have come to understand that this kind of substitution (of an identification for an object cathexis) has a great share in determining the form taken by the ego and that it makes an essential contribution towards building up what is called its *character*.' This developmental process can also have a pathological outcome: 'If (these object identifications) obtain the upper hand and become too numerous, unduly powerful and incompatible with one another, a pathological outcome will not be far off. It may come to a disruption of the ego in consequence of the different identifications becoming cut off from one another by resistances; perhaps the secret {10} of the cases of what is described as *multiple personality* is that the different identifications seize hold of consciousness in turn. Even when things do not go so far as this, there remains the question of conflicts between the various identifications into which the ego comes apart [Aufsplitterung], conflicts which, after all, cannot be described as entirely pathological.'[137]

Freud then distinguishes between the ego and the superego (ego ideal): the superego represents the substitute for the object, and the ego submits to it and offers itself to it as a love object, as it once did to the parents. But the superego has a 'double-aspect': it not only says, 'Thou *shalt* be thus (like the father)', it also contains the prohibition, 'Thou *shalt not* be thus (like the father); that is, not everything the father does is permitted to the ego; many things are reserved for him alone'[138]. With *The Ego and the Id* , Freud has created for us a scaffolding for more detailed work on character formation. In particular, the question is still open as to the influence of the various libidinal zones on the formation of the ego ideal, which is intimately connected to the question of *libidinal stage-specific object relations* [*spezifisch-erogene*

[137]Freud, S. (1923), pp. 24-26.
[138][Ibid, p. 29.]

Objektbeziehungen].

It must be of far-reaching importance for the final structure of both the reality-oriented and pathological ego

1) *which* attitudes of the parental personality the child incorporates into its ego ideal as a) affirming or b) prohibiting elements, and

2) whether the ego ideal formation of the boy is predominantly based on the *father* or *mother* (it is the same for girls), and how the model for the ego ideal was created.

3) Also, it cannot be a matter of indifference in which *stage of* {11} *libidinal development* an effective identification develops. The specific determinants of character must be sought in the interactions between sexual and ego development as they occur at particular stages (for example an identification at the genital as opposed to the anal phase)[139].

4) We do not know the conditions under which the demands of the ego ideal are *realized*; along with the real ego, which represents the sum of *realized* ego ideal demands, the *thus it is*, there exists a series of unrealized ego ideal demands (the *thus it should be*). And we know that the tension between the thus it is (the real ego) and the thus it should be, or respectively, the thus it should not be (superego), is at the root of so much illness.

5) We must also take into account that a primitive 'pleasure ego' clearly already exists before any identifications and is responsible for carrying them out; its response to these identifications must be decisive for their outcome.

[139]Freud writes in *Three Contributions toward a Theory of Sex* (1905a), p. 213: 'It cannot be a matter of indifference whether a given current [of sexual impulses] makes its appearnce earlier or later than a current flowing in the opposite direction...Divergences in the temporal sequence in which the components [of a current] come together invariably produce a difference in the outcome.' Thus it would be important to find typical deviations from the normal temporal course of development and to relate them to particular pathological outcomes.

If the problems briefly sketched here immediately present themselves when one approaches any analysis characterologically, the difficulties in making progress with them in mild transference neuroses are very great. The cases best suited to that are those which exhibit gross defects of ego structure—those people who remain in constant battle with the external world and thus look as if {12} they have never progressed beyond the first stages of identification or of superego formation. The typical neurotics under the sway of the repetition compulsion, the antisocial, the occasional criminal—people who systematically blight and destroy their own existence, and whose egos remain completely infantile—are best suited to the study of ego ideal formation in statu nascendi. They give us valuable clues to the analytic understanding of the milder character anomalies, because they represent only gross distortions of the latter. These patients, under the sway of their uninhibited drives, form their own category which hitherto has only been studied intensively from the psychoanalytic side by Alexander[140]and Aichhorn[141]. That these patients are still, as it were, on the psychoanalytic frontier can probably be attributed to the fact that they are usually poorly suited to outpatient treatment; for the most part they lack insight into their illnesses, and if they do find a foothold in an analytic treatment they have difficulty learning to use the delicate instrument of analysis. I will go into all of these points in detail. The patient material at my disposal was for the most part recruited from cases of severe character neurosis presenting to the Vienna Psychoanalytic Outpatient Clinic[142] whom I selected for treatment. To be clear, I cannot avoid presenting some of the cases synoptically, even if it is plain to me that all the faults of an abbreviated psychoanalytic case history also attach to them. Their publication in this form is all the more justified as the mere description of the experiences of these patients without the usual interpretation is sufficient to present the essential and typical features of these cases to the analyst. {13}

Our study, then, will proceed in two directions which will eventually converge: we will discuss a category of patients hitherto little appreciated psychoanalytically, which we, with Alexander, call ‘impulsive characters’; at the same time, we will investigate character formation itself by means of this material. We are by no means attempting a systematic

[140]Alexander, F. (1923)

[141]Aichhorn , A., ‘Über die Erziehung in Besserungsanstalten ' [‘On Education in Reform Schools’], *Imago*, Vol. **IX**, 1923, pp. 189-221.

[142][This is the Ambulatorium; see footnote 18.]

account of these topics, which the inductive and empirical method of psychoanalysis at present prohibits. We will have to content ourselves with pointing out some typical defects of character development, which we will show are founded on the better known mechanisms of sexual development. {14}

II . Overview of the neurotic and the impulsive characters

When approaching a field that has not yet been explored psychoanalytically, one does well to keep a firm grasp on those manifestations of mental disturbance which are already thoroughly understood. We may begin therefore with the assumption, which psychoanalysis has clearly demonstrated, that there are no sharp boundaries between the different syndromes and symptom pictures, indeed, between even the 'normal' and the 'sick'. It is a mistake in any case to begin with the normal because the dynamics and genesis of the normal psychological state, insofar as there is such a thing, are a much bigger problem for us to explain than, for example, the well known mechanisms of hysterical symptoms. If despite this one tries to separate syndromes and symptom pictures from each other and from the 'healthy', one is justified in doing this on the basis of the fact that different *dominant* mechanisms result from different configurations of conflictual material in the mind, and that these mechanisms in turn constitute this or that syndrome as well as the normal state. That a particular configuration determines an ability to function adequately in reality (and by mental health we can presently understand nothing else) is a matter of the conventional values which are established in a {15} society and adopted by its members. It is different when we establish relationships between the different disease syndromes. It doesn't really matter if we say that the neurotic character, the impulsive character, psychopathy, is a borderline state between health and psychosis as clinical psychiatry generally assumes, or that 'every neurotic character carries the germ of a particular neurosis' (as Alexander says), and thus to a certain degree represents a borderline state between health and neurosis. It all depends on the point of view with which we approach the issue and what we hope to gain from it. We put no special emphasis on the point of view

which we are adopting in this work, namely that with reference to certain specific dynamic mechanisms, the impulsive character lies between symptom neurosis and psychosis. According to Alexander, those with a neurotic character 'suffer no pronounced symptoms, but behave conspicuously impulsively in life, and often compulsively, too; they are especially strongly ruled by unconscious tendencies', further, that 'some of those with a neurotic character, certain impulsive criminal types,...evidently [suffer from] defective...defense reactions'. Alexander aptly points out the appearance of transient symptoms in these patients under the influence of the deprivations of the analytic situation, and raises the question 'whether the pressure of the pathogenic element—*libido stasis*—is not great enough to force a discharge into new pathways, that is, into symptoms, or if the defense reaction of the organism—*repression*—is not strong enough to block real gratification'. {16}

But to formulate the problem this way is not quite correct. In the analysis of impulsive characters one runs across amnesias which differ in no way from typical hysterical amnesias. Other mechanisms of repression, such as the rupturing of the connections of genetically related experiences, the displacement of guilt feelings, or reactive defenses against destructive tendencies, are at least as prevalent in the impulsive character as in compulsion neurotics. We will illustrate this with examples later on in the discussion. Since it is not a question of a weakness of particular repressions, we will make the focus of our study the process which determines the defective defense, the defective mechanism of repression, which permits actions to the impulsive which never gain access to motility in a simple symptom neurotic.

Alexander's observation that 'every neurotic character carries the germ of a particular neurosis' is simply to say that there exist very occasional cases of neurotic character which exhibit no circumscribed neurotic symptoms. In fact, Alexander's case is an example of such a symptomless character neurotic. But the vast majority of those with an impulsive character display, in addition to their mostly ego-syntonic impulsivity, every type of symptom: phobias, compulsive behaviors and ceremonies, ruminative thinking, and especially in women, all the known forms of conversion symptoms. The symptomatology of such cases is characterized precisely by its grotesqueness; we might say that it is a pathological distortion of 'respectable bourgeois' symptoms. How banal and innocuous seem the {17} simple neurotic's obsessions

to murder his child or friend next to the compulsion of the impulsive to slowly roast her child over a fire. One can no longer call it a compulsion (despite a similarity of structure) when a patient of mine found her greatest pleasure in setting everything in the house on fire and in brandishing burning matches at her child. How mild seem the passive castration tendencies of a patient who compulsively lost and misplaced his belongings compared to the compulsions of a patient who had to severely injure her cervix with a knife handle and cause copious bleeding as a condition of orgasm during masturbation, finally resulting in uterine prolapse. Thus these patients do not lack circumscribed neurotic symptoms, but they also have an added quality which not only distinguishes them from classical conversion and anxiety hysteria and compulsion neurosis, but brings a considerable number of them perilously close to schizophrenia. This type of grotesque impulsivity is not uncommon in the history of schizophrenics and later we will discuss a case in which even after months of psychoanalytic treatment it was difficult to decide between a diagnosis of schizophrenia and transference neurosis.

But the cases I am drawing on differ in one essential respect from Alexander's, which justifies putting them in a different category from his. When we speak of the impulsive character, we are always referring to a character dominated by actions and attitudes towards the external world which are dictated by the repetition compulsion. It {18} all depends on whether these actions represent primitive tendencies in undisguised form or are disguised by extensive secondary elaboration. Alexander's case stood out because, out of a deep need for punishment, he had repeatedly (unconsciously) chosen friends who cheated him out of his money, which ultimately left him materially and psychically ruined. He was one of those people about whom Freud wrote in *Beyond the Pleasure Principle*[143] :

> 'The compulsion which is here in evidence differs in no way from the compulsion to repeat which we have found in neurotics, even though the people we are now considering have never shown any signs of dealing with a neurotic conflict by producing symptoms. Thus we have come across people all of whose human relationships have the same outcome: such as the benefactor who is abandoned in anger after a time by each of his protégés, however much they

[143]Freud, S. (1920b), pp. 21-22.

> may differ from one another, and who thus seems doomed to taste all the bitterness of ingratitude; or the man whose friendships all end in betrayal by his friends;...the lover each of whose love affairs with a woman passes through the same phases and reaches the same conclusion. This "perpetual recurrence of the same thing" causes us no astonishment when it relates to active behavior on the part of the person concerned and when we can discern in him a character trait which always remains the same and which is compelled to find expression in a repetition of the same experiences. We are much more impressed by cases where the subject appears to have a passive experience, over which he has no influence, but in which he meets with a repetition of the same fatality.'

Our cases exhibit the same 'daemonic trait' in their characters, but what is impulsively enacted and experienced is primitive and pervaded by undisguised masochistic, sadistic, anal, oral, and similar drives. {19} There may also be cases of the impulsive character for whom our question as to the nature of the *defect* of repression is not apt and who exhibit a different dynamic of psychic conflict.

In view of what we have discussed so far, we can pose three questions which will concern us in what follows:

1.) What are the dynamic similarities and differences between the impulsive character and the simple transference neuroses? *2*.) Is there a specific defect in the mechanism of repression in the impulsive character? And closely connected to this question, *3*.) if there are such specific defects of repression, are they related to the defects in schizophrenia? Here we are approaching the view of general psychiatry that 'psychopathies', to some extent, are at an 'early stage of psychosis proper' (Kraepelin[144]), and especially of schizophrenia, or at least have a very close relationship to the latter.

Our concept of the impulsive character is admittedly a much narrower one than the concept of 'psychopathy' in the psychiatric literature, where the term is commonly stretched to include phenomena which we would judge to be symptoms in an otherwise organized personality. Because of the lack of a genetic viewpoint, there is enormous clinical heterogeneity even when the concept is more narrowly defined. Bleuler[145] also believes, rightly, that any attempt to

[144]Kraepelin , E., *Einführung in die Psychiatrische Klinik* [*Introduction to Clinical Psychiatry*], 3rd ed., Barth, 1916, p. 386.

[145]Bleuler , E., *Lehrbuch der Psychiatrie* [*Textbook of Psychiatry*], 2nd ed., Springer, 1918, p. 441.

define psychopathy on purely descriptive grounds is mistaken. It can only be a question of investigating the *dominant* mechanisms. Bleuler writes: 'The clinical syndromes belonging to this category of mental illness have no sharp boundaries between {20} themselves or with the normal....I might say that they lack boundaries altogether; the number and severity of symptoms which are presently used to define psychopathy are an arbitrary matter. There are broad transition and mixed zones between this group and all the other psychiatric illnesses, especially hysteria. Paranoid tendencies do not necessarily lead to paranoia in these cases. Symptoms from different syndromes can occur in the same patient...affective abnormalities and neurotic phenomena in particular are almost never absent.' With such a view of psychopathy it is understandable that the system by which Bleuler himself classifies these patients is only provisionally useful as an orientation: the excitable [Erregbare], the inadequate [Haltlose], the impulsive [Treibmenschen], the eccentric [Verschrobene], liars and swindlers [Lügner und Schwindler, pseudologia phantastica], the antisocial [Gesellschaftsfeinde], and the pseudoquerulous [Streitsüchtige, pseudoquerulanten]. The basic error of all such systems of classification is that one outstanding characteristic is made into the main criterion of a syndrome and the fact is ignored, for example, that any impulsive, in Bleuler's sense, is just as inadequate as the eccentric patient, or that the eccentric is antisocial and for this reason must also be pseudoquerulous. While Bleuler's system is adopted from Kraepelin, he has brought out more clearly than Kraepelin did the relationship of many forms of psychopathy to psychosis. Liepmann[146] also defined the psychopath as 'pathological deviations from the normal state which do not belong to the category of fully developed psychosis because of a lack of the more severe symptoms'.

The close kinship of the psychopathies to the psychoses, particularly to dementia praecox, has attracted the attention of those authors especially who do not stretch the concept of psychopathy so far {21} as to include symptoms of uncomplicated hysteria and compulsion neurosis. Thus Kraepelin and Bleuler, for example, distinguish neurasthenia from

[146]Liepmann, H., 'Die Beurteilung psychopathischer Konstitutionen (sogenannter psychischer Minderwertigkeit)' ['Assessing the Psychopathic Constitutions (so-called mental inferiority)'], *Zeitschrift für ärztlich Fortbildung*, Vol. **9**, 1912, pp. 129-140.

psychopathy, while for Schneider[147] a neurasthenic is an insecure, mood-labile, and asthenic psychopath. Kraepelin characterizes some psychopaths as being at an 'early stage of psychosis proper', others as 'aberrant personalities whose development has been disturbed by unfavorable heredity, congenital abnormality, or other early impediments. If the defects which result are restricted to disturbances of affect or initiative, we call such patients psychopaths'[148]. With regard to the psychoses, Dieckhoff[149] found that hebephrenia, dementia paranoides, and paranoia, especially, develop out of psychopathy: 'Some psychoses are based entirely (paranoia simplex) or to a great degree on the further progression of psychopathic inferiority'. 'Shorter or longer periods of psychosis occur in the higher grade of psychopathic inferiority with, or more rarely without, external cause; they show little regularity in symptomatology and course. The prognosis for the individual episodes is generally good but there is a high probability of further attacks'.

Some authors, like Birnbaum[150], Gaupp[151], and Mezger[152], construe the concept of psychopathy very broadly; the latter for example {22} declares that 'any deviation from the normal, any abnormality...is morbid, is pathological'.

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Hitherto we have used the terms 'impulsive character', 'neurotic character', and 'character neurosis' indiscriminately; we must now adopt a more precise terminology. In view of the ambiguity of the concept of 'character', this is not an easy task. We will have to navigate carefully between Scylla and Charybdis. On one hand we want to avoid the mistake which is all too often made when official science discusses living processes, namely to lose sight of the living phenomenon itself for the sake of terminological discussion. Equally, we want to avoid

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[147] Schneider, K ., *Die psychopathischen Persönlichkeiten* (1923) [*Psychopathic Personalities*], in Aschaffenburg, G., *Handbuch der Psychiatrie* [*Compendium of Psychiatry*], Deuticke, 1911-1928.

[148] [Kraepelin, E. (1916), p. 386.]

[149] Dieckhoff , C. 'Die Psychosen bei psychopathisch Minderwertigen' ['The Psychoses in Psychopathic Inferiority'], *Allgemeine Zeitschrift für Psychiatrie* , Vol. **55**, 1898, pp. 215-250.

[150] Birnbaum , K., *Über psychopathischen Persönlichkeiten: Eine psychopathologische Studie* [*On Psychopathic Personalities: A Psychopathological Study*], J. F. Bergmann, 1909.

[151] Gaupp, R., 'Über den Begriff der psychopathischen Konstitution' ['On the Concept of the Psychopathic Constitution'], *Zeitschrift für ärztlich Fortbildung* , Vol. **14** , 1917, pp. 565-569.

[152] Mezger , E., 'Die abnorme Charakteranlage' ['Abnormal Character Dispositions'], *Archiv für Kriminal Anthropologie und Kriminalistik* , Vol. **49**, 1912, pp. 23-52.

the mistake of arbitrarily introducing terminology which only serves to confuse. If for the sake of discussion we provisionally define the character of a person as the specific mode of expression of his mental attitude to the environment [spezifische Erscheinungsform seiner psychische Haltung zur Umwelt] which in turn is determined by disposition and experience in the sense of a Freudian 'complemental series'[153], then *neurotic* characters impress us as those characters exhibiting more or less gross deviations from reality-oriented sexual and cultural strivings, and from the ability to adapt socially. The conflictual and contradictory quality of their life experience can be seen as a common characteristic of all forms of neurotic character, and leads to an indecisiveness in behavior and attitude. We know from psychoanalysis that these characteristics are {23} the consequences of a disturbed development in which whole fragments of the personality are left behind and held fast at earlier stages of development by the process of fixation. Stated most aptly, we feel that the difference between a neurotic symptom and neurotic character is that the circumscribed neurotic symptom corresponds directly to the *part* of the personality fixated here or there, while the neurotic character is always an expression of the *total attitude* corresponding to this fixation. Thus a fixation (and the psychic conflict associated with it) *always simultaneously* has two aspects: the *neurotic symptom* specifically corresponding to the fixation (e.g., hysterical vomiting as the expression of an oral-genital fixation) and the *neurotic character* corresponding to the disturbance created in the total personality by the fixation of a portion of it. We have to assume, therefore, that even the most inconsequential fixations do not leave the rest of the personality untouched. Every neurotic symptom is based on a neurotic character. Symptoms rest on a hysterical or compulsive (or possibly even schizoid) character like peaks on a mountain range. The neurotic character is as precisely determined by the stage at which developmental inhibition takes place as the neurotic symptom. The compulsion neurotic, for example, who seeks analysis because of an impulse to stab his friend in the back with a knife (thus, a compulsive symptom) also exhibits a compulsive character: he is pedantic, orderly, overly conscientious.

[153][Freud's term for the reciprocal, additive, relationship between innate disposition and life experience in producing psychopathology. At one extreme, strong innate vulnerability needs little external triggering to cause pathology; at the other extreme, minimal innate risk requires intense trauma to achieve the same result. In between, the two factors complement each other inversely to cause pathology.]

Both the symptoms and the character traits bear {24} the marks of the anal-sadistic stage of development. The expression '*impulsive character*', then, can only refer to a particular form of the neurotic character, namely, *a disturbance of the total personality*, which is recognizable by more or less *uninhibited behavior*. And as we have distinguished between neurotic symptom and neurotic character, we must now distinguish between compulsions, in the form of uncontrolled compulsive actions, and the actions of the impulsive character. While the first seem to be encapsulated, like foreign bodies in an otherwise well-ordered personality which also condemns them, the uninhibited actions of the impulsive are an attribute of the total personality and for the most part are not experienced as pathological. The actions of the impulsive are mostly diffuse and not directed toward particular objects or bound to particular situations; they vary in nature and intensity depending on the environment. In contrast, the behavior of the compulsion neurotic is restrained, rigid, and largely independent of external circumstances. The purpose of the impulsive character's actions are in general much clearer and easier to grasp than that of circumscribed neurotic symptoms. The behavior of the impulsive never seems as senseless as the compulsion neurotic's and is rationalized to a far greater degree.

The boundary between the impulsive character and schizophrenia, especially the paranoid and catatonic forms, is in many cases just as blurred as that with the classical transference neuroses. What distinguishes a fair number of especially blatant forms of impulsivity from out-and-out schizophrenia is the presence of an intense and lively relationship {25} with the external world which is often marked by a quality of apparent exaggeration. For example, in some cases from the Vienna Psychiatric Clinic[154] who were first diagnosed as 'psychopathically inferior' vagrants, liars, or complainers, and who then developed marked grandiosity and ideas of persecution, the exaggerated quality of their relationship to the external world could be understood as a reactive defense against a regression to autism. Further, they lacked the typical schizophrenic splitting of the personality, which was replaced instead by intense states of depersonalization, which all of my impulsive patients also

[154]I am very pleased to take this opportunity to sincerely thank Herr Hofr. Prof. Wagner-Jauregg for giving me the opportunity to study the rich clinical material at the Clinic. [Hofr. is an abbreviation for Hofrat, or court councillor (of the Habsburg court). This was an honorary title bestowed by the Emporer on high-ranking professionals, professors, and civil servants.

Reich is referring here to the Steinhof, Vienna's public neuro-psychiatric hospital and outpatient clinic. See footnote 17.]

exhibited. Depersonalization, however, cannot be considered to be a valid diagnostic criterion of schizophrenia because, as Nunberg[155] rightly points out, every psychic illness begins with a state of depersonalization as a consequence of detachment of the libido. On the other hand it is certainly true that feelings of alienation, whether from the external world or from one's own body, are rarely so striking or blatant in pure transference neurosis as in the impulsive character or in schizophrenia . One of my cases, whom I will discuss extensively below, suffered for several weeks from what appeared to be severe stuporous states lasting from the Saturday to the Monday sessions. She sat huddled on the sofa in her room with the door locked, eating nothing and speaking to no one. These states always occurred when the patient had experienced a shock in the analysis and when the transference seemed to falter.

Grandiose ideas and ideas of persecution are otherwise usually absent; ideas of reference[156], on the other hand, are not infrequent and appear {26} to be the consequence of the idea of being rejected, and are thus frequently seen in simple transference neuroses as well. To be sure, they can easily progress to persecutory delusions in the impulsive character. Reality testing and the assessment of ego boundaries, however, are in general unaffected, although they occasionally can be clouded by strong affect.

Periods of frank auditory and visual hallucinations during analysis have occurred in only three of my cases. One patient had hallucinations during a hysterical episode, another after a sudden breakthrough of anxiety, and a third during a phase of acute paranoia.

Although auditory hallucinations are commonly seen in hysterical psychosis, I must point out that the first case referred to, whose analysis had to be abandoned because of persistent twilight states, strongly suggested a diagnosis of schizophrenia; even the consultants on the

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[155]Nunberg, H. ' Über Depersonalisationszustände im Lichte der Libidotheorie' ['On States of Depersonalization in Light of the Libido Theory'], *IZP*, Vol. **X**, 1924, pp. 17-33.

[156]Kretschmer, E., *Der sensitive Beziehungswahn: Ein Beitrag zur Paranoiafrage und zur psychiatrischen Charakterlehre*, [*The Sensitive Delusion of Reference: A Contribution to the Problem of Paranoia and to Psychiatric Characterology*], Springer, 1918.

case (Doz.[157]Dr. Schilder and Dr. Jekels) could not exclude the diagnosis despite the presence in other respects of a typical clinical picture of hysteria. According to the most recent psychiatric work on 'schizoid disorders, especially that of Kretschmer[158] and Bleuler[159], we may assume that schizoid hysteria can activate latent schizophrenic mechanisms when the split hysterical personality lapses into a twilight state[160]. Those of us who believe that schizophrenia is not qualitatively (i.e., constitutionally) different from hysteria or compulsion neurosis will always frankly allow for the possibility that hysteria or compulsion neurosis can transform into it under particular {27} circumstances which are now totally obscure.

Because of a defective mechanism of repression, impulsive characters almost always manifest *undisguised* perversions, particularly of the sadomasochistic type. Based on Freud's researches on the superego (ego ideal), we will learn to see this special affinity of the impulsive character for the destructive drive as an expression of disturbed superego development.

We will defer the discussion of the specific developmental disturbances of the impulsive character for a brief discussion of such disturbances in the typical character neurotic, as would be found in any symptom neurosis, in order to let the important differences stand out more clearly. Our aim is to compare the dynamics of the *impulse-inhibited* character neurotic with those of the *impulsive* character. {28}

III . Ambivalence and superego formation in the impulse-inhibited character

Freud has taught us that everything that we call culture and civilization is based primarily on the suppression of drives [Triebunterdrückung] and secondarily on their sublimation. Every individual must recapitulate the cultural progression from primitive man to the average man of

[157][Doz. is an abbreviation for Dozenten, the plural for Dozent. The latter is an academic title in the Austrian university system roughly comparable to an assistant professorship in the U.S.. Drs. Schilder and Jekels held this rank at the University of Vienna; Dr. Wagner-Jauregg was a full professor.]

[158]Kretschmer, E., *Körperbau und Charakter: Untersuchungen zum Konstitutionsproblem und zur Lehre von den Temperamenten* [*Physique and Character: Studies on the Problem of Constitution and the Theory of Temperaments*], Springer, 1921.

[159]Bleuler, E., ' Die Probleme der Schizoidie und der Syntonie' ['The Problems of Schizoidy and Syntony'], *Zeitschrift für die gesammelte Psychiatrie und Neurologie*, Vol. **78**, 1923, pp. 373-399.

[160]Reich, W., 'Eine hysterische Psychose in statu nascendi' ['A Hysterical Psychosis in statu nascendi'], *IZP*, Vol. **XI**, 1925c, pp. 211-222; Reich, W. (1975), pp. 222-236.

today in an abbreviated but basically complete way. A pure drive-ego is born into a world of severe restrictions and restraints to which it must adapt by abandoning most of its claims for immediate gratification in exchange for partial gratification at a much later time. This adaptation takes place gradually in more or less sharply circumscribed phases, but not automatically as growth in the embryo does. The 'psychic embryo' needs clear reference points in its immediate environment, usually represented by the first care-givers, who are the objects of the first instinctual demands. They are not only the first, to a certain degree, drive-gratifying objects, especially in infancy, but also play the decisive role of frustrating the drives, which represents the earliest and most significant restrictions. {29}

It is in the nature of the impulses that there is no ultimate extinction of the drives, but only an evolution and shifting of their aims and pathways; that is, no drive satisfaction 'disappears' without a substitute. The fact that there are stages of sexual development is based on this substitution. The anal phase is most conspicuous in children when the oral phase has already yielded to frustration. Any frustration causes a splitting-off of part of the libido that is currently dominant. At present we are aware of the following consequences of this splitting-off: first, there is the preservation of the partial drive[161] in a more or less unchanged form, which has an important role to play in later life as sexual fore-pleasure. Second, depending on the nature of the drive there are more or less energetic reaction formations, e.g., disgust as a reaction against anal erotic tendencies. Third, there are sublimations, e.g., cleanliness as a primitive sublimation of anal erotic drives. As psychoanalysis can prove, later sublimations of a much more complicated nature provide a central dynamic energy in every field of human activity. Fourth, every erotic drive serves to establish relationships with care-givers. Clear signs of object love are already noticeable in the oral phase; they evolve into the very intense object relations of the genital phase, which we assume peaks around age four. The portions of libido which are split off during development are not isolated from each other but are quite interdependent. Thus, object love has the important role of creating reaction formations and

[161] [This is the translation of 'Partialtrieb' which I use throughout the book. In the *RSE*, Strachey translates this term as 'component instinct'.]

making instinctual renunciations bearable. The very young child is so much a creature of pleasure (a *pleasure ego* according {30} to Freud[162]) that at first it can and will only exchange pleasure for pleasure. It accepts cleanliness at first 'for mothers sake'. Disturbances of earliest object love immediately make themselves felt as defiance, which has become particularly familiar to us in the form of anal spite. If the child renounces a certain type of pleasure for the mother's love, it has taken ownership of one of the mother's demands and we have before us a case of the most primitive *identification*. But it is an identification that still retains a great deal of object love, without which it would not be sustainable. These early identifications serve to prepare the way for the later, definitive, identifications necessary for life in society. But before those take place, a phase of the most intense object relations occurs, the manifestations of which Freud has grouped under the rubric of the Oedipus complex. The boy begins more or less openly to replace the father in his relationship with the mother and wants to remove him as an annoying rival; the girl has the same attitudes towards the mother. An identification with the homosexual object accompanies the object love toward the heterosexual object. But in a fair number of cases this simple Oedipal relationship is complicated by conspicuous contrary strivings; in many more cases this may only be suggested. Thus, the boy also loves the father and identifies with the mother, the girl loves the mother and identifies with the father. Because of the universal predisposition to constitutional bisexuality, Freud (loc.cit.)[163] believes that one would do well to assume that a 'double Oedipus complex' exists in every case. The conflicts of this phase, among the most significant experiences of man's existence and central to every neurosis without exception, mobilize powerful guilt feelings whose origins, according to Freud, are still completely unknown. Guilt develops especially easily into the attitudes of hate {31} which are a part of the Oedipus conflict. This is certainly not to say that the hate originates here; it seems rather to have been long prepared, and we regard the little child's first impulses to dominate and destroy as primitive manifestations of hate. We can establish that no frustration is accepted without arousing feelings of hate even if in favorable cases they are hidden by an effective substitute pleasure or by object love. They are always ready to break through whenever frustrations are too severe.

[162][Freud, S. (1911a).]
[163][Freud, S. (1923), p. 29.]

Freud contrasted the libidinal tendencies with destructive ones which, originally directed towards objects, succumb to suppression by way of reaction formation and sublimation, thus leading to the development of social conscience and moral judgment; they also experience a special fate, as was revealed in the study of melancholia: *a turning against the self* in the form of masochism in all of its manifestations. (We acknowledge in passing Freud's[164] assumption that there is also an original erogenous masochism which comes to light as sadism when directed against the external world, and which then, as just mentioned, can become a secondary masochism.) The situation seems to be that the primitive drive ego is held in check by an agency that Freud calls the ego ideal or superego. Its source is the abandoned object cathexes and comprises all of the demands which the parents or other care-givers have placed on the drive ego. The parents are ultimately given up as objects, and retained as the superego by means of identification. At the same time {32} the object relationships are desexualized. The instinctual force used by this new authoritative agency to hold the drive ego in check, in other words, to do the work of repression, is sadism in its sublimated form of moral 'masochism', that is, masochism disconnected from its erotic component (the masochistic perversion).

The realization of the demands of the superego

Superego formation begins with frustration and is consummated in the frustration of the Oedipal wish. Since frustrations are met with at every step of libidinal development, one can say that superego formation begins shortly after birth. Even the infant's adaptation to fixed mealtimes is a frustration of its constant need to suck. One could go further and say that the first frustration begins with birth itself and the interruption of an undisturbed and therefore pleasurable intrauterine existence[165].

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[164]Freud, S., 'Das ökonomische Problem des Masochismus' ['The Economic Problem of Masochism], *RSE*, Vol. **XIX**, 2024, pp. 149-161.

[165]See especially Rank, O. (1929) and Garley's beautiful essay: ' Über den Schock des Geborenwerdens und seine möglichen Nachwirkungen' ['The Shock of Birth and its Possible Aftereffects'], *IZP*, Vol. **X**, 1924, pp. 134-163.

The demands of these early superego precursors are completely realized. If the demand 'you must defecate at certain times and places' were not satisfied, there would be no progression of libidinal development, because every drive tends to persist unchanged. But realizing these demands would also be impossible if, as mentioned, other pleasures did not present themselves. Later it is different. The more completely developed and integrated the child's personality is, the more it rebels against restrictions, especially during the narcissistic stage that precedes full object love. Like {33} all children, even those who remain healthy go through an intense phase of rejection of authority. In fact, undue submissiveness can be a sign of neurotic weakness later on of the well known neurotic inability to assert oneself in the struggle for existence. Consequently, the realization of educational demands is now only partially successful. The pleasure ego asserts itself more or less successfully against the superego and its demands. This secures a piece of individual development. In particular, infantile masturbation is now in its domain. Clearly, the tension between unrealized superego demands and the drive ego engenders guilt feelings, while obedience to ego ideal demands reduces guilt. *For the most part, therefore, the real ego originates in the realized demands of the super ego*. The process of attempting to realize the demands of the ego ideal never ends; throughout life there is a constant oscillation between real ego and ideal ego. The ego ideal is always changing: its demands become broader and more comprehensive as soon as some of them are met and as soon as one becomes what one wants to be. Here we are presented with a typical conflict between *what one is* (real ego) and what *one wants to be* (superego). Inferiority feelings and their compensations, in Adler's[166] sense, are one expression of this conflict.

The real ego of children differs in one essential respect from that of adults. While the real ego of children is composed of realized superego demands, that of adults also includes sexual elements—all of those realistic sexual strivings which do not cause conflict with the superego. Most conflicts from which neuroses arise set in during the phase of *the development of a sex-* {34} *affirming real ego from a sex denying real ego*, which normally begins a few years after

[166][See. Adler, A., *Über den nervösen Charakter* [*The Neurotic Character*] (1912), 2nd ed., Bergmann, 1919. An early adherent of Freud's, Adler broke with psychoanalysis with the publication of this book, in which he introduced the concept of the 'inferiority complex' as the main motivator of neurotic character development; feelings of inferiority experienced during development are the motivation for compensatory measures that can lead to the neurotic character.]

puberty. The sex-negative real ego of children is based completely on the moral standards of the care-givers. It is feasible and, from a psychoanalytic point of view, it would be laudable if the real ego of children were also to contain sex-affirmative elements. There is much to be said in favor of permitting the child some genital satisfaction. Since it is physiologically normal to masturbate in childhood, it makes no sense from a prophylactic point of view to keep those elements out of the real ego of the child. It creates conflicts over masturbation which invariably have consequences in puberty which are often pathological.

The realization of the demands of the superego is normally a slow process. The superego of the healthy boy identifies completely with the father, that of the healthy girl with the mother. It is heuristically useful to distinguish between *drive-affirming* and *drive-negating* superego demands, or, corresponding to the two moral principles of *thou shalt*[167] and *thou shalt not*, between *positive* and *negative* superego demands. Drive-negative demands are realized from the very beginning, while the drive-affirming demands are only realized much later. Mental health requires that drive-affirming tendencies be incorporated into the superego. A superego which only prohibits creates a situation such as is found in the ambivalent, inhibited, ascetic-religious compulsion neurotic. A drive- {35} affirming ego ideal will create a real ego which must come into conflict with reality very quickly. This type of ego ideal is represented by the impulsive character.

The influence of the partial drives on superego formation

How does the realization of the superego demands take place in the healthy boy? Heterosexual strivings for the mother and identification with the father predominate in the double Oedipus complex. At first, the father identification also includes genital impulses, but they quickly

[167]The question was once raised in private discussion whether such positive ego ideal demands exist from the very beginning. We accept the possibility that all later thou shalt ideals could develop in complicated ways from prohibitions.

yield to suppression and then repression. The corresponding superego demand would be: 'Thou shalt not desire your mother sexually, and accordingly, genitally'. The realization of this superego demand establishes the incest prohibition. The positive superego demands are realized to a great degree in the boy's striving to emulate his father, and in play which is organized around the idea of being a grown up, but with *genital exclusion* (Abraham[168]). If genital exclusion is unsuccessful, the repressed genitality pushes for expression, resulting in symptom formation. With successful genital exclusion, the sublimated ego ideal demand resulting from identification with the father becomes: 'I want to be as big, as strong, as smart as my father'. If it is not inhibited by castration anxiety, pride in possessing a penis leads to contempt for the woman or the little girl, as the case may be. This, however, prevents the development of an ominous mother identification.

As psychoanalysis has repeatedly shown, puberty reawakens the incest wish, although it is normally not conscious. If the father {36} identification is strong enough and castration anxiety is not overpowering, there is a phase of genital masturbation accompanied by heterosexual fantasies of an incestuous nature, after which valuable sublimations are established. If the young man is to remain healthy, however, the ego ideal demand, 'thou shalt not desire your mother', which was realized in childhood, must be fundamentally modified in this way: 'thou shalt not desire your mother, but all other women are permitted'. Thus, there is an *overturning of the sex-negative superego, with maternal exclusion.* It can be shown that the guilt-free breakthrough of heterosexual genital tendencies is a precondition of later health. The father identification must be strong, indeed, it must include a capacity to overcome the father's prohibition against sex, even when the sex-denying father identification had been effective hitherto. The overcoming of the father's prohibition is only successful if the phallic stage was fully achieved in childhood. The full development of genital activity soon leads to sexual intercourse, and when a real young woman is won, the sexual devaluation of the mother ensues. This is a precondition of successful object choice. The dissolution of an incestuous fixation in analysis likewise falls under the rubric of the sexual devaluation of the mother. One of my patients condemned his now conscious incest wishes with the following words: 'How stupid man is to want to possess his old, ugly mother so much when there are so many

[168] Abraham, K. (1924) [Abraham, K. (1927), pp. 494 ff.]

young women around'. We assume that in the normal course of events, finding a genital object involves changes to the incestuous attachment similar to that just described.

But successfully overcoming the father's prohibition against sex also leads to a comprehensive *liberation from the original* {37} *paternal ideal*. Neurotically fixated men often reveal a typical rigidity of the superego which takes the form of wishing to imitate the father without regard for their own talents and abilities. Later on we will discuss the different forms of the typical neurotic fixations of the superego based on identification with the father ('I *must* be like my father'). Healthy men can show significant deviations from the paternal ideal and occasionally arrive at the formula '*thou shalt not be like the father*'. They are able to follow qualitatively different father images, significantly refining their personalities in the process. No cultural advance would be conceivable without the possibility of an identification with qualitatively different father images, that is, without the establishment of new ego ideals after the dissolution of old ones. This *sublimating transformation of the paternal ideal* has similarities to a neurotic transformation known as *reactive* superego formation, which will be discussed further on. It is not unimportant whether a social revolutionary 'revolutionizes' merely in reaction to the father or in conformity with a revolutionary father image and without regard to paternal attitudes. The absence of an inhibiting object libidinal tie to the father is the condition of such a favorable superego development.

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In men, genital identification with the father is necessary for psychic health, while overcoming the paternal ideal releases creative powers. Likewise in women, *vaginal* identification with the *childbearing* mother is the precondition of subjective well-being and the ability to function in reality. {38} Psychoanalysis has shown that the girl has more work to do in overcoming the mother ideal than the boy has in overcoming the father ideal. From the start, the wish for a

penis strongly pushes her in the direction of an identification with the father. Everything depends on whether the maternal identification predominates at the beginning of the Oedipal phase. This is most likely to occur if the wish for a child has replaced the wish for a penis. Psychoanalysis can show that at first penis envy and the wish for a penis gain a foothold, which is then in favorable cases replaced by the wish for a child. Karen Horney[169] has highlighted another typical course which I can confirm from my own experience with neuroses in women. In this second group, an intense wish for a child first develops normally by way of an identification with the mother; the wish for a penis develops in consequence of the frustration of this wish. The child is a replacement for the penis in the first group, while in the second group the situation is reversed: the fantasy penis is a replacement for the denied child. The first scenario seems, however, to be much more common. It is more favorable for psychic health, that is, for the eventual establishment of the maternal position, if the maternal identification takes hold *first*, so that the willingness to have children will have developed long in advance. Then, by repressing her genital wishes, the little girl realizes the maternal ideal: 'Thou shalt not desire your father'. In most cases, the little girl's genitality has a demonstrably clitoral quality which is equivalent to the phallic eroticism of the little boy. But while the boy's phallic eroticism is completely in harmony with his eventual sexual role, active clitoral sexuality conflicts with the receptivity of the {39} vaginal position of the mature woman. As H. Deutsch has recently detailed in a lecture, the transition from clitoral to vaginal eroticism takes place during puberty, normally after the former goes through a period of intensification (a 'surge of activity'). The consolidation of the maternal ideal is accompanied by the final renunciation of the penis. It is still a riddle from where the vagina obtains its erotic qualities. The theory of the 'displacement of clitoral eroticism' leaves the question open as to how it is possible that clitoral eroticism, experienced entirely as phallic-aggressive in nature, undergoes a transformation into vaginal-passive eroticism. H. Deutsch believes that here we have a typical example of a transformation of the drives, such that a passive aim replaces an active one. However: certain vaginal erotic qualities which we have had the opportunity to study during the analysis of vaginally anesthetic women permit the assumption that the vagina is only, as it were, ready to succeed to clitoral eroticism if it is closely connected with erogenous qualities of another nature.

[169]Horney, K ., ' Zur genese des weiblichen Kastrationskomplexes' ['On the Genesis of the Female Castration Complex'], *IZP*, Vol. **IX**, 1923, pp. 12-26.

First and foremost, anal drive energies seem to contribute to vaginal eroticism. The vagina and anus have an unconscious equivalence: 'the vagina is leased from the anus' (Lou Andreas-Salomé[170]); see also Jekels[171] and Ferenczi[172]). In her lecture to the Psychoanalytic Congress in Salzburg[173], H. Deutsch rightly derived the 'sucking' actions of the vagina during the sexual act from oral drive energies. But if vaginal eroticism is not preformed as such from the beginning, as is the case, e.g., with phallic eroticism, but is composed only later on from anal and oral qualities, then, after phallic frustration, a *partial regression to earlier libidinal stages is a normal* {40} *part of female development*[174].

The transformation after puberty of a purely drive-negative ego ideal into one that is also drive-affirmative normally occurs in women in the same way that it does in men. That this doesn't often actually happen, however, is due to the 'sexual double standard'. Although the actual numbers are not known, the consequence of this is that the overwhelming majority of women are frigid. If the ability to have vaginal orgasms is the criterion, it is estimated that 80% to 90% of women are frigid.

The universal view of the 'feminine ideal' is maternal in nature almost without exception and is composed of *anal* and *oral* qualities. The bourgeois ideal of the quiet, orderly, thrifty, and compliant housewife also includes the demands that the woman should nurse her child, cook, and take care of her family; one may argue about the meaning of such ideals and claim that this ideology was created by men in order to make things easier for themselves. We can confirm that what a man is looking for in such a woman is a caregiver, ultimately, a nursing

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[170][Andreas Salomé, L., '"Anal" und "Sexual"', *Imago*, Vol. **IV**, 1916, pp. 249-273, esp., p. 259.]

[171]Jekels, L., ' Einige Bemerkungen zur Trieblehre' [Remarks on the Theory of Drives], *IZP*, Vol. **I** , 1913, pp. 439-443.

[172]Ferenczi, S., *Versuch ein Genitaltheorie*, IPV, 1924. [*Thalassa: A Theory of Genitality*, (trans. Bunker, H.A.), Psychoanalytic Quarterly, 1938, pp. 27 ff.]

[173][The 8th International Psychoanalytic Congress took place in Salzburg in 1924.]

[174]Frau Dr. H. Deutsch has told me that starting from different premisses she reached the same conclusion, which she will present in her forthcoming book, *Psychoanalyse der weiblichen Sexualfunktionen* [*Psychoanalysis of the Sexual Functions of Women*], IPV, 1925.

mother. This situation has changed in recent years, especially since the war. Paternal elements have established themselves in the maternal ideal: the woman should have an occupation; she should share the family responsibilities; she should be just as active as the man in every sphere of human activity. {41}

These recent changes in the maternal ideal, which are also desired by men, can reduce the conflicts surrounding the final renunciation of the penis. According to the pure maternal ideal, the wish for a penis can only transform into a wish for a child. Today, however, there are opportunities for the *sublimation* of this wish. Presently this takes place on the model of the father. But maybe as soon as the next generation, women's social and scientific activities will no longer be viewed as the realization of paternal ideals but as the realization of maternal ideals as such. For the neurotic woman of today, the realization of the paternal ideal is reactive and not a sublimation. Most women in 'masculine' occupations have not renounced the penis and are incapable of realizing the maternal ideal (childbirth, vaginal disposition). The analysis of women who are reactively striving to realize the clitorally-invested paternal ego ideal has one of two outcomes: either they renounce the penis and accept the child (and the husband) in its place, or the wish for a penis is partially sublimated. The patient who before had studied frantically, that is, reactively, who had rejected every maternal attitude and stressed every masculine quality, comes to the realization that academic studies or other 'masculine' occupations are completely consistent with femininity. She accepts her biological role as a child bearer and no longer clings to the characteristic paradox of the entire women's movement—that one can study only as a man, and one can enjoy 'sexual freedom' only as a man. The only meaning that a woman's movement could have would be to bring the woman to her full development *as a woman*. {42} Grete Meisel-Heß[175] has correctly grasped this fundamental error of the woman's movement. But the movement threatens to founder because it (unconsciously) wants the impossible, namely to provide the woman with the missing penis. Social necessity has managed to achieve in the proletarian masses what analysis has in individual cases: *the reconciling of a maternal attitude with social activity*. Among the bourgeois, however, partial success in this regard can only be seen in the field of education. The ideology that social and scientific occupations are masculine pursuits, and thus that one

[175]Meisel Heß, G., *Das Wesen der Geschlechtlichkeit* [*The Nature of Gender*], Diederichs, 1917.

absolutely requires a penis to participate in them, has only been abandoned here and there.

To summarize this part of our discussion:

1) The realization of the maternal ideal in women and the paternal ideal in men are the conditions for an adaptation to reality.

2) Both are absolutely dependent on erogenous readiness:

a) The *realization of the paternal ideal* requires the successful activation of the phallic phase and that the castration complex be overcome. This enables a possible breaking away from the paternal ideal if changed life conditions demand it. Pregenital drive energies are sublimated into cultural and social strivings, while the phallic drives continue to exist as such.

b) The *realization of the maternal ideal* has as a precondition the renunciation of the penis and its replacement with the child (and husband). Clitoral qualities are poorly suited to the development of the maternal ideal. {43} The latter is based instead on partially reactivated anal and oral drive energies which help to constitute the female character. In part, clitoral sexuality helps to establish vaginal eroticism, in part it is transformed into social activity and an active character.

3) In both sexes, the *drive-affirming ego ideal demands* are normally based on the *genital stage* of libido development. The complexity of the genital structure of the healthy woman consists merely in the fact that the erogeneity of three organs (clitoris, anus, mouth) must combine in order to create the reality-oriented libido position. The only *negative superego formation at the genital stage* is the incest prohibition. This negative superego

demand rarely comes into consideration in genitally satisfied people, because, as well as being suppressed, the incest wish itself is diminished. The remaining negative ego ideals are based on pregenital libido insofar as it presses for its original satisfactions. Insofar as pregenital libido is sublimated, the negative ego ideals blend with the positive ego ideals of the genital stage to create a harmonious, purposeful, fully reality-oriented personality. In summary, these antitheses: health—illness, reality principle— pleasure principle are paralleled by these: genital—pregenital, positive superego—negative superego, sublimation—reaction formation.

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We will now move on to a discussion of

Pathological superego formation on the basis of sexual misidentification

Once again we turn our attention to the erogenous basis of ego development, but are focusing this time on pathological outcomes. {44}

A daughter's identification with her father (the 'masculinity complex') and a son's identification with his mother ('a passive-feminine attitude toward the father') have both long been recognized and studied by psychoanalysis. 'Whether the Oedipal situation results in an identification with the father or the mother appears...in either sex to depend on the relative strengths of the sexual predispositions (Freud, *The Ego and the Id*[176]). But the 'sexual predispositions' make use of definite erogenous positions, e.g., anal libido as the basis of the man's passive-feminine attitude. This doesn't exhaust the facts of the case, however. For example, we know of identifications with the mother in which a masculine bearing is not given up. The typical representative of this situation is the narcissistic, masculine-appearing homosexual, who, as Sadger has shown, is seeking in men for the mother with a penis[177]. At the same time, with his predilection for the young men whom he chooses as love objects he

[176][Freud, S. (1923), p. 28.]

[177][The mother with a penis, or 'phallic mother', is a ubiquitous infantile fantasy of the early genital phase of psychosexual development in both genders. Its function is to allay castration anxiety by, in effect, denying the possibility of there existing people without penises. See, e.g., Freud, S., 'On the Sexual Theories of Children' (1908b), *RSE*, Vol. **IX**, 2024, pp. 183-196, esp. pp. 188-190.]

unconsciously plays the role of the mother who is a caregiver and adviser. Everything else being equal, it is likely that there are identifications with the parent of the opposite sex in every case.

In the end it all depends on how much this pathological identification expresses itself in a person's total bearing: how much a woman *actually* has the stamp of the masculine and how much the man has the stamp of femininity. In other words, it depends on *whether the pathological identifications take place in the ego ideal or in the ego*, and are thus realized. Before moving on to a detailed discussion of this, we wish to establish that in general there are two factors which give rise to sexual misidentifications: *1)* the identification can be based on *erogenous dispositions*[178]. Thus {45} a strong anal disposition in a boy will tend to keep him in the anal stage and encourage an intense identification with the mother. A strong clitoral position in a girl has an analogous outcome in relation to the father. *2) an experiential element*, which should not be underestimated, may be added to the erogenous disposition: analysis shows that *superego formation is based mainly on the parent towards whom there was the greatest ambivalence*, in other words, on the parent who was the source of the most important frustrations. Due to the rigidity [Starre] of the libido, object-libidinal ties do not lead to identifications as long as they are strong and effective. The libido withdraws to the ego, bringing the object with it, only with the onset of frustrations and the ambivalence that follows. The little girl normally has a more or less unequivocally positive attitude toward the father and is ambivalent toward the mother, while the situation is reversed for the little boy. If there are no other complicating factors, the little girl identifies with the mother and the boy with the father. The identifications are rooted in ambivalence.

The mere existence of the father is all that is needed for the boy to experience the frustration of his incest wishes, and likewise, the existence of the mother for the girl. The analysis of

[178]It is important to note that erogenous dispositions can be strengthened by the caregiver's behavior. Excessively long nursing intensifies the oral position, while an anal milieu strengthens the anal position.

neurotics with strong pathological identifications highlights the fact that in addition to the, so to speak, normal frustrations from the parent of the same sex, frustrations were also typically experienced to a significant degree from the parent of the opposite sex. This leads {46} to the development of acute ambivalence toward the parent of the opposite sex, which leads in turn to a subsequent withdrawal of object libido and the introjection of the object, and finally to a pathological identification. Whether the frustration of masturbation, play, incestuous wishes, etc., comes from the mother or father is absolutely decisive for the development of the ego. More precisely, the character of the frustrating parent, or respectively, the differences between the characters of the two parents, must be specifically expressed in the child's ego development.

If the two factors contributing to pathological identification coincide, then the 'masculinity complex' of the woman and the 'femininity complex' of the man will result[179]. But just as the fact that everyone has an 'Oedipus complex' is a commonplace, so is the existence of the 'masculinity complex' in women and the 'femininity complex' in men. Today the question is not so much if they exist, but how they exist, that is, how the respective conflicts have been dealt with. The advantage of putting the question in this way is that it not only protects us from one-sided explanations, but it also opens up an extremely fertile area to psychoanalysis—the issue of the choice of neurosis. Even if we are presently still very much in the dark as regards the question of specific etiology, here and there we can see distinctive neurotic types exhibiting distinctive developmental disturbances. An attempt to construct a *genetic-psychoanalytic* theory of neurotic types today, however, would certainly obstruct all research in this direction. Psychoanalytic {47} theory building belongs at the end of research, not at the beginning. For example, psychoanalysis lacks a fundamental theory of schizophrenia. The present effort must therefore be limited to the identification of typical mechanisms of character formation; we will have to leave the task of filling in the gaps in the theory to further research.

In the man, identification with the mother exhibits two typical clinical pictures, corresponding to two different erogenous fixations: *maternal identification at the ambivalent genital stage*

[179][I.e., if erogenous disposition and frustration from the opposite-sex parent coincide.]

(Abraham), and *maternal identification at the anal stage*. The typical representative of the former is the narcissistic, more or less conscious, homosexual that has already been well described by Sadger[180]and Abraham[181]. This superficially confident 'compensated narcissist'[182] exhibits the following typical libido development: he has never overcome the Oedipus complex and remains fixated at the ambivalent genital stage[183] without, however, having significant regressions to earlier libidinal stages. The idea of the phallic mother is of central importance. Two patients whom I treated had blatant dreams of women, clearly mother figures, who had hoses or even male genitalia in place of female genitalia. Typically, this idea of the phallic mother functions in two ways: first, the idea of the woman without a penis is completely unthinkable due to castration anxiety, so the unconscious clings to the idea of the phallic woman (Freud); second, the female penis regularly signifies the breast. These men have never {48} overcome an oral fixation; passive and active fellatio therefore play a large role in their sexual lives. They were initially able to forge a path to genitality by way of a normal father identification, but retreated from it due to castration anxiety, and began to identify with the mother. These men always tend to the active form of homosexuality. They choose effeminate young men, that is, the phallic woman again, when they become sexually active, but they also assume a maternal role of protector and guide, and introduce them to sexual life. They are either partially or completely impotent with women. Due to the mother identification, fellatio is typically accompanied by passive and active breast fantasies. Two of my patients of this type grew up without fathers; the father of one died young, the other had a single mother. The absence of a father did not seem to prevent the activation of the genital phase, rather it actually seemed to make it especially intense while also facilitating the maternal identification. The latter is all the likelier when the castration anxiety is directed at

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[180]Sadger, I., *Die Lehre von den Geschlechtsverirrungen (Psychopathia sexualis) auf psychoanalytischer Grundlage* [*The Theory of Sexual Aberrations (Psychopathia Sexualis) on a Psychoanalytic Basis*], Deuticke, 1921 [pp. 137 ff.]

[181]Abraham, K., 'Über ein besondere Form des neurotischen Widerstandes gegen die psychoanalytische Kur' ['On a Particular Form of Resistance to Psychoanalytic Treatment'], *IZP*, Vol. **VIII**, 1922, pp. 173-180. [in Abraham, K. (1927), pp. 303-311.]

[182]Reich, W. (1922), op. cit.

[183]Abraham, K. (1924) [in Abraham, K. (1927), p. 493 ff.]

the mother, especially if she is the main caregiver . It is entirely consistent with all that has been said so far that these active and narcissistic homosexuals also seek themselves in the object, as Freud and Sadger found. Any object love is borne by narcissistic impulses. The mother identification is expressed precisely in this search for the self in the object ('narcissistic object choice', Freud).

The situation is very different with a *maternal identification on an anal basis*. These patients have not attained the genital stage and are always impotent, mostly in the form of premature ejaculation with or without erectile impostence . They {49} have soft, feminine characters which submit meekly to strong father imagos . They have a *neurotically resigned* bearing due to the presence of a strong paternal superego which remains largely unrealized. The wish to be sexually and socially competent in a masculine way is mostly lived out in daydreams. What is actually realized is the maternal character, which stands in stark contrast to the unrealized paternal ideal. These people display the inferiority feelings and their typical compensation by means of the 'guiding fictions' ['fiktive Leitlinien'[184]] which Adler has described. Unable to realize their paternal ideals, they play the role of the martyr, behind which they hide the narcissistic belief that they alone are noble and good; in the final analysis, they believe they are worthier than the rest of the world, whose brutality and materialism (i.e., ability to deal with reality) they have to tolerate. They toy with 'brutality' in the hope that they can become as tough, materialistic, and ultimately as potent, as their fathers.

> One day a patient of this type told me that he didn't believe that analysis could free him of his impotence, which would only happen with his father's death. Interestingly, he condemned his 60 year old father for 'tormenting his mother', also 60, 'with bestial intercourse'. The patient not only suffered from premature ejaculation on a urethral erotic basis, but he also exhibited an unusual anal fixation. He had suffered from severe constipation from early childhood. He might not be able to defecate for 10 or 12 days at a time, especially if he were traveling. He was only able to have a bowel movement under certain conditions. He either had to squat over a pot filled with hot water, or he had to have an enema administered *by his mother*. He had a *central anal fixation on his mother*. Even as a very little boy, he received enemas from his anally-preoccupied mother. The entire family suffered from severe constipation. The patient's constipation remitted during the analysis. When he first tried to have intercourse a peculiar thing happened: *he turned his back* {50} *on the woman* and fell asleep. Analysis revealed that unconsciously he was expecting an enema. He had transferred his specifically anal relationship with his mother to the situation with the woman. His character was the same as his mother's down to the smallest detail. He was as clean, orderly, pedantic, introverted, restrained, and as fearful and obedient to the father as she was. His three older siblings had left home and married

[184]['Guiding fictions' are subjective, imagined, future goals that are created, often unconsciously, to overcome feelings of inferiority experienced in childhood. See Adler (1919).]

> long before, but he was unable to separate from the mother. He felt it was his obligation to 'cement his parents' miserable marriage'. The wish to receive an enema from the mother was reinforced by a deeper wish: to have anal intercourse with his father. The patient had never overcome the anal stage, and had manifested only the first signs of genitality . His masturbation was anal and urethral in nature. He fantasized licking a woman's breasts and vagina, crawling between her legs, being tied up by her, etc., but never having heterosexual intercourse. There was a brief period of genital masturbation at age four, which was completely repressed after an older brother threatened castration. His mother's anal attitudes and practices then helped to fixate him in the anal position.
> He cultivated sexually inhibited friendships with dominating, completely masculine, men who were totally different from him in character. He admired and felt himself to be inferior to them, in the end withdrawing from them on some trifling pretext. An intense passive-feminine transference developed in the analysis. The analysis of his constipation revealed florid pregnancy fantasies. In one dream he has a bowel movement; the feces disappear and are replaced by 'tiny little children' playing, which were of the same size as his usual movements. In another dream, the analyst or a friend fertilizes him through his mouth (theory of oral impregnation).
>
> The patient's character blended traits which were the exact opposite of his father's with a realization of the maternal ideal with sexual exclusion. The father was nosy and opened everyone's mail; the patient was extremely discreet. The father was tight-fisted; the patient squandered money contemptuously. The father heedlessly imposed himself on other family members, for example, passing wind in their presence. The son suffered severely from the inability to pass wind (which promptly abated permanently once the connection was made in analysis). The father was a womanizer; he was the opposite. Finally, the father was, as the patient stated, 'über-potent'; the patient was impotent. {51}

The *realized* paternal identifications were without exception of a reactive nature. His motto was 'Thou shalt be the exact opposite of your father'. Such *reactive superego formations* are extremely common in neurotics. They help to constitute the personalities of the (inhibited) passive-feminine man as well as the woman with an inhibited masculinity complex, and are expressed particularly clearly when the characters of the two parents are very different. It is especially ominous for the boy if a cold and strict father is alienated from the rest of the family. As the mother and children band together defensively, the boy identifies with the mother he loves and wants to defend from the father. He renounces genitality and regresses to the anal stage. He surrenders in the battle with his father and never achieves full independence (*neurotic resignation*).

In this case, the reaction against a strong father led to a maternal identification. The outcome can be similar if the father is soft, affectionate, and indulgent, while the wife was 'the man of the house'. There is no maternal identification in this circumstance, but an identification with the gentle father. These effeminate men choose a virago to love—a harsh, strict, mother to whom they submit masochistically. What they demand of themselves in relation to their love object colors their total behavior.

Misidentifications in women are best examined in the different forms of frigidity. There are two major forms of this. In one, a maternal character and the wish for children are prominent; in the other type, the woman displays a pronounced masculine character, often has a 'masculine' occupation, {52} and either totally rejects intercourse or, once married, remains cold, hard, and unapproachable during the act. In the first form, there is a prominent but inhibited maternal identification. It is easier to treat than the second form, and is caused by an unconscious attachment to the father which was never given up. Even when there is a persistent wish for a penis, it devolves into a wish for a child, which always signifies the male organ; the wish never becomes strong enough to make the character masculine. This fact strongly suggests the need for a sharper distinction between the concepts of 'penis wish' and 'masculinity wish'. The latter is the broader concept and includes the former, but the reverse is by no means always the case. Despite their frigidity, women of the first type can develop intense love for their husbands or lovers, only failing in this due to the maternal demand, 'Thou shalt not desire thy father'. Their frigidity quickly remits once they are relieved of the paternal attachment and the prohibition which accompanies it.

Women of the second type have been cruelly disappointed in love by the father and, according to the well-known formula, have incorporated him. They became what they could not have. The wish for a penis and compensated castration anxiety are conspicuous: these women postpone the realization of maternal ideals and strive to realize paternal ideals[185] . But the early histories of such {53} women not infrequently reveal a strong maternal identification: devotion to the father as wife (mother), and the wish to receive a child from him. Such cases

[185]Freud describes a particular form of such a conflict in ' Über die Psychogenese eines Falles von weiblicher Homosexualität' ['On the Psychogenesis of a Case of Female Homosexuality'] (1920a), *IZP*, Vol. **VI**, 1920, pp. 1-24: *RSE*, Vol. **XVIII**, 2024, pp. 139-162. The girl turns away from the father and towards a masculine woman as her wife. The particular conditions of this outcome are unknown at present. (Strict mother—gentle father?)

have a favorable prognosis because analysis can reactivate the repressed, reality-oriented, maternal ideal. Analysis can thus convert the second and more difficult to treat type of frigidity into the first type.

But if the wish for a penis and castration anxiety develop before the 'normal' simple Oedipus situation has a chance to unfold (for example, due to precocious play with boys during which the erect penis is seen, or due to the father's rejection of his daughter's expressions of love), the analysis has a much more difficult task. It would be important to find out whether (manifestly) masculine homosexual women had ever displayed a feminine attitude towards their fathers as children. I myself have no relevant clinical material at my disposal, but can refer instead to cases which have the same specific determinants but with a different outcome. Simply put, libido development proceeds as follows: the father is very rejecting and unaffectionate, the mother warm and kind but restrained. The girl develops intense ambivalence *towards the father* from early on which weakens her heterosexual strivings and strengthens a masculine disposition. All of her love, which is mainly *oral* in nature, is directed toward the mother. The attachment to the mother is repeated in later life in the form of intense *infantile* attachments to mother imagos, with or without the presence of masculine strivings. These girls have trouble meeting the demands of reality and always recreate the role of the spoiled child with their later love objects. {54} A longing for the womb is more prominent than in other types, and leads to an often far-reaching inability to deal with reality.

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It would be tempting to discuss other types of pathological character formation, but we will refrain from this with due regard for the gaps in our empirical knowledge. We are aware of the schematic nature of our account up to this point, which is supported, however, by

contemporary analytic theory and practice. But the diversity and complexity of human experience can never be captured by mere concepts. Those with *analytic* experience will confirm our remarks, and can certainly also correct and augment them.

Pathological identifications, persisting Oedipal or other conflicts, and the influences of particular experiences on erotic dispositions can so shape the character of a person that the ability to deal with reality and enjoy life suffers, with or without the formation of neurotic symptoms. We believe we have shown that the realization of certain ego ideal demands is what creates the neurotic character: the individual identifies with the demands of care-givers, which firmly establishes the ego ideals in the personality; the ego, in turn, 'identifies' with the ego ideal, realizing its demands in the process. The difference between the impulse-inhibited neurotic character, which is the basis of every symptom neurosis, and the uninhibited impulsive character, is to be found in a developmental defect of the ego. We will turn to a discussion of this in the next chapter. {55}

IV . Ambivalence and ego formation in the impulsive character

The psychoanalytic exploration of the child's experience between the ages of two and five has been extremely fruitful. However, because we rarely access material from before age two in the analysis of adults, we undeniably lack essential information regarding mental development. Memories from earlier times occasionally surface, but they are so vague and so unrelated to the rest of the material that firm conclusions cannot be drawn from them. Nevertheless, today we can safely assert that the experiences of the first two years of life are the most decisive of a person's life. The child enters the critical phase of the Oedipal era with character attitudes and traits which, if not fully formed, are largely so. The Oedipus complex is like a lens that refracts the drives. The drives give the Oedipus complex a specific character and on the other hand are extensively modified by it. Anna Freud's[186] report of a {56} two year old with hysterical symptoms shows how little we know about this period in a child's life. The methodological difficulties seem to be insurmountable. The reports of direct child observation published to date only concern children who are older than two. And there is a lack of

[186]Freud, A., 'Ein hysterisches Symptom bei einem zweieinvierteljährigen Kinde' ['A Hysterical Symptom in a Child of Two Years and Three Months Old'], *Imago*, Vol. **IX**, 1923, pp. 264-265.

analytically educated infant and child care-givers.

The clinical investigation of certain forms of schizophrenia and melancholia, whose fixation points we believe are to be found in the earliest stages of postnatal life, is another, indirect, way of studying very early development. Some schizophrenics exhibit behaviors and mechanisms appropriate to the infant or one year old, or even the fetal state itself. A case reported by Tausk[187], for example, is very illuminating about the loss of boundaries between the ego and the external world; another case, reported by Nunberg[188], is instructive about very early sexual conflicts.

If in certain forms of schizophrenia ego boundaries are partially or completely effaced, and at the same time we can observe in them the presence of certain infantile traits, then it is no longer mere speculation for psychoanalysis to assume that the ego of the child detaches itself only gradually from the chaos, that ego boundaries take a long time to develop, and that abnormalities in ego development have their origins in this early phase of ego formation.

A pure drive or pleasure ego is confronted by stimuli from the environment; it 'identifies' itself with them as long as they are pleasurable and rejects them if they are unpleasurable, even if they {57} originate in the drive ego itself. The original pleasure ego has wider boundaries than the later real ego when it has to do with pleasurable experiences (Freud[189]), and narrower boundaries when it is a matter of unpleasure. Pleasurable objects, such as the breast, which is the central object of this first phase of development, are experienced as being a part of the ego. Thus we can understand the motive for the sending-out of object libido from the narcissistic

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[187]Tausk, V., ' Über die Entstehung des "Beeinflussungsapparates" in der Schizophrenie', *IZP*, Vol. **V**, 1919, pp. 1-33; ['On the Origin of the Delusion of the "Influencing Machine" in Schizophrenia', *Psychoanalytic Quarterly*, Vol. **2**, 1933, pp. 519-556.]

[188]Nunberg, H., ' Über den katatonischen Anfall' ['On the Catatonic Attack'], *IZP*, Vol. **VI**, 1920, pp. 25-49.

[189]Freud, S. (1911a).

reservoirs: the breast must eventually be acknowledged as belonging to the external world; it must be 'moved out' of the ego, and as this happens it pulls along the portion of libido associated with it. For the first time, narcissistic libido is converted into object libido. The first objects in the environment are not whole persons, but the organs of care-givers, insofar as they give pleasure. In analysis, the object gradually disintegrates into individual organs; for example, the breast, especially, separates itself from the mother. Just as in analysis the tender object libido ultimately leads back to a pure organ libido, the infantile organ libido progressively transforms into its sublimated form of affectionate libido. The libido stretches out from the breast to the provider of food, love, and tranquillity—to the mother.

The influence of upbringing

But there are already frustrations in the first phase of this important process—the breast is withdrawn periodically. Gratification and frustration confront each other at every developmental stage, indeed, frustration is necessary for there to be a progression from stage to stage. {58} We agree with Graber[190] that the *ontogenetic root of ambivalence is to be found in the juxtaposition of drive satisfaction and drive frustration*. The child loves the gratifying person and hates the frustrating person. If hate is older than love, as Stekel and Freud[191] have stated, it is due to the unpleasure of birth. Organ pleasure makes us forget this unpleasure, but, as Rank[192] maintains, it reappears from the very first in the form of birth anxiety or the wish to return to the womb when drive frustrations are too severe.

Ambivalence is thus a necessary part of psychic development. Since every person experiences situations which give rise to ambivalence, we must ask what must occur for the ambivalence to become pathogenic. It seems that it depends on the form and strength of the instinctual gratifications and frustrations, the stage in which they occur, and the attitude of the child

[190] Graber, G., *Die Ambivalenz des Kindes* [The Ambivalence of the Child], IPV, 1924.

[191] [In his *Die Sprache des Traumes* [*The Language of Dreams*], Bergmann, 1911, p. 536, Wilhelm Stekel states that hate is the fundamental attitude of the individual towards the world. In 'Drives and their Vicissitudes' (1915), *RSE* , Vol. **XIV**, pp. 103-123, esp., 120-123, Freud echoes this theme. For Freud, the pleasure ego incorporates drive-gratifying objects as part of itself, while expelling frustrating ones as external and hated. Thus the first object perceived as external to the ego is a hated one.]

[192] [Rank, O. (1929), esp. pp. 11 ff.]

toward the caregiver at the time in question. In principle, there are four possibilities:

1) *Partial gratification and stepwise frustration of drives, leading to gradual repression*. This situation is optimal for the process of development. While experiencing partial satisfaction, the child learns to love the caregiver and accepts frustration 'for their sake'. Indeed, we try to establish this situation in analysis also. Gratification must be partial from the very first; for example, the infant must get used to feeding at certain hours. Frustrations {59} must become more stringent without, however, ever leading to complete inhibition of the drive: a drive to be suppressed must have the opportunity to be transformed or be replaced by another partial drive.

2) *Acute frustration of the drives in every phase of development.* This leads to a total inhibition of the drives, as can be typically seen in abulic[193]patients. These frustrations impair the ability to love, as, for example, in babies who have been bottle fed, or in cases where genital masturbation has been totally frustrated[194]. If the drive disposition is strong, the frustrations reinforce the hate in the ambivalence. This is certainly the case in many impulse-inhibited compulsion neurotics.

3) *A complete lack of drive frustration from the very beginning due to a lack of supervision by care-givers*. The result of this can only be untrammeled impulsivity. Sooner or later these people must come into severe conflict with their environment. While we have analytic evidence to support our formulations for the first two categories, we can only surmise about this third, extreme, category. We are convinced, however, that the analytic investigation of criminals, prostitutes etc, will bring such facts to light.

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[193]['Abulia' is a term for a state of the absence of agency; Hinsie , L., Campbell, R.*, Psychiatric Dictionary*, 3rd ed., Oxford, 1960, p. 5.]

[194]Reich, W. (1924), see Case 6; Reich, W. (1975), pp. 158-179.

Lastly, we arrive at the situation which in my experience is typically found in the impulsive character. There is a partial overlap with the previous category. We find with surprising regularity that {60}

4) *Uninhibited drive gratification is met with a traumatic (and often belated) frustration* . Thus, for example, one of my impulsive patients was sexually molested by her father, but then was beaten unconscious by him when she played in the street with her friends. Another patient grew up without any supervision, and had already been introduced to genital play by the age of three (and probably even earlier), but was beaten horribly by her mother when she was caught at it once by chance. It is extremely common for children to be treated very strictly in regard to certain matters but otherwise to be left completely to their own devices. The father of a patient of mine was very rigid about mealtimes and the children cleaning their plates, but paid no attention to the fact that they played with their feces, masturbated, etc. Just as commonly, the uninhibited behaviors that had been tolerated by parents seem one day to be 'too much' for them, and suddenly, violently, and without warning they 'change their tune'. Further examples are unnecessary. Any observant caregiver could supply many more. Inconsistency of upbringing is the common theme in the development of the impulsive character: an absence of frustrations on one hand, a sharp focus on relatively unimportant matters or the sudden, belated, imposition of frustrations on the other.

Ambivalence takes on characteristic forms in this context. Either chronic attitudes of hate and fear toward the care-givers predominate, accompanied by an uninhibited impulsivity which is periodically intensified by defiance, or just as commonly, there is {61} an intense, unsatisfied, craving for love accompanied by a hate which is just as intense. Other factors determine whether the outcome of development will also exhibit a more masochistic or a more sadistic picture. The inability to love is always glaring and is much more in evidence than in a simple symptom neurosis. In addition, there is a strong craving for love.

The essential difference between the ambivalence of the compulsion neurotic and that of the impulsive is that reaction formations are inadequate in the latter: the sadistic impulses are more or less completely lived out. In the typical compulsion neurotic the ambivalence is

displaced onto neutral issues or trivial details in an apparently meaningless way. Such displacements occasionally occur in the impulsive, too, but the ambivalent relationship to the original objects or suitable replacements is typically very evident. The damage done by the relationship with the caregiver is very obvious in the impulsive; while such damage occasionally comes to the fore in simple neuroses, in most cases it is either totally lacking or is at least no more prominent than in the healthy. The childhood experience of impulsives is conspicuous for an *accumulation of traumata* which is absent in the symptom neurotic. While those who remain healthy are not uncommonly threatened with castration or witness their parents engaging in sexual intercourse, these experiences are especially blatant in impulsives. They are subject to cruel treatment for trifling offenses, sexually seduced by the care-givers themselves, or grow up in a sadistic milieu. Every degree of marital misery is exhibited in their backgrounds, from the bad marriages of the higher social classes to the crude marital excesses of the {62} alcoholic indigent. Freud's assumption that neurosis and pathological character formation is for the most part acquired[195]is validated precisely by this category of neurotic illness. Indeed, it is obvious that an environment characterized by defective drive inhibition will lead on one hand to defective ego ideal formation in the child, and on the other hand to frustrations that are more brutal than would otherwise be necessary. As to the typical acute and sharp ambivalence which results, the impulsive can justifiably say that he has never known anything else. His inconsistent attitude toward the environment reflects the inconsistency of the 'care-givers'. It would be completely erroneous to speak here of the lack of an ego ideal. Rather, both *drive-denying* and *drive-affirming* ego ideals have been established simultaneously. If this were not the case, uninhibited impulsivity *without neurotic manifestations* would result, as occurs in some antisocial types.

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[195]Rousseau writes in his *Confessions*, 'In truth, the foolish whims ascribed to nature are rooted in upbringing', *Rousseaus ausgewählte Werke, Band I: Bekenntnisse* [*Selected Works of Rousseau, Vol. I: Confessions*], Cotta, 1900, p. 51. [See also Freud, S. (1905a), pp. 211-212.]

The *ubiquity* of guilt feelings, especially in the masochistic forms of the impulsive character, is also evidence of the presence of a strong ego ideal. If the impulsivity is to be expressed, however, the ego ideal must be periodically paralyzed.

The external factors which mainly determine pathological superego formation in the impulsive character are reinforced by a dispositional factor. We are referring to the abnormally early sexual readiness, the excessively strong {63} accentuation of all the erogenous zones which can always be found. Full genitality develops abnormally early in these patients. As a rule, infantile sexual activity can be noted in the mildly neurotic and in the healthy, especially during the genital phase which appears to peak between ages three and five. Frequently, however, drive activity at this age is totally inhibited; the full sensual force of sexual wishes and incestuous desires never become conscious but retain all of their force unconsciously. By

contrast, impulsives not only begin to live out their sexuality at a very young age, they also experience their incest wishes in a completely conscious way. Because of this, the partial drive associated with this activity doesn't detach itself from the other partial drives as it does in symptom neurosis; rather, all of the partial drives are active simultaneously, in a state of approximate equivalence. As children, these patients typically exhibit polymorphously perverse sexual play. Such patients have seen and understood much more of the sexual life of grownups than is generally the case in simple neurotics. Latency is brief or entirely absent. If one considers the important role which latency plays in supporting sublimation and the development of reaction formation in the course of ego development, one can begin to appreciate the damage that results. Puberty begins with an intense breakthrough of sexuality. Masturbation or the very early initiation of sexual intercourse does not relieve the ensuing stasis because the whole libidinal organization has been ruptured by disappointment and guilt.

The following case is illuminating in this context. In addition to a polymorphously perverse libido structure, it displays guilt mechanisms which are also seen in other forms of the impulsive {64} character. This case also serves to introduce a later discussion of the 'isolated superego'.

The question of 'borderline cases'

This is a case of compulsion neurosis in which the diagnosis of schizophrenia was a strong consideration.

> A 19 year old woman sought analysis because she was tormented by the thought that *the world was falling apart and coming to an end* whenever she felt she had done something wrong. If she had work to do, she obsessed, 'Why bother? The world is going to end tonight'. She was always amazed the next morning to see that 'the world hasn't ended yet'. There was no manifest anxiety associated with this; instead, the end-of-the-world fantasy was accompanied by hopeless, empty feelings: 'everything is dead, killed; sometimes I'm surprised that the people are still moving'. These states of depersonalization always accompanied the end-of-the-world fantasies, but could also occur several times daily on their own. The fantasy was a real possibility to her rather than the symptom of an illness. At times, she seemed to be very lost, absent-mindedly breaking off a conversation in mid-sentence and gazing off into the distance; at other times, she spoke incoherently. The initial impression was that she was schizophrenic. Her parents report that she spent days at a time at home daydreaming and avoiding work supported this diagnosis.
>
> Before continuing our report, we might mention that, as far we know, her older and prettier sister was completely functional and exhibited no signs of neurotic illness. The father, though irritable, irascible, and overbearing, was a capable and intelligent man. The mother, someone with a somewhat limited mental horizon, was allegedly healthy.
>
> The patient, however, also had attitudes and behaviors revealing an intense relationship to the external world, characterized by a defiance and contrariness directed particularly towards her parents and sister which contrasted vividly with the typical schizoid characteristics described above. The patient felt extremely inferior; she couldn't manage to do any of the things she felt she ought to be doing. She wanted to learn all the trades, to understand mathematics, to grasp the design of a motor. She attributed her inability to achieve these aims to 'men's oppression of women'. When she saw a girl in the street trying to learn to ride a bicycle, {65} she had the obsessional thought that a man would learn to ride much more quickly, and she experienced the girl's difficulties in learning as an oppression. Her feelings of inferiority were closely connected with conscious self-punishing tendencies. To cite just one example: she learned to cook but felt she was no good at it, so she consciously and deliberately made many mistakes and got great pleasure from being scolded by her mother. She herself admitted to deliberately making mistakes in order to get people angry with her so that they would rebuke her. For example, she learned to sew, but then deliberately cut the material into pieces so that it had to be thrown out. She was defiant and refractory in the analysis. 'So why aren't you kicking me out of treatment?', she asked after a few sessions. The end-of-the-world fantasy regularly accompanied the self-punishments. But she also tortured others, especially her mother, whom she deliberately tripped so that she would be 'smashed to smithereens'. She amused herself with cruel fantasies which had both sadistic and masochistic aims. For example, a sword is thrust into her vagina, passing through her body, and out of her head. Or, she is forced to walk with bare feet on a board studded with nails until she bleeds.

> The first fantasy is connected with a case of gonorrhea that she reported having contracted at age three, supposedly from her governess. She also dated her 'craziness' from age three. The sword fantasy is based on the gynecological treatment she underwent for six years, which consisted of painful dilatations of the cervix. The second fantasy is connected with masturbation which she had practiced uninterruptedly since early childhood. When she was four, her father had angrily shouted the familiar castration threats and tied her hands down at night, among other things. The sadistic fantasies can all be derived from the masochistic fantasies. She told her mother, 'Take a board, hammer nails into it, and hit Father over the head with it'. And, 'Throw yourself out the window; if I'm eating when you do this, don't think that I'll try to stop you. I'm going to calmly finish eating and then go to the courtyard to look at your smashed corpse'. She made these statements calmly and without emotion, viewing them as neither sick nor annoying. But then she would throw herself on her mother and kiss her. It took a lot of effort in the analysis to make clear to the patient that the end-of-the-world fantasies connected to the banal incidents she described actually represented guilt feelings relating to her own {66} sadistic impulses. For example, it was a special pleasure for her to make her fingers into claws and threaten to scratch her mother's eyes out.
>
> She felt oppressed by her father but obeyed him because he was 'smart' and the master of the house. He was a sadistic character who beat the children without mercy (often with a switch) for the slightest infraction. Despite this, or rather, consistent with her masochistic attitudes, she obeyed him implicitly; indeed, she had appropriated some of her father's attitudes, acting towards her mother exactly as he did. She smashed plates in fits of rage and was sarcastic and cruel towards her, while eventually exhibiting the same love and admiration toward her great rival, the preferred and prettier sister, that her father did. The 'mere presence' of her mother annoyed her. She was weak and stupid, she put up with everything, and was thus unworthy of respect.

We can clearly see how the brutal paternal ideal has been established in the patient and how strongly it is identified with the father. At the same time, there is a masochistic surrender to the father deeper down, which parallels the sadistic attitudes towards the mother. *The sadistic and the masochistic tendencies are both completely conscious.* We believe that it is typical of these cases that they are conscious of tendencies that in a simple compulsion neurosis would be subject to the strongest repression. Our patient lacked the typical overconscientiousness of the compulsion neurotic; on the contrary, she was essentially devoid of conscience.

Her main symptom, the end-of-the-world fantasies, represent an equivalent to the compulsive's conscientiousness. They correspond to the enormous guilt she felt towards the mother, which were displaced from deeper determinants onto everyday banalities. It is precisely this displacement which permitted the blatantly sadistic behavior. As her guilt was reconnected with her sadism in the analysis, the {67} patient began to feel her sadistic impulses towards her mother as *a compulsion* . An element of the impulsive, compulsion neurotic, character had undergone a transformation into a typical compulsive symptom.

In the symptom of the typical compulsion neurotic, there are undisguised compulsive thoughts or impulses which are directly linked to guilt feelings. *A sharp separation between the sadistic impulses and guilt is one of the typical mechanisms of the impulsive character*. The fact that guilt feelings are also associated with banal events in the overconscientious compulsion neurotic who has completely repressed his sadistic impulses is further evidence of our contention.

Later on we will address the cardinal issue of the impulsive character, that is, what is it that allows this separation of guilt and manifest sadism. For now we will briefly sketch out the libidinal structure of our case. Her sexuality was completely uninhibited.

> The patient masturbated almost every day with profuse masochistic fantasies, but without orgastic sensations. She did not have intercourse. Moreover, her libidinal structure was completely polymorphous perverse. In one fantasy, *she and her father are eating stuffed vaginas which had been cut out and stuffed with feces*. There are elements of all three libidinal stages in this fantasy. Eating (*oral*) instead of intercourse—vaginas (*genital*)—stuffed with feces (*anal*). The whole situation is experienced masochistically: in the fantasy she is being forced (*masochism*). Fantasies of normal coitus played an insignificant role. The oral component of this history had a special history: she and her sister had suffered from eating disorders as children. The family doctor (!!) had recommended that every means necessary should be used to force them to eat, and if they were to vomit, they should be forced to eat the vomitus. This actually happened repeatedly. It is understandable, then, that the {68} repression and sublimation of oral and anal tendencies failed, and that the patient was still eating feces and vaginal secretions at the age of six and seven. At the time of the analysis, the patient found great pleasure in smearing vaginal secretions between her fingers.
>
> A womb fantasy was prominent in both the symptomatology of the case and in the libido development. The end-of-the-world fantasy, a punishment dictated by guilt, represented a transient regression to the womb. It was accompanied by a vivid visual representation: the patient saw herself lying in the 'globe' of the earth[196]. The patient herself supplied a drawing: a) represents the globe, c) is the patient herself, b) are the 'eyelids' which line the inside of the globe, dividing it into compartments, and which are also connected to the patient's body. We

[196][Readers should consult the drawing, which is not reproduced here, in the original or in other translations. The drawing depicts a crudely drawn human figure lying supine inside a womb-like globe. The inner walls of the globe appear to be membrane-like. An umbilical cord connects the figure to the globe.]

have no hesitation in interpreting the drawing as representing a fantasized womb[197].

To better understand the libido structure of such patients it is necessary to compare it to that of the classical hysteric and compulsion neurotic. In the analysis of pure anxiety hysteria, we are confronted by repressed genital libido as the central pathogenic factor. If other partial drives emerge in the symptomatology or in the course of the deepening work, we are still never in doubt that the *major fixation point* in pure anxiety hysteria is at the genital stage. Hysteria is a disease of the genital stage, according to Freud[198]. If we find an oral fixation at the center of the {69} libidinal profile of a conversion hysteric of the oral type, e .g., in hysterical vomiting, the meaning and aim of the oral symptoms, as well as the analysis of the total personality—of the hysterical character—soon show us that the oral zone has acquired a *genital significance* ('displacement upwards'), as Freud and Ferenczi have demonstrated[199]. In a typical, pure compulsion neurotic, whether it concerns sadistic impulses or anal-erotically based cleaning rituals, a pregenital anal-sadistic fixation is central (Freud[200]); it creates the symptoms and gives the compulsive character its special stamp (excessive scrupulousness, orderliness, etc., as reaction formations against repressed sadism and anality). As Abraham[201] has convincingly shown, there is a central oral fixation in melancholia, a fact that any analytically trained clinician can easily corroborate. In the analysis of mixed forms of hysteria and compulsion neurosis, it is not difficult to see that individual symptoms and particular character traits correlate with particular fixation points. Even if a series of still unsolved and important problems can be grouped around the developmental shift from the anal-sadistic to the genital stages, which belongs in general to the problem of the specific etiology of the neuroses, we can still establish that in the purer and milder forms of hysteria and compulsion neurosis, there are circumscribed fixations and developmental inhibitions of a part of the personality corresponding to more or less sharply demarcated libido positions. The situation is completely different in severely impulsive characters like our patient. If one tries to relate a series of behaviors and symptoms to an anal or genital fixation, one is compelled to ascribe to an oral fixation a just as significant role. Even in the course of thorough analyses, one finds {70} that

[197]Regarding the peculiar arrangement of the compartments, I would point out that their structure is quite reminiscent of that of the amniotic membrane. I will not attempt an interpretation, but would only note that, as far as I could determine, the patient had never seen a picture of the fetus, and had this fantasy since early childhood.

[198][See Freud, S. (1905a), p. 150.]

[199][See Freud, S. (1905b), p. 27; Ferenczi, S. (1924), p. 11.]

[200][Freud, S., 'The Disposition to Obsessional Neurosis' (1913), *RSE*, Vol, **XII**, 2024, pp. 313-321.]

[201][Abraham, K. ([1924] 1927), pp. 442-453.]

there is no major fixation point at a single libidinal stage, but a more or less equal emphasis on all the known partial drives in mostly indissoluble connections and mixtures. To use a drastic analogy, one has the impression of an elephant in the china shop of childhood development.

Our patient displayed an intense and persistent ambivalence towards her parents which was expressed particularly in cruel remarks and acts towards the mother. Her superego was oriented in a completely masculine direction. She admired her crude, strong father and behaved toward her 'stupid', weak mother as he did. This identification was completely conscious. Her prominent complaints of inferiority were based on the identification with the father and an envy of the sister whom he favored.

The analysis showed that not only had the father gravely injured the patient with his sadistic behavior, not only had he been the model for her sadistic ego ideal, but he had also made the largest contribution to her defective drive inhibition: he had made undisguised sexual approaches to the children. Indeed, when I learned that he had suffered from chronic gonorrhea, I had to assume that it was actually he who had inflicted it on the patient. The patient dated the beginning of her illness to age three, the time of her gonorrheal infection; she had always felt extremely timid in her father's presence, and constantly fantasized about a 'sexual attack' by him. But the father was also instrumental in the patient's defective mastery of anality .

He forced the children {71} to eat their own vomit, thereby supporting coprophilic tendencies which had been present from the start[202]. Understandably, the repression of anality turned out to be defective. He beat the children without mercy for the slightest offence, but he didn't inhibit himself anally in the least.

[202]The fantasy of feces-stuffed vaginas.

It will be objected that the older sister remained healthy despite growing up in the same milieu. We respond that she was always held up as a model, was favored in everything, and was loved inordinately. The latter factor is important enough to be decisive. Incidentally, we have no insight into the vicissitudes of the sister's libidinal history, and don't really know what fostered her favorable development. She hated her parents as much as the patient did, yet she was able to escape the household.

The patient clearly exhibits both schizophrenic and classic compulsive mechanisms. Some readers will diagnose her with schizophrenia. The nature of her main compulsive symptom, the obsession about the end of the world, is schizophrenic both in content and in the manner in which it was experienced. The patient tended towards autism; her defective repression and her awareness of her sexual wishes speak for schizophrenia. However, a crude affective dissociation and mental distraction were both lacking for the strict diagnosis of schizophrenia, and there were no delusions or hallucinations. While it is not pointless to discuss the issue of her diagnosis, there is no prospect of our distinguishing between compulsion neurosis and schizophrenia now. Only her further course will tell us. If we use Bleuler's[203] broader concept of schizophrenia, {72} we would lean towards the diagnosis of latent schizophrenia with compulsive symptoms; on the other hand, according to the narrower Kraepelinian[204]conception of dementia praecox, we conclude that we can probably assign the patient to the category of the 'psychopathies', which according to Kraepelin , represent a 'preliminary stage of true psychoses'. Ultimately, we can see that the whole discussion threatens to degenerate into a dispute over words.

A theoretical discussion of the issue of 'borderline cases' is all the more necessary now because we are dealing in this treatise with a clinical category whose representatives not only display individual schizophrenic symptoms in the majority of cases, but whose whole libido structure is not in a stable equilibrium between autistic and object libido. We must ask in almost every case of pronounced impulsivity whether they are schizophrenic.

At the present time, psychoanalysis can contribute only a consideration of libido dynamics to a

[203]Bleuler, E., *Dementia Praecox, oder die Gruppe der Schizophrenien* (1911) [*Dementia Praecox, or the Group of Schizophrenias*], in Aschaffenburg, G. (1911-1928).

[204]Kraepelin, E., (1916).

discussion of this issue. Even in psychoanalysis we talk about 'latent schizophrenia', but that term cannot be understood to mean that there actually is a schizophrenic position in such patients which is being concealed by transference neurotic symptoms and behaviors. Such an assumption would completely contradict the dynamic principles of the libido which we observe clinically. It would introduce a *static* point of view into a situation which can only be grasped dynamically. As long as typical schizophrenic symptoms are lacking, such as stupor, delusions, looseness of associations, or hallucinations, there is no question of schizophrenia, 'latent' or otherwise. If we still use the term {73} despite this, we must always remember that it can only refer to a greater *tendency* of some patients to detach libido from the external world. We are often in the habit of concluding that the presence of 'latent' schizophrenia whenever there is a particularly strong narcissistic position. Yet there are neuroses in which there is no question of schizophrenia which display a narcissistic position which is in no way inferior to that of the schizophrenic. Many paranoid schizophrenics, on the other hand, have strong object relationships.

The problem of what distinguishes the narcissism of the schizophrenic from that of the 'narcissistically inaccessible' transference neurotic has not yet been solved. It is not our intention to engage with the issue further here. But precisely the analytic investigation of 'borderline cases' of the type of our patients warns us against the idea of the, as it were, preformed schizophrenias which then 'becomes manifest'. I treated a forty year old psychopath who since early childhood, and especially since puberty, presented the clinical picture of the 'latent' schizophrenic. She was querulous, was treated badly by everyone, and believed herself to be persecuted by fate. In addition to suffering from phobias, obsessional ideas and compulsions, and conversion symptoms, she had states which were barely distinguishable from catatonic stupor. She was variously diagnosed at the psychiatric observation ward as psychopathic, a compulsion neurotic, and finally as paraphrenic, despite

the fact that her clinical picture was essentially unchanged since puberty. The presentation of many typical compulsion neurotics with cyclothymia appears to completely rule out schizophrenia, yet others {74} (like our patient) seem to have a particular kinship with schizophrenia.

The whole problem becomes clearer if we free ourselves of the prejudice still prevalent in analytic circles that schizophrenia is a different illness *in principle* from the 'psychogenic neuroses', because of its organic nature (Jaspers[205] refers to a schizophrenic 'process'). Schilder[194] still also adheres to this view. A connection between current experience and the onset of psychosis is often not noticed in the psychiatric literature, because of the preconception of a mature organically preformed psychosis. Hartmann[195]had the opportunity of observing two sisters who simultaneously became ill with schizophrenia upon the death of their father. How is this compatible with a preformed psychosis? There are two main hypotheses regarding the organic etiology of schizophrenia: firstly, that it is endocrine in nature, and secondly, especially since Kretschmer[196], that it is constitutional. Neither of these hypotheses conflicts with psychoanalytic theory. Freud has always assumed that there is also an endocrine etiology of the transference neuroses; his entire theory of the 'erogenous zones', which is central to the theory of neuroses, is based on this assumption ('sex hormones'). But then the transference neuroses would not be different in principle from schizophrenia. The hypothesis of a specific constitutional etiology of schizophrenia, e.g., the 'schizoid physique' (Kretschmer), doesn't conflict with the {75} psychogenic point of view either. The clinical scope of the schizoid physique is much more comprehensive than that of schizophrenia. Even compulsion neurosis and hysteria are included in it. The pathological changes in the cerebral cortex which can be found in elderly demented schizophrenics also do not contradict our views. To begin with, we don't know what kinds of (possibly cytoarchitectonic) changes there are in hysteria and compulsion neurosis, although none have been found hitherto. On the other hand, the rarity and meagerness of these findings do not parallel the prevalence of

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[205]Jaspers, K., *Allgemeine Psychopathologie : Für Studierende , Ärzte und Psychologen* [*General Psychopathology : For Students, Physicians, and Psychologists*], Springer, 1920.

[194]Schilder , P., *Seele und Leben: Grundsätzliches zur Psychologie der Schizophrenie und Paraphrenie, zur Psychoanalyse und zur Psychologie überhaupt* [*Soul and Life: Fundamentals of the Psychology of Schizophrenia and Paraphrenia, Psychoanalysis, and Psychology in General*], Springer, 1923.

[195]Hartmann, H., 'Ein Beitrag zur Lehre von den reaktiven Psychosen' ['A Contribution to the Theory of the Reactive Psychoses'], *Monatsschrift für Psychiatrie und Neurologie*, Vol. **57**, 1925, pp. 89-108.

[196]Kretschmer (1921).

schizophrenia, even if we disregard the possibility that the changes that have been found in schizophrenic patients with dementia lasting several decades might be attributable to the 'atrophy of inactivity. But if this is all true, we are left with the problem of the transformation of a compulsion neurosis into schizophrenia, and we feel that no interest is served by erecting a wall between these illnesses. The relationships between them are far too clear[197]. {76}

One can observe in the analysis of impulsives the development of transient delusions in statu nascendi; one can also see a pattern of impulsive behaviors transform into compulsions— that is, one can see actions and wishes which are not initially experienced as forced metamorphose into typical compulsions Thus, the content remains the same in both these situations, but the form changes. A patient of mine with erythrophobia developed a well-organized delusion of persecution which lasted for five days when his homosexual transference intensified in the analysis. He was Aryan, I was Jewish, so I must wish to harm him. He felt watched by me and was afraid of me. I was a sensuous swine, with sensuous lips, I looked at him very sensuously. He had projected his acutely intensified homosexual wishes onto me. As this

[197]Wilmann's discussion in 'Vorträge zur Schizophreniefrage' ['Lectures on the Problem of Schizophrenia'] of the question of the etiology of schizophrenia ('Die Schizophrenie', *Zeitschrift für die gesammelte Psychiatrie und Neurologie*, Vol. **78**, 1922, pp. 325-372) is exemplary. He has compiled all the relevant literature, and has also managed to find an appropriate place for the psychoanalytic viewpoint.

The cases of impulsive character with a strong antisocial streak which I have either investigated analytically or merely observed have the common feature that their behavior has been uninhibited since early childhood. In 'Über den Mechanismus der postencephalitischen psychopathicähnlichen Zustandbilder bei Jugendlichen' ['On the Mechanism of Post-Encaphalitic Psychopathic-like States in Adolescents'], *Archiv für Psychiatrie und Nervenkrankheiten,* Vol. **71**, 1924, pp. 165-182, Gerstmann and Kauders have recently published some interesting case reports of post-encephalitic patients [presumably post-encephalitis lethargica] who developed an asocial-impulsive state as well as the more common hyperkinetic states. Analysts should not disregard such facts. The pre-morbid personalities, and particularly the libidinal histories, of these patients were not investigated thoroughly, however, so no conclusions can be drawn . It is remarkable how often the question is raised, especially by Schilder, to what extent brain diseases trigger psychogenic processes. That an affection of the diencephalon, for example, or the basal ganglia [i.e., two of the anatomic structures affected by encephalitis lethargica], 'cause' asocial states is surely as out of the question as that a paresis [i.e, general paresis of the insane, a form of tertiary syphilis] 'produces' delusions. Rather, a somatic process intrudes at some point in the chain of psychic events. (Schilder, P. 'Cortex-Stammganglien: Psychose-Neurose' [Cortex-Basal Ganglia: Psychosis-Neurosis], *Zeitschrift für die gesammelte Psychiatrie und Neurologie*, Vol. **78**, 1922, pp. 684-692, and 'Über den Wirkungswert psychischer Erlebnisse und über die Vielheit der Quellgebiete der psychischen Energie' ['On the Effect of Mental Experience and on the Multiple Sources of Psychic Energy'], *Archiv für Psychiatrie und Nervenkrankheiten*, Vol. **70**, 1923, pp. 1-15. See also *Soul and Life*, Berlin, 1923.)

acute phase abated, he recognized the provenance of the homosexual wishes and began to accuse himself of sensuousness, wishing to have intercourse with his eyes, etc. As H. Deutsch[198] has shown convincingly, exaggerated and neurotic mistrust, especially in the compulsion neurotic, is caused by the displacement of a person's own repressed sadistic tendencies onto others. We know the role played by mistrust in paranoia. A patient to be discussed later, in whom schizophrenia could likewise not be excluded, developed auditory {77} and visual hallucinations during the analysis. She had lost someone she loved, and didn't want to believe that the person had died. She heard her voice, heard her knocking on the door, saw her standing in front of her during a session. An intense denial of the loss that had been experienced—the wish that the beloved might yet live—was fulfilled in a hallucinatory way. There is in every such case a transitory blurring of reality such that mental content is experienced *delusionally*. Now our cases are frequently subject to transitory blurring of reality testing. This is unquestionably due to a narcissistic regression—to a withdrawal of object libidinal cathexis and the establishment of a narcissistic cathexis. We would very much like to know how such a withdrawal of libido leads to an impairment of reality testing. Flooding the ego with narcissistic libido must affect that part of consciousness which receives perceptual stimuli (Freud's System Pcpt.) and which is governed by the reality censor [Realitätszensur][199]. It is as if in such cases the path connecting the object libidinal position to the 'narcissistic reservoir' (that is, the path between ego and external world) is much 'broader' than in a pure transference neurosis. This is the simplest assumption we can make that might explain the tendency to regression in our cases. Their libido is in a *constant oscillation*. The slightest frustration or disappointment causes an acute withdrawal of libidinal investment. Freud has explained the difference between regression in transference neurosis and in schizophrenia clearly: in the former, a disappointment in reality leads to the libidinal investment of *fantasy* {78} *objects*; in the latter (as in transference neurotics exhibiting schizophrenic mechanisms), the libido is withdrawn into the ego. Even investment in fantasy objects is given up. Thus, object libidinal investment in fantasy objects is a defense against narcissistic regression. Whatever may be the nature of the greater tendency to libidinal

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[198] Deutsch, H., 'Zur Psychologie des Mißtrauens' ['On the Psychology of Mistrust'], *Imago*, Vol. **VII**, 1921, pp. 71-83.

[199] ['Reality censor' is not a term found in Freud's work. It refers to the part of the ego that performs the function of reality testing—judging what is real and what is not—and was a term used in the discussions of the Vienna Psychoanalytic Society as early as 1919. See, e.g., Reik, Theodor (1919). Protokoll des 5. Vortragsabends des 17. Vereinsjahres der Wiener Psychoanalytischen Vereinigung am 23. Februar 1919. Walter Fokschaner: Analyse eines Falles von Paranoia.]

regression towards autism, it works to the disadvantage of the investment of fantasy objects. {79}

V. The isolation of the superego

The case just discussed may be viewed as paradigmatic of a group of impulsive characters with partly compulsive and partly schizophrenic mechanisms, such as may commonly be seen in any psychiatric observation ward. The investigation of such cases gives the analytically trained clinician a means of better understanding patients with similar mechanisms. However, this case leaves several questions open. The most important of these is that we are unable to deduce from the structure of her ego ideal the reason for her inadequate repression: the most prominent feature of her ego ideal, the attempt to imitate her father in every way (her paternal superego), is often seen in female compulsion neurotics who, apart from their symptoms, have intact repression.

It is well known that when investigating a fundamental clinical question one must wait for a suitable case to appear which illuminates at a stroke many aspects of similar cases that were previously unclear.

The answer was eventually supplied by a patient with genital masochism and a completely infantile character whose analysis I began a year and a half ago. Her ego structure was relatively easy to understand because {80} it was much more simply constructed than, for example, that of the patient just discussed or other impulsives whom I have had the opportunity to treat. The patient's main libidinal positions had preserved a certain constancy since early childhood, and there were no later confusing complications in her development that needed to be addressed or worked through first.

To briefly restate the problem we began with: how is an uninhibited impulsivity compatible with the existence of repressions and amnesias? In other words, what does the ego ideal look like in these patients? It undoubtedly exists, but it only partially performs its well-known function of drive repression.

> A 26 year sold single woman presented to the Ambulatorium for the treatment of chronic sexual excitement. She wanted satisfaction but felt nothing during intercourse, not even the insertion of the penis. She would lie there 'tensely', 'listening to see if she is going to be satisfied'. The slightest movement of her body, however, would immediately put an end to any nascent sexual feelings. In addition, she suffered from insomnia, anxiety states, and frequent masturbation. She masturbated up to ten times daily with a knife handle. She stimulated herself to an intense excitement which, by frequent interruption of the friction, she did not permit to be relieved. She continued this until either she was so exhausted that she could not have an orgasm or to the point of vaginal bleeding, after which she achieved satisfaction with the help of masochistic fantasies. Vaginal bleeding was a condition of her satisfaction. She imagined that she was being penetrated deep in her uterus: '*I can only be satisfied in my uterus*'. *During masturbation, she fantasized that her genital, which she called Lotte, was a little girl.* She talked to Lotte constantly during masturbation, playing both roles. 'Now, my child, you will be satisfied; look (during the treatment), the doctor is here. He has a beautiful long penis, but it will hurt you'. Lotte: 'No, I don't want it to hurt me!' (crying). 'You have to suffer, that is the punishment for your horniness. You are a slut. It has to hurt even more, the knife should come out of your back', and so on. {81} For the patient, masturbation was a sin for which no punishment could atone. During masturbation, she also consciously fantasized about all the men she knew, as well as 'Mommy', a female analyst with whom she had been in treatment for eight months three years previously. (The patient had relapsed after a two year remission.)
>
> The patient's father, older sister, and younger brother were allegedly healthy and well-adjusted. Her father appeared to be subjugated in his unhappy marriage to a domineering woman. Her mother was strict and loveless, but extremely capable. She had always been in charge of the household. An older brother was serving a sentence in a penitentiary for sexual abuse of a minor [Schädung] at the time of the treatment.
>
> The patient felt abused and rejected by her mother. She tried to establish the role of the unloved and rejected child in the transference, which was very intense (the analysis was completely dominated by her enactments). Once her attachment to the previous analyst was resolved, her ambivalence toward her mother became very clear. She longed for 'Mommy', and at first saw no connection to her own mother on the grounds that she could never love a mother who had always rejected her, beat her, treated her so badly, and never cared about her (this all corresponded to the facts). A longing for the womb came into the foreground; she fantasized suckling the breasts of a series of 'Mommies'. Her complaints that she had to suffer and be punished for the offenses of others were explained when we learned of a fantasy she first had as an eight year old. Her mother worked at one inn and the patient at another. The mother, in a horrible marriage with the father, was frequently visited by an important man whom she referred to as 'the Count'. The patient was introduced to this man once. She then believed that she was rejected by her mother because she was the daughter of this Count, and was now bothering her. She fantasized (it cannot be determined whether this is only fantasy) that the Count had once raped her with the help of her mother (cf. her masturbation fantasy). She felt a large penis inserted into her vagina, causing great pain. She is in a dark room and someone is shouting at her that she mustn't cry and must keep still. The analysis later uncovered a similar fantasy (or dim memory?) dating from the age of three. She is taken by two men, who are lodgers of her parents, into the room they are letting; as one holds her down, the other forces his outsized penis into her vagina. She wants to scream but cannot. She has clear memories from an earlier period of sexual play in a cellar with boys her own age. She had sexual intercourse with {82} an older brother at the age of ten. Once as a six year old, she saw her two year old brother's penis when playing with him. She tried to insert a knitting needle

into it; it bled and she pulled it. Her mother beat her and pulled her hair when the boy screamed.

The patient began working as a nanny at the age of twelve. For two years her employer made advances toward her almost every night without ever going further. She thought she was pregnant when, at the age of fifteen, her periods stopped for three years, only resuming after her first analysis broke off. It was then that she got the idea of binding a piece of wood in her vagina. Later, she often came to analytic sessions with a knife in her vagina, clearly only possible if she had vaginismus. She was unable to fall asleep without a knife inside her.

Masturbation in its present form began at the age of fourteen, after she spent the night in the same room as her father. She'd had a bad dream but couldn't remember it, and woke up early in the morning lying on the floor. The bedstead was broken. Without providing any information himself, her father asked her what had happened during the night. So far, the analysis has not been able to resolve this detail. Most likely, the proximity of her father was very arousing and led to the anxiety dream. The scenario also suggests that the patient had masturbated.

She relapsed after she made the acquaintance of a sadist who beat her with whips, pulled her hair, verbally abused her, and forced her to perform criminal acts: she had to steal for him, twice had to bring little girls to him, etc. She called him 'her best friend', couldn't live without him, and followed him in the streets for hours. She only broke off with him under threat of the treatment ending. She immediately transferred her masochistic attitudes onto the physician. She brought a whip to the analytic session and began to undress to be beaten. Only the strictest interventions dissuaded her from continuing. She began to follow me in the streets and came to my house late at night. She couldn't bear it, I must have intercourse with her or beat her, she must have my child, only I could satisfy her. This went on for approximately eight months; no explanation, no argument made the slightest impression. Whenever she did something wrong, she masturbated more harshly and more frequently 'to punish herself'. 'I have to finish myself off'. In the eighth month of the analysis she tried to poison her sister and brother-in-law. There is no doubt about this due to circumstances {83} that need not be reported here. The patient was amnestic but betrayed her guilt in dreams and by particularly brutal masturbation. A few days before, she had brought rat poison to her session. She loved it so much that she had to hoard it.

She remained in analysis only with the strictest prohibitions and under the direst threat of breaking off the treatment altogether.

The patient remembered completely forgotten scenes from her parents' bedroom during a calmer phase in the fourteenth month of the treatment. Sadistic theories and ideas of the sexual act and of childbirth found their explanations here; some of the patient's anxiety was eliminated, she took a job and began to do much better. Characteristically, she acquired an eating compulsion and put on a lot of weight, corresponding to an oral impregnation fantasy. With the breakthrough of what seemed to be the most important material, her tendency to protract the analysis interminably had to be counteracted by setting a long-term termination date six months later. Discussion of the bedroom scenes was accompanied by a resurgence of both masturbation, which had to be prohibited, and guilt. The ban was particularly warranted

> because local damage, such as uterine prolapse and torsion, was already evident.
>
> The recovery of clear incest wishes, hitherto completely repressed, met no condemnation. On the contrary, the patient consciously fantasized about having intercourse with her father and having his child.
>
> Her fantasies sometimes intensified to the point of hallucination. For example, she saw a devil taunting her that she would not be able to refrain from masturbating; she struggles against the urge, to no avail. Sometimes the devil had the Count's face, at other times that of her mother.
>
> The devil represented sadistic and incestuous wishes which she had to resist, her mother, and her forbidden father especially.

Let us summarize our findings. We are dealing with a patient who remains infantile in both her libidinal and, especially, in her ego structure. Her masochistic genital masturbation is impulsive and cannot be restrained. Initially, it was neither felt as a compulsion nor viewed as a symptom. The introjected maternal prohibition, 'You may not desire your father nor masturbate' , was transformed into, 'You (the genital = the patient) are a {84} "filthy whore" who must die by masturbation for your sins . Thus, the patient's form of masturbation represents a compromise between an attempt to satisfy incestuous fantasies ('I can only be satisfied by a long penis penetrating my uterus') and an ominous association of death wishes and destructive tendencies, on one hand, with genital pleasure on the other. She identifies her self with her genital ('the little girl') during the act of masturbation, while her ego identifies with her punishing mother. *Her excessively punitive superego is modeled entirely on the mother, whose demands are completely realized in the act of masturbation*. This part of the ego, introjected from the mother, confronts the remainder of her rather undeveloped ego, which is characterized by:

1) a masochistic attitude toward the punitive mother (later, toward the punitive superego)

2) a complete identification with the genital ('the little girl'), i.e., with the pleasure ego

3) a completely repressed genital object relationship with the father, and

4) an oral and womb relationship to the mother

While the wish for a penis exists, it did not lead to the formation of a masculine character. The patient remains childlike and feminine; an intense conscious wish to have children corresponds to these characteristics.

We can assume that her major libidinal fixation point is at the *genital stage*. An intense castration complex maintains a masochistic fixation at the genital stage, which is accompanied by an oral fixation to the mother. But now we must ask if and where a fixation of the ego also exists in this case. To approach this question, it will be necessary to consider the development of the ego in the case of a simple symptom neurosis. {85}

In a typical compulsion neurosis, the ego develops significantly faster than the sexual component of the personality. While the pregenital, anal-sadistic stage is predominant libidinally, not only has the ego completely formed, but it usually has reached a culturally advanced level. If the objection is raised that the animistic and magical tendencies (e.g., superstitiousness) of the compulsion neurotic (Freud, Ferenczi)[200] suggest the existence of a fixation of the ego at an early stage, we would respond that, if the total personality is considered, we can speak only of a *partial fixation of the ego* in these cases, while in our patient the whole of the ego remained at a primitive stage. But what does this total fixation of the ego look like, and what does it consist in?

The most striking feature of our case is the enormous contrast that exists between the ego and the ego ideal: the mother is entirely represented by the superego, while the ego, strictly separated from the superego, is infantile, impotent, and permeated by incest wishes. Normally, the child's ego adapts to the external world by incorporating parts of it in the form of a superego, which in turn initiates the processes of reaction formation and sublimation. A child's development consists of a gradual and bit-by-bit absorption of the real outside world in the form of superego demands which are *fused most intimately with the existing ego*. As the demands are assimilated, partly changed, into the structure of the ego, a vigorous drive ego is forced to modify itself, which it does entirely by means of compromise formations. In the

[200][See Freud, S., *Totem and Taboo* (1913), *RSE*, Vol. **XIII**, 2024, pp. 11-150; Ferenczi, S. (1913).]

analysis of the healthy or of those with mild neurotic disturbances, it is usually impossible to trace ego ideal formation back to particular identifications, and to the degree that it is possible, one finds the ego ideal in the most manifold and {86} complicated relationships with, or better, soldered to, the sexual and other ego components of the personality. The further we pursue a comparison of the normal with the severely pathological, the clearer it becomes that we are confronted in the latter with an *isolated superego* and in the former with an *ego ideal which is organically fused to the rest of the developing personality*.

The ego originates from and is composed of a series of identifications. Yet we must consider that a 'something' must already exist which the later identifications consummate. This 'something' can only be a primitive ego, differently constructed than the more mature ego, an ego consisting entirely of drive tendencies of a sexual and destructive nature. Freud has taught us how to understand the complicated trail which this primitive *drive or pleasure ego* must blaze if it is to develop into the ego of a normal adult. The attitude of these drives toward the external world is one of complete ambivalence from the very beginning. In the course of normal development, it is only out of love for the caregiver that some of the destructive tendencies are turned against the self and, in the sublimated form of 'conscience', erected as a barrier against the gratification of a quotient of sensuous pleasure which the ego must learn to renounce. The drive ego is completely dependent on the external world *as to the way* in which the assimilation of its demands takes place. Now there are two circumstances, already mentioned in the third chapter, which can push the processes of identification in a pathological direction: *1*) Can the drive ego resist from the first external restrictions on its pleasure? That is, can it resist identifying with the prohibiting caregiver? Indeed, it is in the nature {87} of the pleasure ego always to try to do just that. In view of this, the strength of the resistance to external restriction will depend on the intensity of the autoerotic organ pleasure that has already been experienced. The more intensely and the earlier real organ pleasure is experienced, the more difficult it becomes to establish a prohibiting ego ideal. We believe that this factor is strongly influenced by constitutional forces (e.g., hormonal influences?). *2*) Can the ambivalence towards the primary caregiver be strong enough that any identification that is established engenders a defiance that is just as strong? To better understand identifications born of extreme ambivalence, we must recall that the formation of identifications depends on positive object love. A child will accept a prohibition more easily the more it is doing it *for*

the sake of a loved one. This 'for the sake of' eventually falls away, leaving the prohibition to persist in the form of a demand of the ego ideal. But if equally strong negative attitudes, equally strong defiance, compete with the 'for the sake of', then the prohibition is still erected into an effective force, but only in isolation from the rest of the ego. *This isolation is tantamount to a repression*. The prohibition then behaves impulsively as if it were a repressed sexual wish: due to successful identification it strives to prevail; it is inhibited in this by negativistic attitudes originating in the pleasure ego. Consequently, the prohibition is not organically incorporated into the total personality. It follows that there must be conflict within the ego which resemble in every respect conflicts between sexual wishes and the repressive forces of the ego. (The relationship between 'isolation' and 'repression' of the superego will be discussed later.)

We will now try to apply the hypothesis of the 'isolated superego' to our case. The {88} distinguishing feature of the patient's personality is her intense and acute ambivalence towards her mother. The positive side of this is motivated by her oral fixation to the maternal breast and by her longing for the womb. She doesn't ever want to grow up; she isn't 26 years old, she is really only two. Her mother repudiates her, damns her, curses her; she can only be calm if her mother takes her back. A wish to nurse at her mother's breast is completely conscious.

The negative component of the ambivalence is based on an uninhibited attachment to incestuously-tinged objects. Until she began analysis, only the figure of the father himself was subject to strong repression. At the age of three, the unsupervised child was already engaged in crude sexual play with her brothers and other boys. Then one day, the mother suddenly imposed a strict prohibition: the children were caught in the act and savagely beaten. The mother's beating and scolding ('you are a filthy whore', etc.) only had the effect of greatly increasing the child's guilt feelings, while at the same time the child's defiance and negative

attitudes, intensified by her experiences of sexual pleasure, prevented the victory of the mother's prohibitions over her impulsivity which had already been completely acted out. In this process, the ego to a large degree misses the opportunity to develop further, because although the maternal ideal ('you must not engage in sexual play') is certainly taken in, it is not fused with the rest of the personality. The ego remains infantile, at the stage of identifying with the pleasure-giving genital, and is therefore condemned to do battle with superego demands which have been adopted by it but which are completely antithetical to it. This unresolvable conflict cannot be expressed, as in a typical {89} neurotic, in the form of, 'I want to masturbate, but I mustn't', or 'I desire my father, but mustn't', etc., but rather in the form of *'I must die by the pleasure of masturbation or intercourse'*. This situation culminates in the symptom *of genital masochism*.

The 'isolation of the superego' thus signifies a particular structuring of the personality. We believe we can pursue the genesis of this structure a bit further by briefly discussing it from the dynamic and economic viewpoints. Structurally, we are dealing with an impulsive character whenever the superego is isolated or separated from the ego rather than being 'organically' fused with it as it is in the impulse-inhibited neuroses. The *dynamic* consequences of this structure include impaired functioning of the superego as the actuator of repression and reaction formation, as well as the mechanism of the 'criminal from a sense of guilt' (Freud)[201]. The isolated superego functions like a repressed drive, and creates a need for punishment that seeks satisfaction mostly in the form of undisguised masochism. This leads us to the *economic* significance of such a dynamic. The impulses *secondarily* act in the service of relieving guilt feelings by way of the pathological path of the satisfaction of the need for punishment. But as it has formed secondarily, we must be wary of overestimating this essential economic motive. The primary motive of the impulses is undoubtedly to regain the original organ pleasure, which can be experienced without manifest guilt in such a personality structure[202]. {90}

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[201] [See Freud (1916).]

[202] Here we touch upon Sachs' discussion in 'Zur Genese der Perversionen' ['On the Genesis of the Perversions'] (*IZP*, **IX**, 1923, pp. 172-182), where he states: 'Nevertheless, if (in the perversions) the repressions are to be even partially successful, they must result in a compromise which permits a component of the pleasure to be preserved and accepted in the ego, a component which is, as it were, sanctioned by the ego'. We leave the question open as to whether this sanctioning of pleasure, or avoidance of unpleasure, respectively, by the ego in perversions does not have as a prerequisite an ego structure similar to that in the impulsive character.

But it would also be impermissible on other grounds to attribute the motive for impulsivity to the need for punishment alone, despite the clear examples of the 'criminal from a sense of guilt' in the sadistic impulsive, and the self-punishment of the masochistic type. For the need for punishment can also be found in almost every case of impulse-inhibited neurotic character. The disease itself serves to gratify the masochistic need for punishment in these patients. But it is the dissociation between superego and ego in the impulsive which enables the sadistic type to torment those around him, thereby rationalizing his guilt feelings, and the masochistic type to arrange effective punishments. Although the need for punishment is clearly present to a high degree in impulsives, it is not specific to them.

The impulsive character took an interesting turn in another patient. This patient was in constant conflict with her parents for the first 22 years of her life. She lied, deliberately misbehaved, ran wild in the house, hung around with boys, repeatedly hit her mother without compunction, masturbated, and was often 'raped', though without actual intercourse. The latter made her extremely anxious. She also suffered from anxiety states and occasional insomnia. She finally surrendered to a father figure at the age of 22, whereupon there was a breakthrough of guilt feelings. Her mother kicked her out of the house; she fled to Vienna where she developed hysterical vomiting {91} and abdominal pains. She had two unnecessary laparotomies because the doctors didn't recognize the functional nature of her symptoms and thought that the patient had cardiospasm. Suddenly the impulsive behavior diminished. The patient became quiet and depressed, and began to recreate situations which reproduced in every detail her banishment by her mother. She behaved similarly in the analysis as well. Before the outbreak of her hysterical symptoms she had resisted accepting the superego demands. It was only upon the gratification of her incest wishes in the sexual act that the hitherto isolated ego ideal functioned effectively as a repressing agent: it inhibited the impulsive behavior and gave rise to a symptom neurosis. (The vomiting and abdominal pain

were the result of a pregnancy fantasy.)

If one compares several such cases of uninhibited impulsivity, with particular attention to those which also display symptoms arising from repression, such as anxiety, compulsive thinking, phobias, etc., in addition to impulsivity, one is immediately struck by the fact that it is not always only acute ambivalence toward a caregiver that creates the pathological isolation of the ego ideal. Another typical outcome presents itself: the behavior of the care-givers, which should serve as the model for the child's ego ideal formation, is not directed against the original impulsivity, but on the contrary is completely in harmony with it. In psychoanalysis, one is accustomed to underestimating the importance of the lack of a model for ego ideal formation. Aichhorn (loc.cit.)[203] has shown that such people very commonly exhibit antisocial characteristics, and either were born out of wedlock and grew up without a father, or were orphaned very young. But it is still not clear why the ego ideals of such children are not modeled on other {92} care-givers, or if they are, why they display a lasting lability in their inhibitions. It would be extremely valuable to understand whether and to what degree a frequent change of care-givers causes a lasting weakness of the defensive agency. It is only to be expected if frequent changes in *the way* children are raised were to lead to internal contradictions and inconsistencies in the ego ideal.

> A 28 year old patient, brought to the Ambulatorium by the Department of Public Welfare of the City of Vienna for the treatment of hysterical mutism, displayed such a contradictory and heterogeneous ego ideal. She exhibited tremendous anxiety which was expressed in sudden startle reactions, holding her arm in a defensive posture, and sudden attempts to flee. The mutism represented a hysterical defense against a compulsion. She lived with three children in direst material need, supporting the family on the ridiculously small amount of money she earned as a seamstress. She had decided to seek death with her children, but her attempt to act was foiled by the crying and screaming of her youngest child, a two year old girl. The patient then developed a compulsion to tell everyone about what she had done, accompanied by the fear that she would be involuntarily hospitalized in a psychiatric facility in consequence. (She had already been hospitalized due to a suicide attempt.) And now the patient was mute, in order to defend against acting on her compulsion. The mutism began after an anxiety dream. She dreamt that her middle child was dead. She had been pregnant with this child when her first husband died in an accident. She had cursed the child inside her and thought it would be better off dead.
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> The patient had been married twice. The first husband died, as noted, and she left the second because he was an alcoholic who abused her. Of note, although the patient had many relationships, she was totally frigid. It was immediately obvious that the patient not only had homicidal wishes towards her children, which she condemned, but that she was also fully aware of blatantly criminal intentions towards her father-in-law which she did not condemn and thus

[203] [Aichhorn (1923).]

were not compulsive. She wanted to poison him, to which end she made the acquaintance of a pharmacist who refused in the end to hand the poison over to her. During the three week analysis she lay in wait and ambushed me by the entrance to the clinic and in its garden in order to 'blow off' some of her rage {93} at me by 'pulling out a few hairs at least'. She tried to buy a revolver to shoot me with. She had the conscious thought that it would be wonderful to castrate both her father-in-law and the analyst. She had pyromanic impulses which she gave in to without condemnation, indeed, gave in to with great pleasure. She burned everything in the house she could get her hands on and chased her child around with a piece of burning kindling. As a ten year old she set a haystack on fire to get revenge on the owner for scolding her. The same year, she set a fire in the next door neighbor's house which had endangered the whole village. She reveled in the anxiety she caused 'the others', whom she felt should suffer as much as she did.

In fact, she'd had a wretched childhood. She was born out of wedlock and was abandoned by her mother. For four years she was 'raised' in an orphanage. She was sent to live with a distant relative who systematically encouraged her, as well as her own children, to steal. She was beaten constantly. She slept with eight others, sometimes including adults, in a small, constricted room. She was not only witness to the most intimate sexual matters, but was also abused by an uncle and another young man. She didn't willingly steal, only doing so because she was cold. She hated her environment, but only because she was beaten. She was vengeful and malicious, especially in school, which she only irregularly attended. Her greatest pleasures were in beating up boys, tormenting the teachers, and finally setting fires (she was enuretic until age twelve). The new director of the school took her under his wing when she was eleven and took her out of the house. He began to exert an influence on her. He taught her how to read and to understand what she read, and wanted to pay for her further education and support out of his own pocket. But the relatives took her back, and she resumed her old life. But now, for the first time, she began to suffer from anxiety symptoms; she was also able to inhibit partially her impulsive behaviors. Her hate for her oppressors had grown immeasurably but at the same time the influence of the director had come into effect: *her hate was opposed by strivings originating in her newly acquired superego, based on the good director*. She obtained some books, read a great deal, acquired some culture, and developed a relatively good writing style. I can attest to this because I read some of the letters she wrote from the Steinhof[204]. At age fourteen, she met her mother for the first time, who took her along with her to the city. There a life of total misery and deprivation continued. The old impulses were as strong as ever, but were now partially {94} blocked. She tormented her first husband without remorse. She reproached herself severely when he died (attempted suicide, hospitalization) and experienced a phase of agitation to the point of delusion: she believed that her husband was still alive and was following her on the street. She entered into several relationships which all ended unhappily, couldn't stand her second husband, finally became unable to work, and made the decision to kill herself and her children.

Analytic treatment of the patient was impracticable in the Outpatient Clinic because of her

[204][Presumably the letters date from the time of her hospitalization (at the Steinhof) for attempted suicide which is referred to on the previous page.]

dangerous behavior. Thus, her sexual development could not be subjected to analytic scrutiny. What did become clear, however, was the intense contrast between the lack of development of an effective ego ideal for the first eleven years of her life and the subsequent influence that the director had on her. Only then was she able to restrain her impulses, even if it was mostly unsuccessfully. At the same time she acquired guilt feelings, which intensified the fear of beatings which already existed. Her uninhibited impulsivity was partly checked by her belatedly acquired but nonetheless intense superego, and was led into paths of neurotic symptom formation. The superego was unable to adequately facilitate the work of repression only because it was activated so late. When I refer to the work of repression here, it is in the crudest sense. Yet there is no doubt, for example, that our patient's frigidity corresponded to a repressed wish for a penis, even if *conscious* castration wishes existed. We must ask, without having an answer, what the repression of her masculine wishes achieved. We mustn't forget, however, that the patient had been beaten, and must assume that the phylogenetic disposition to repression, or guilt, as the case may be, supported these 'child rearing measures' as an aid to the establishment of repression. She had been sexually abused by her foster father and had resisted him; as an adult, she manifested hostility to {95} men accompanied by a tendency to neurotic entanglements with them associated with total frigidity. Was the child only able to hate? Had her resistance to her foster father been genuine, because she was starved for tenderness? Or was she repressing an intensely masochistic love? We cannot answer these questions either.

We must not look in this case, however, for a fundamental difference from the genital-masochistic patient. It seems that it is only important that a culturally appropriate ego ideal be established at some point, regardless of whether this occurs in the twelfth or fourth year of life. Everything depends, however, on there being a correct balance of tolerance for and restriction of drive expression in effect *from birth*. We cannot yet characterize the nature of this healthy balance further. Any inconsistency, in the form of strictures suddenly imposed, will lead to developmental defects of the ego which will more or less approximate the isolated, or respectively, repressed, superego described in the extreme cases discussed here. I have no doubt that there are other typical forms of ego defect yet to be described.

The repression of the superego

In discussing the structural and dynamic differences between compulsion neurosis, hysteria, and the impulsive character further, we consider a possible objection to our thesis. Even the egos of the compulsion neurotic and the hysteric rebel against the brutal severity of the superego. Freud acknowledges this fact in *The Ego and the Id* when he writes: 'In certain forms of obsessional neurosis the sense of guilt is over-noisy but cannot justify itself to the ego. Consequently the patient's ego rebels against the imputation of guilt and seeks the physician's {96} support in repudiating it...Analysis eventually shows that the superego is being influenced by processes *that have remained unknown to the ego*. It is possible to discover the *repressed* impulses which are really at the bottom of the sense of guilt. Thus in this case the superego knew more than the ego about the unconscious id'[205]. The difference between the impulsive and the compulsion neurotic now becomes clear: in contrast to the ego of the impulsive, the ego of the compulsive knows nothing about what is being repressed despite its resistance to superego demands. It behaves towards the superego like a rebellious slave does towards a brutal master—it continues to serve it despite an inner resistance. In contrast, the ego of the impulsive is engaged in deliberate and open rebellion. The fact that this rebellion is successful in the impulsive and not in the impulse-inhibited compulsion neurotic is attributable to the reaction formations in effect in the latter at the time (about which more below); that is, the prohibiting personality is completely incorporated into the ego of the compulsive, even if it later rebels against it, while in the impulsive the act of identification is never complete but only involves a part of the ego.

It is different and more complicated in the hysteric, in whom, according to Freud, the guilt remains unconscious: 'Here the mechanism by which the sense of guilt remains unconscious is easy to discover. The hysterical ego fends off a distressing perception with which the

[205][Freud, S., (1923) pp. 45-46; all emphases in the quotes are added by Reich.]

criticisms of its superego threaten it in the same way in which it is in the habit of fending off an unendurable object cathexis—by an act of repression. It is the ego, therefore, that is responsible for the sense of guilt remaining unconscious. We know that as a rule the ego carries out repressions in the service and at the behest of its superego; but {97} this is a case in which it has turned the same weapon against its harsh taskmaster. In obsessional neurosis, as we know, the phenomena of reaction-formation predominate; but *here* [in hysteria] *the ego succeeds in keeping at a distance only the material to which the sense of guilt refers*.[206] The ego of the impulse-inhibited hysteric is able to repress id drives in the service of the superego due to an *unconscious acceptance*[207] of its demands, while at the same time resisting its strict admonitions by way of a (systematic) repression[208] of guilt, which can only be discerned in the analytic situation from anxiety and conversion symptoms.

Thus, in every case of impulse-inhibited hysteria and compulsion neurosis there exists an unconscious acceptance of superego prohibitions. The difference between the two lies in the respective attitudes of the ego towards guilt. But what mainly interests us here is the question of the *repression of the superego*. We need to clarify the relationship between the repression and the isolation of the superego. Earlier we said that isolation resembles repression because the isolated superego can act like a drive breaking through a repression.

But upon closer consideration of the matter we are immediately struck with an important objection: aren't the core demands of the superego always unconscious? Can the incest prohibition, for example, ever be conscious? If it were, wouldn't the incest wish then also be conscious? The close connection of wish to prohibition condemns both to unconsciousness and is a problem that {98} *The Ego and the Id* attempts to solve with the theory of the necessary unconsciousness of a part of the ego—the superego.

But 'unconscious' is not the same as 'repressed'. The issue is clearer if we hold fast to Freud's distinctions between *dynamic* and *systematic* (system *Ucs*) repression on one hand,

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[206] [Ibid,, p. 46.]

[207] The *conscious* acceptance of superego demands can be found in the ascetic-religious compulsion neurotic. I need hardly emphasize that this conscious acceptance rests on a deeper unconscious acceptance.

[208] [By systematic repression (systematische Verdrängung), Reich means that at least a portion of the superego itself remains in the unconscious (i.e., the system Ucs.) but is not dynamically repressed. See immediately below.]

and *successful* and *unsuccessful* repression on the other[209]. Only unsuccessful dynamic repression is pathogenic. In the healthy person and in the impulse-inhibited neurotic the nucleus of the superego is always systematically and successfully repressed. This systematic repression does not go beyond a preventing of awareness of mental content [e.g., incest wishes and prohibitions] and is highly compatible with the unconscious acceptance and pursuit of superego demands by the ego. Indeed, lack of awareness of content seems to be a precondition of this acceptance. For it is striking how often the core demands of the superego (the incest prohibition, for example) are fully conscious in severe cases of the infantile impulsive[210]. (Incidentally this is also very frequently the case in schizophrenics.) *In the impulsive, systematic repression is incomplete and dynamic repression turns out to be very intense but unsuccessful*.

We believe that we can see more clearly now:

In the *impulse-inhibited neuroses* there is a successful systematic repression of the superego core; dynamic repression does not go beyond preventing {99} awareness of its contents. The ego knows nothing of the contents of the superego core and is only aware of its own rationalizations. It submits, however, to the demands of the superego to repress the strivings of the id. Symptoms are created, we know, when these repressions fail. In the impulse-inhibited symptom neurotic, *the psychic conflict plays out between the ego plus the superego on one hand and the repressed portions of the id (the prohibited object relationships) on the other*.

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[209] [See Freud, S., 'Repression' (1915), *RSE*, Vol. **XIV**, pp. 129-139; 'The Unconscious' (1915), *RSE*, Vol. **XIV**, pp. 147-180.]

[210] This statement only appears to contradict the assertion made in the second chapter that the impulsive character displays repressions of just as intense a nature as the impulse-inhibited neurotic. This clinical observation is entirely consistent with the fact that the isolation of the ego ideal impedes its ability to initiate repressions; at the same time it is also not totally disconnected from the ego. Another possibility is that only a part of the ego ideal is isolated.

The superego in the *impulsive character* is 'dynamically' and 'unsuccessfully' repressed, and the systematic repression is inadequate. It is easy to understand the reason for the inadequacy of the systematic repression, which has similarities to the inadequate repression of the partial drives and sadism in these patients. It is a consequence of the dynamic repression of the superego by the (pleasure) ego. *Psychic conflict in these patients is played out among three agencies: on one hand, the ego wards off the id in the service of the superego (as happens in the impulse-inhibited neurotic), and on the other hand it wards off the superego in the service of the id.* This double conflict (*double anti-cathexis*) is the cause of the intense turmoil usually seen in the lives of these patients.

Thus, the concept of the isolation of the superego implies failed dynamic repression, but it also implies a particular structural organization of the personality, and, as will be discussed in greater detail shortly, a normal phase of superego formation. In justifying the coining of a new term, it should be noted that we are dealing here only with *one* special case of superego repression. It is possible that one day, when the theory of dynamic {100} 'ego repression' (as a pendant to the theory of 'sexual repression') is consummated and its relationship to personality structure understood, the concept of 'isolation' will be absorbed into that of 'repression of the superego'.

Isolation of the superego as a normal phase of ego development

We must now confront a further objection. We derived the isolation of the superego genetically from the child's ambivalence towards its object, which is later replaced by the superego. We established isolation as the defining developmental defect of the impulsive character, in contrast to impulse-inhibited, classical compulsion neurotics. But ambivalence is a central factor in compulsion neurosis and is at the root of such symptoms as compulsive doubting, indecisiveness, etc. Why doesn't ambivalence result in isolation of the superego in these patients? It is precisely the compulsion neurotic who exhibits a far-reaching realization of negative superego demands, such as over-conscientiousness, pedantry, a tendency to ascetic ideologies, sexual abstinence, etc. This objection is easily countered if we consider that psychic development depends on the form of the ambivalence, that is, how it manifests itself, and on the phase in development when it manifests. With regard to this point, I refer to the

discussion in the last section on the differences between the two forms of illness. An ambivalent attitude can either 1. *be persistent and manifest* (*manifest ambivalence*) or 2. transform into love or hate, respectively. Thus, in analysis we encounter a phenomenon, first described by {101} Freud[211], which gives the impression of *reactive love* or *reactive hate* (*latent ambivalence*). In the former, hate transformed into love is added to the original loving attitudes toward the object; in the latter, love transformed by disappointment into hate is added to the original attitudes of hate. What is typically found in the compulsion neurotic is that the manifest ambivalence is expressed in symptoms and is mostly displaced onto banalities, and then either the reactive love or hate is turned onto the original ambivalently-held object. The ambivalence toward the object only becomes manifest in analysis. The impulsive character has a persisting attitude of manifest ambivalence toward the object which is maintained in its attitude toward the ego ideal, as explained above. Thus, a transformation—the *reactive accentuation* of one or the other side of the ambivalence and a *displacement* onto banalities—is added to the original manifestly ambivalent attitude of the compulsion neurotic, which in the prototypic impulsive either doesn't occur at all or only to a partial degree. The reactive transformation of the ambivalence into a manifest and unambiguous attitude of love or hate is naturally a consequence of repression, which, as we know, is defective in the impulsive. Repression and reaction formation in the compulsion neurotic can be ascribed to the strictness and strength of the prohibiting ego ideal. The clinical manifestations of defective repression and reaction formation, manifest ambivalence, and isolation of the superego fit very well together in the impulsive character. A table describing the two prototypes might make the differences between them clearer: {102}

Compulsion neurosis	**Impulsive character**

[211][See, e.g., Freud (1923), 38-39.]

1) manifest ambivalence	1) manifest ambivalence
2) reactive transformation of the ambivalence	2) no reactive transformation, or hate predominates
3) strict superego integrated into the ego	3) isolated superego
4) strong repression and reaction formation	4) defective repression
5) sadistic impulses linked with guilt	5) sadistic impulses without guilt
6) character is overly conscientious; ascetic ideologies	6) character is without a conscience; manifest sexuality with accompanying guilt possibly anchored in neurotic symptoms or totally repressed
7) the ego submits to the superego	7) the ego sits between the pleasure ego and the superego with ambivalent attitudes towards both agencies; in actuality has allegiance to both the pleasure ego and the superego

The fork in the road toward the development of either compulsion neurosis (or other symptom neuroses) or the impulsive character, respectively, can be found under 2) . A person's *life experiences through the anal-sadistic stage* determine which way development will go. If strong ambivalence first develops at this stage and there is no earlier damage, then development proceeds in the direction of compulsion neurosis (or hysteria); if there is already intense ambivalence from an earlier stage, then integration of the ego ideal and reaction formation will founder. Premature sexual activity, as discussed earlier, and especially *activation of genitality before the full Oedipal phase* will strengthen the narcissism of the primitive pleasure ego in such a way that the ego ideal can only be established in a more isolated form. Other determining factors for development include all of the damage forthcoming from the {103} love objects and care-givers which we have thoroughly described earlier.

It was not the aim of this discussion to contribute more to our knowledge of the pathological development of the ego and ego ideal than would emerge from a consideration of the position of the latter in the impulsive character. The genetic psychology of the ego inaugurated by Freud and Ferenczi[212] will presumably have to deal with characteristic 'developmental stages

[212]Ferenczi, S. (1913).

of the ego' in the same way that characteristic stages have been established for sexual development. We must consider the phenomenon of the isolated superego as the pathological permanent state of a phase which presumably everyone goes through on the developmental path from primitive pleasure ego to membership in a social group. The civilized real ego is only formed by way of the ego ideal, by realizing certain of its components[213] . A large part of the ego ideal may never by realized, and psychoanalysis enables us to obtain insight into the pathological results of inadequate realization of the superego. The acquisition of the ego ideal does not take place without a struggle. It is in the nature of the impulsive pleasure ego to ward off the restrictions of care-givers. This defense is paralyzed by object love, resulting in the establishment of the ego ideal. But inserted between complete rejection of restrictions and their actual acceptance is a phase of acute *manifest* ambivalence toward the restricting objects, or later, toward the ego ideal, respectively. There are {104} two possibilities in the course of further development: either transformation of the manifest into latent ambivalence by a reactive accentuation of love or hate, or an overcoming of the ambivalence toward the object and ego ideal. We see the latter outcome as normal and strive for it in the analysis of every case. It is clear that overcoming ambivalence in the ego can only follow overcoming ambivalence in the sexual relationship with the object, that is, by achieving the *unambivalent genital stage*. The former outcome is represented by compulsion neurosis and hysteria. Thus we arrive at the following schema:

1) *The stage of the primitive pleasure ego*: unambiguous rejection of restriction.

2) *The stage of manifestly ambivalent object cathexis*, or, from the standpoint of the superego, *the ambivalent response to the superego*. Fixation at this stage results in the

[213]We are not forgetting that there is an *immediate* identification of the ego. It must be decisive for the structure of the personality whether the fundamental identifications are in the ego or superego. (Cf. our discussion of sexual misidentification in Chapter III.)

permanent establishment of an *isolated superego* and the disposition to uninhibited impulsivity in the sense we have been discussing it.

3) The stage of the reactive transformation of the ambivalence: the ego identifies with the restricting care-giver (*realization of the care-giver's demands on an ambivalent basis*). This is the stage at which sexual misidentification[214] occurs. There is a disposition to compulsion neurosis if this process occurs during the anal-sadistic phase and a disposition to hysteria if it occurs in the genital stage.

4) *The stage of (relatively) ambivalence-free ego structure.* However little we may yet know of its genesis and dynamics, analytic experience tells us that this reality oriented position of the ego cannot exist without drive-affirming {105} elements in the ego ideal, that is, without the possibility of an orderly libido economy[215].

This schema can only provide a provisional orientation to the problems of ego development. We would add that phases 1 through 3 must occur at every stage of libidinal development because in every sexual phase the conflict between pleasure strivings and frustrations plays out anew. So it turns out that we can distinguish the impulsive character from the compulsion neurotic and the hysteric depending on whether the fixation of the phase of the isolated ego ideal occurs at the anal-sadistic or genital stages of libido development.

We anticipate the objection that an attempt to distinguish such developmental phases in cross- and longitudinal-section must remain empty speculation because we will never be able to reconstruct perfectly the attitudes of the child up to the age of five. Those who refer only to the analytic reconstruction of childhood are to a certain degree right, even if we respond to this objection by pointing out that the best established part of Freud's theory, the theory of the developmental stages of the libido, was developed in just this way, and that everyone can convince themselves of the correctness of this theory, that is, the precise sequence of oral, oral-sadistic, anal-sadistic, and genital stages by the direct observation of children. But our schema of the development of the superego in phases, expressly labeled as provisional, is

[214] See Chapter III.
[215] See. Reich, W. (1925b).

based only to slightest degree on analytic reconstruction; it is supported, rather, by our experiences in the treatment of impulsive characters, and particularly in the analysis of their ambivalence conflicts and transferences. Their superego structures changed continuously in the course of analysis, {106} corresponding to the state of their transferences. Since the latter is a precise copy of early object relations, we are thus able to gain a deep insight into the development of the infantile ego, especially since *The Ego and the Id*.

We conclude this section with reference to a more general problem: self-love ('secondary narcissism'), in the sense of Freud and Tausk[216]) and object love are the *life-affirmative* (life drive) elements in man, guilt (need for punishment) is the *life-negative* (death drive) element. They stand in opposition to each other. Occasionally guilt transforms self-love into a more primitive form of narcissism, the *primary narcissism* [*Urnarzißmus*] of the womb situation. The suicide of the melancholic is the prototype of this kind of merging. But ontogenically, guilt develops later than narcissism which is why the life affirmative tendency predominates. A completely developed narcissism, sustained by an unambivalent genitality, is the best defense against guilt. It is of decisive significance for man's fate *in which developmental phase of narcissism guilt appears*, thus *weakening the life-affirmative tendencies*. It seems certain that the severity of an illness depends on how early guilt begins to exert its life- and reality-negating effects. We must count this equation [of the severity of illness with the early establishment of guilt] as empirically the most difficult to demonstrate, but also as one of the central problems of the specific etiology of mental illness. {107}

VI . Some observations on schizophrenic projection and hysterical splitting

Our hypothesis of an isolated superego proves to be heuristically valuable in two directions: it

[216][Freud, S. (1914a), pp. 64-65; Tausk, V. (1933), p. 543.]

helps us understand more precisely the dynamic determinants of projection in the schizophrenic and of the splitting of the personality in the hysteric.

Our genital masochistic patient developed an acute (hysterical?) psychosis upon learning of the death of the physician who had first treated her and become a mother image to her. She had auditory and visual hallucinations of 'Mommy' knocking on her door at night and calling her to join her in the grave; during a session she saw 'Mommy' in the grave beckoning to her. She heard voices calling out to her that *she must not masturbate* because 'Mommy' would not tolerate it. She spent hours anxiously praying in front of a picture of the deceased and saw it moving. We have good reason to assume that the same mechanisms underlie these hallucinations as underlie schizophrenic projection: in both cases of projection an agency of the ego, the ego ideal, appears or better, *re*-appears in the external world, as, e.g., the persecutor and critic do in paranoid schizophrenia. The mechanisms of introjection have been reversed. It is only {108} logical to assume, then, that *those fragments of the personality, those ego ideals, that most readily and easily experience the fate of paranoid displacement from the ego into the external world* are those fragments and ego ideals which are not intimately fused with the rest of the personality but *persist as isolated components of it*. The fact that the contents of the delusional projection, whether it be in the form of delusions of persecution or a paranoid hallucination, also include drive impulses (mostly of a homosexual nature) condemned by the ego does not contradict our interpretation of the matter. Here the patient is behaving like an innkeeper who has thrown out two guests who are beating each other up; he still has to put up with the racket outside the door. The situation in the clinical phenomenon of resistance is similar: both sides of the conflict, the repressed and the repressing, are present (Freud).

Our hypothesis partially solves a problem which has always been linked to Freud's thesis of the projection of homosexuality in the paranoid. The latter was understood, from the economic point of view, to be an attempt at discharge: 'I don't love him—I hate him—because he persecutes me'[217]. But this economic explanation does not explain precisely why the

[217]Freud, S. 'Psychoanalytische Bemerkungen Über Einen Autobiographisch Beschriebenen Fall von Paranoia (Dementia Paranoides)' (1911b) ['Psychoanalytic Notes on the Autobiographical Description of a Case of Paranoia Dementia Paranoides)'], *RSE*, Vol. **XII**, 2024, pp. 9-71. See also 'Über Einige Neurotische Mechanismen Bei Eifersucht, Paranoia Und Homosexualität' ['On Some Neurotic Mechanisms in Jealousy, Paranoia, and

paranoid schizophrenic uses projection in an attempt to discharge his drive tension rather than attempting to repress the drives in the typical way. We must now assume that this projection is facilitated by an unattached part of the ego which points the {109} proscribed impulses precisely to this specific way of coping. A defect in the development of the ego— an inadequate fusion of its components—yields a disposition for the ego ideal, whose contents were *borrowed from the external world*, to be delusionally projected back *into the external world*. Observations of the paranoid forms of schizophrenia teach us nothing as to the nature of this defect and its timing, and thus nothing as to the creation of the disposition to projection. The ambivalent nature of delusions of persecution in particular shows us that ambivalence plays an essential part in the process. The analysis of paranoid character neurotics can merely suggest a fixation point. But if our view of the genesis of this disposition is correct, we will have won a clue as to the timing of schizophrenic fixation, and we believe that we are justified in making hypotheses as long as they can explain phenomena.

Schilder once pointed out in a course that the loosening of ego ideals in schizophrenia explained, among other things, how such patients can be aware of the unconscious meaning of symbols. He raised the question, without being able to answer it, as to the timing of schizophrenic fixation. A line of thought running parallel to our work, closely connected to it and also focused on the question of the origins of the formal disturbances of mental life, begins with the refutation of the false assumption that one would find the stage of fixation of schizophrenia on the same path as those in melancholia (oral-sadistic), compulsion neurosis (anal-sadistic), and hysteria (genital). First, in investigating the fixation point in schizophrenia, great significance must be attributed to the formal disturbances which characterize the disorder; secondly, it must not be {110} lost sight of that in schizophrenia every manifestation of psychic illness (compulsion neurosis, hysteria, melancholia,

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Homosexuality'], *RSE*, Vol. **XVIII**, 2024, pp. 215-224.

hypochondriasis, etc) can be exhibited, though modified in a formal respect; and thirdly, the assumption of a narcissistic fixation is much too broad to have an exact meaning. In the final analysis, it is a question of *a definite stage* of narcissistic autoerotic development, presumably the stage in which the bridge between the primary ego and object is first created[218], the first identifications[219] ensue, and reality testing {111} is established. The fixation resulting in schizophrenia must be sought in the phase of the first identifications with objects.

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Another way the ego fulfills its task as mediator between the superego and primitive tendencies (in contrast to the expulsion of the superego by way of delusional projection) is by means of the *hysterical splitting* of the personality (*Janet's 'double conscience*'). What occurs here is not that the two antagonists are ejected from the ego (which after all is a clear decision, even though the effort never achieves its goal), but that *the ego alternately identifies itself with one antagonist and then the other*. Thus, *while masturbating*, which we must regard as a hysterical altered state, our nymphomaniac patient completely identified herself with her punitive mother while her pleasure ego identified itself with her genital. *Apart from these altered states*, she played the role with suitable people of a little child: she tried to cling to the doctor, the nurse, etc, and became extremely sullen and swore if she were rejected. She entered into innumerable incestuously-tinged relationships looking for a man—the father with a long penis. When she tried to have intercourse, however, the figure of her mother intervened, first in the form of voices calling her a 'filthy whore' and then in the form of a

[218] *J.H. van der Hoop's* article, 'Über die Projektion und ihre Inhalte' ['On Projection and its Contents'], *IZP*, Vol. **X**, 1924, pp. 276-288) was published after this manuscript was already completed. Starting from different premisses, the author arrives at similar conclusions to ours as to the nature of projection: 'Schizophrenia must be regarded psychologically as a state of intense introversion in which an ever-greater regression leads the mind back to an infantile-archaic phase of development characterized by minimal or no separation between subject and object, whereby projection can exert an extremely powerful influence on the clinical manifestations' (p. 288). On the other hand, intense introversion does not suffice as a basis of explanation because introversion itself is only a consequence of a fixation at this phase.

[219] To avoid any misunderstanding relating to our considered use of the expression 'first identifications', we must remember that, with Freud, we have distinguished two phases of identification: *1)* identifications before any clear object choice ('*narcissistic identifications*'), as discussed in *Group Psychology and the Analysis of the Ego* (1921), and *2)* those identifications which ensue upon reaching the object stage and which lead to definite ego ideal formation by a giving up of the object, or as the case may be, to 'superego' formation by means of incorporating the object (*The Ego and the Id* [1923]). There is an inconsistency between the discussions in *The Ego and the Id* and in *Group Psychology*. In the latter, narcissistic identification is assumed to be a forerunner of object choice while in the former, an object cathexis is assumed to be an antecedent to identification. But it is only a seeming inconsistency because pre- and post-object libidinal identifications can actually merge together very well. Thus Freud writes in *Group Psychology* that 'Identification is the earliest form of emotional tie' (p. 97), and in *The Ego and the Id* 'in the normal course of events, the object choices which belong to the first sexual period concerning father and mother result in such identifications, thereby *strengthening primary identifications*' (p. 27). [Reich's italics.]

devil, who cursed her.

Elsewhere, I reported the case of a woman with hysteria who had twilight states which progressed to a chronic splitting of the personality. This case raised the suspicion that the split was actually an {112} attempt at healing. I have been able to convince myself of this in two other cases as well. In the pre-psychotic twilight states the patient on the one hand experienced a sexual seduction by a teacher for which she had otherwise been made amnestic; on the other hand, she also stimulated her breasts and dressed in her finest clothes, while ordinarily she dressed rather simply. Her ego submitted to impulses in the twilight states which were forbidden and thus totally repressed in her usual waking state, and placed at their disposal the means of motor discharge. In her customary waking state her ego was submissive toward her strict maternal superego which preached an asceticism. At the age of one she had already been prohibited from engaging in genital masturbation. It seems to me now that it is characteristic of such cases that the ego will fight on the side of what is proscribed by the superego at one moment and on the side of the superego at the next. The ego is thus the servant of two hostile masters: it loves both and wants to show allegiance to both. The conflict, however, is not resolved by means of a symptomatic compromise as it is in symptom neurosis; rather, the one side must know nothing about the other side (a split into two states of consciousness).

This patient also exhibited an extremely intense ambivalence toward her mother which dated from early childhood and which need not concern us further at this point. We would only mention that the positive strivings toward her mother were based on an intense oral tie and a desire for the womb, while the negative strivings were derived primarily from genital prohibitions which the patient experienced as severe castration threats. Thus, the situation is similar to that of our nymphomaniac patient with the essential difference that in the latter, full

drive satisfaction was never achieved in early childhood. {113} In the end, the patient handled the ambivalence of her ego toward its ideal by letting her ego die ('I have kissed Eva S. [that is, me myself] to death'; 'I am not Eva S., I am nameless'), or at least that part of the ego identified with the pleasure ego. From the beginning, the patient had behaved defiantly toward her mother: we must look for her tendency towards a split in this defiance and in the defective assimilation of the prohibiting maternal ideal which resulted. The expression 'kiss to death' displays her ambivalence very well. The clinical picture of a depressive, pre-psychotic individual who knew she was ill evolved initially into the clinical syndrome of hypomania: the patient's symptoms (insomnia and hysterical abdominal pain) disappeared and she felt well.

In the psychotic phase which followed, the patient told me that she now knew far more about Eva S. than Eva herself had known when she was alive. But she didn't want to tell me what that was. We understand this to mean that now she was allowed to know more about what had been repressed since, according to her delusion, it had belonged to Eva S., whom she had 'kissed to death'.

The predisposition to the development of a schizophrenic or hysterical split would therefore be traceable to the defective fusion of the ego ideals with the pleasure ego. The question as to the difference between the two forms of splitting remains an open one.

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A summary of the issues discussed so far can be roughly schematized as follows:

In schizophrenia with delusion formation and hallucinations, the ego has disintegrated due to conflict; the pressure of the conflict is relieved by way of the *delusional projection* of the ego ideal along with the forbidden id strivings. {114}

The ego in *hysteria with a splitting of the personality* attempts to resolve conflict by *successively taking sides* with each of its two masters while simultaneously being amnestic about the other party.

The ego in the *impulsive character simultaneous sides with both opponents*; conflicts are occasionally resolved by means of schizophrenic projection and hysterical splitting.

In contrast to the dissociation of the ego found in the foregoing clinical syndromes, the ego (that is, ego + superego) of the *impulse-inhibited character* or the *symptom neurotic*, as the case may be, is coherent and integrated. However, we do not wish to give the impression that we deny the existence of any conflict within the ego for those with impulse-inhibited neuroses. Certainly such conflicts exist, as for example between contradictory ego identifications. The outcome of these conflicts depends on whether they are of such a nature that the existing defense mechanism which is highly compatible with the current ego conflicts is adversely affected by the repression of the new conflict. {115}

VII . Therapeutic difficulties

The scope of mental disturbances treated by psychoanalytic therapy has been widening ever since its inception: while initially focused only on the treatment of hysteria, it soon came to encompass obsessive compulsive disorder as well and proved to be the most effective method of treatment for this condition. Freud and Abraham have already attempted the treatment of melancholia and the cyclic states related to it. The outcome of these treatments is not yet clear. The situation is similar with regard to the first cases of schizophrenia under treatment. While it is true that one finds no reference in the psychoanalytic literature to the idea that it may be possible to treat schizophrenia analytically[220], or to successes which may already have been achieved, one also hears here and there in analytic circles that the idea that it may be

[220]Meanwhile, a commendable attempt to clarify the theoretical requirements for the treatment of schizophrenia was recently undertaken by Wälder, R.: 'Über Mechanismen und Beeinflussungsmöglichkeiten der Psychosen' ['On the Mechanisms of the Psychoses and their Potential for Treatment'], *IZP*, Vol. **X,** 1924, 393-414.

possible to treat this most severe form of mental illness analytically is not to be dismissed out of hand. Because it is a psychoanalytic axiom that we can {116} only change what we understand, the first task will be to determine precisely the requirements of such a treatment. This is not possible in advanced cases of institutionalized schizophrenics. At present only early cases are suitable for this, or at least only such cases as, without being 'fully developed' schizophrenics, still display typical schizophrenic mechanisms along with a strong transference neurotic position; thus, cases like our patient with the end-of-the-world fantasy. Our present inability to influence the schizophrenic is attributed both to his incapacity to form a transference and to defects in his ego ideal. The analysis of the impulsive character, therefore, presents a matchless opportunity to discuss the conditions of treatment and the typical difficulties associated with it.

'Inside the man there hides a child who wants to play.'[221] Thus Nietzsche anticipates Freud's classical formula for the neurotic conflict. In analysis we appeal to the 'man' as we set about taming the 'child', the unconscious, the infantile, which rebels against reality. Our therapeutic efforts remain unsuccessful so long as the man does not want to take up the struggle with the child; we triumph if we succeed in getting the man to side with us in helping him to confront the 'child', either to raise it anew or to allow it a certain controlled freedom. The greater part of the personality of the transference neurotic very quickly comes over to our side and identifies itself with our therapeutic efforts. This is certainly not the case in the impulsive character. Even his ego has remained more or less infantile. All of the difficulties in treating this condition psychoanalytically follow from this difference in psychological structure. {117}

The first difficulty we typically encounter is a *partial or total lack of insight into illness*. While the symptom neurotic comes to treatment with an awareness of being ill and is motivated to open up to the analyst even before a transference is established, the impulsive character is at first unaware of the essential issues that trouble him. Even in simple transference neurosis insight into illness at first extends only as far as the disturbing symptoms and there is not usually an awareness of neurotic character traits. Symptoms are a means of accessing the pathogenic material that is acceptable to the patient in the treatment situation; gaining greater insight from this beachhead then becomes a fairly easy matter. It is different

[221][Nietzsche, F., (trans. Tille, A. and Bozman, M.) *Thus Spake Zarathustra,* Dent Dutton, 1933, p. 57.]

with the impulsive character.

The attitude of these patients is mainly one of suspicion. Sometimes they can't be induced to talk at all. If in the first conversation one succeeds in winning his confidence, for example by taking his side and not the side of his perceived adversaries, or by completely avoiding moralizing, then one can quickly determine whether the lack of insight is more profound, as, e.g., can be found in cases of patent schizophrenia, or whether the intense, current conflict might simply have driven the patient into a situation where he was compelled to assert his position against a stronger opponent with hysterical fits, crying spells, tantrums, and similar behaviors. In the latter situation the adversary is usually a not particularly insightful or flexible person who represents the viewpoint of the care-giving husband or father, and is himself severely neurotic. Rationalizations have been able to get a firm foothold in this setting and it is futile to put up a fight against them. What mostly helps is a change in milieu or separation from the adversary; analysis {118} is usually difficult to undertake, especially in those without means.

Insight into pathological manifestations, whether symptom or character trait, can thus only exist if the ego is on the side of a superego which sharply and successfully rejects impulse ridden attitudes and behaviors. But if the superego is of a type that is aligned with a pathological attitude, if it remains isolated, or if the symptom lacks the character of the irrational or absurd, then insight is also lacking. Thus, our patient with the end-of-the-world fantasy was completely lacking in insight regarding her behavior toward her mother because her superego was borrowed from her father who acted in just the same way. Because the superego of our genital masochistic patient remained isolated from her real ego ('You must die from masturbation'), she also lacked insight into illness. Indeed, one may occasionally encounter a lack of insight even in patients with circumscribed hysterical symptoms. Thus, a

patient with hysterical vomiting who was embroiled in an intense conflict with her sister-in-law thought that it was only natural that she would vomit after such agitation.

Different paths lead to the gaining of insight. For example, a strong transference may lead to an identification with the analyst, in turn leading to the transformation of behaviors hitherto not perceived as impulsive into typical compulsions. Thus, as our genital masochistic patient became conscious of her deeply repressed hatred toward her mother, the mother's curse that had accompanied masturbation faded away but the impulse to masturbate now behaved like a typical compulsion: she experienced guilt, condemnation, and the onset of anxiety {119} whenever she tried to suppress masturbation. Her punitive behavior and invective toward the genital stopped during this phase; she began to masturbate with fantasies of heterosexual intercourse and experienced corresponding guilt. The old ego ideal had transformed such that it was now able to function as an effectuator of condemnation.

In the case of the patient with end-of-the-world fantasies the transformation from attitude to symptom was even clearer:

Because of unfortunate experiences with similar cases, I had zealously avoided behaving in any way that would remind her of her father or mother, that is, I refrained at first from any prohibition or intervention in her activities. Had I not, it would have immediately and *insurmountably* heightened her ambivalence toward me. I restricted myself at first to making clear to her without further analysis— which, incidentally, would have been impossible anyway—that all of her actions were simultaneously acts of vengeance: she had endured a great deal because of the behavior of her parents, her older (and prettier) sister had been favored by them over her, and now she was trying to 'turn everything upside down' in the household out of vengeance. I expressed the point of view that while she was absolutely right, she was actually ruining herself with her vengeful actions. This initially provoked a violent defensive reaction. Gradually, however, the positive transference began to prevail; eventually she told me that she agreed with me and began *tentatively* to act in a calmer way. Though she was only able to manage this by an immense effort of self mastery, the mere attempt was evidence of progress. Her old behavior broke through again after two weeks. Now I explained to her that her parents would end the analysis if she did not behave more calmly at

home (this was a valid assumption). The transference was now strong enough that she feared the loss of the treatment. *Now for the first time she experienced her sadistic outpourings toward* {120} *her mother as compulsions which troubled her*. She began to see the futility of her behavior; she herself linked her guilt, which was anchored in the end-of-the-world fantasies, to her sadistic impulses. But now that she had restricted her sadistic eruptions, the situation became critical; they began to turn against her self and she wanted to take her life.

It is typical in such cases for the emergence of insight into illness to lead to a crisis of this type. I had a similar experience in two other cases: *if insight into aggressive actions against the surroundings emerges in such a way that guilt,* which is always present*, is correctly linked to the aggression, then suicidal impulses break through*. Our patient reported the following verbatim: 'I can see that I've been acting crazy to get my parents' attention and respect. I feel so inferior (the rivalry since childhood with her older sister), if I lose that what is left for me?' The patient clung to this secondary gain of her illness for a long time.

The ego ideal changes as a result of the analysis of the object relations which underlie it. When the original object is devalued, which is partly an intellectual process but mostly takes place by way of the new connection with the physician, then the old superego is also deprived of its dynamic foundation. The acquisition of insight into illness occurs more or less typically in the following phases:

1) *The phase of lack of insight*: the pathological reactions are in accord with the effective superego, or the isolation of the superego from the ego {121} enables the complete submission of the latter to the impulsive strivings.

2) *The phase of a growing positive transference*: the patient makes the physician the

object of his libido. This pushes the old ego ideal back to the object stage; any narcissistic libido bound to the old ego ideal is transformed into object libido. Insofar as the new object, the physician, represents the viewpoint of the reality principal, he can become the foundation of a new superego and can also explain how the pathological attitudes, which hitherto had been unappreciated as such, are hostile to reality.

3) *The phase of effective insight into illness*: a part of the new object which, incidentally, is strongly incestuous in nature is introjected and made into the new ego ideal; the old ego ideal, together with its source, is condemned. Only now can a proper analysis be conducted.

In the first phase, patients immediately transfer their attitudes and aggression into the analytic situation; hate, suspicion, and ambivalence, however, threaten to make every attempt at analysis futile. Suspicion and ambivalence are also typically seen in compulsion neurosis, but there they merely result in a rejection of the analyst that is usually accessible to analysis. In the impulsive character they result in action. The analyst becomes a virulently hated enemy whom the patient wishes to kill. The last patient discussed in Chapter V[222] made a detailed plan to ambush and shoot me in the street. She went to a gun shop to buy a revolver.

Where the actions are dictated not by hate but by a longing for love, they likewise display all the characteristics of a {122} defective ego ideal. Love is demanded openly and there is no appreciation of the transference nature of the feelings, despite the analyst s efforts to remind the patient of them. Our nymphomaniac patient was prevented only with difficulty from disrobing and masturbating during sessions. Another patient quickly developed the unshakeable belief that the physician would have a relationship with her. When she was expressly told that such a relationship could never happen, she broke off the analysis. A patient demanding homosexual intercourse from me flew into a rage when he was refused, threw the cushion at the wall, thrashed around the couch with his legs, and was calmed down only with difficulty. Similar transference manifestations would be inconceivable in a simple transference neurosis. Here the transference is only conscious in the form of intimations of an affectionate nature; sexual wishes tend either first to crystallize out of dreams or be

[222][See pp. 92-95.]

immediately condemned as soon as they have become conscious.

Impulsive characters are usually involved in acutely conflictual relationships with parents or parent images, and are in general people who have repeatedly experienced severe disappointment; these conflicts are brought into the analysis under the influence of the repetition compulsion. Provided that what is repeated stays within reasonable limits, one can spare patients further disappointment. One can be friendlier and more accommodating with them than they are usually accustomed to from their environment. But how should patients be treated if they create situations which are completely intolerable? The nymphomaniac patient I have cited so frequently as paradigmatic of the impulsive was brilliant at making me be strict with her. At the end {123} of sessions she would often declare that she did not want to leave. Gentle coaxing didn t help. She only left when I told her that she would be forcibly removed, crying or frequently screaming that I was too strict with her, that no one loved her, that I was punishing her, and the like. She experienced the encounters masochistically and would masturbate fantasizing about them. After months of hard work, I had finally helped another patient to the insight that the only reason she was always late for sessions, behaved disobediently, etc, was because she wanted to be beaten by me. She frankly declared that she had always known that and that she was only testing my patience as she did her father's, whose beatings she enjoyed.

Criminal impulses must be strictly prohibited, if necessary backed by the threat of breaking off the analysis. One must work with a much stronger transference than usual if one is at all to suppress the enactments. We must contrast this Scylla with the Charybdis of the possibility of creating an insoluble fixation, especially in masochistic patients. Experience has taught me that extreme cases of the latter may be untreatable. The only thing that works to any extent is *daily* discussion of the transference, with a strong emphasis on the hopelessness of the

patient's wishes even partially being fulfilled in the treatment[223]. The transition described in the third phase succeeds quite well in milder cases. The inability of intensely infantile patients to associate in sessions is one of the biggest difficulties encountered. They either cannot or {124} will not understand what is being asked of them[224]. Their tendency toward enactment also stands in the way of association work. If one is able to bring a patient to the point of free associating and beginning the memory work, if only occasionally, one confronts a new difficulty which I will now describe.

The nymphomaniac patient's ability to work had been restored to her over the course of over a year of analytic work. A six-week vacation break had the favorable effect of partially weaning her from the physician; her enactments had lessened and the memory work had progressed well over a period of three weeks. The patient remembered incest wishes from ages two and three for which she had been completely amnestic. Then her 80 year old father with senile dementia returned to Vienna. The patient became agitated, felt increasingly guilty, and fantasized having intercourse with him. As excessive as these manifestations were in this case, they occur in a similar though attenuated way in the typical impulsive: the *forbidden wishes were not condemned upon coming to consciousness as regularly occurs in simple transference neuroses, but pressed for discharge.* The degree to which the ego ideal has been consolidated determines how frequently this occurs.

The theoretical formula would therefore read: *ego analysis precedes everything else in cases where the ego ideal is defective.* As nice and neat as this theoretical prescription sounds, {125} in practice things are always much more complicated. In the first place, we know nothing today about what so-called 'ego analysis' would look like; we doubt that it can be separated at all from the rest of analysis[225] , as long as the latter doesn't mean crude suggestion without regard to psychic determinants and associations. Nothing can be done with our cases without encouragement and persuasion, especially in the beginning. Educational interventions must prepare the way for a proper analysis. But we would lapse into the grossest error and

[223]The recent attempts to deal with this kind of intense masochistic fixation by systematic interruption of the treatment ("weaning from the doctor") cannot be reported as yet due to the incompleteness of the results.

[224]The way that many intellectually defective impulsives lose their 'debility' as their egos are reintegrated raises the suspicion that even intellectual defects can be based on psychic conflict.

[225]The theoretical elements of 'ego analysis'—which are also easy to appreciate clinically— such as the analysis of identifications (especially superego identifications), the analysis of narcissism, etc., at present cannot in practice be separated from the analysis of the libido transference. The libido transference is the main vehicle of the analysis of the ego.

would only be displaying a fundamental ignorance of mental dynamics if we separated out this introductory phase and contrasted it to analysis proper, perhaps under the rubric of Psychagogic [Psychogogik[226]]. It could be pointed out to us as we would readily admit that the uncovering of repressed impulses in such cases is accompanied by a drive for motor discharge which contraindicates analysis. We would even advocate such purely educational measures if we could convince ourselves that they were able to achieve what analysis could not. While Aichhorn's (loc.cit.) reports of his educational work with antisocial youths are extraordinary, his antisocials are not identical to our impulsive characters even if there are abundant similarities. Secondly, no physician and certainly no institution can permit the cathartic destruction of furniture by patients. Thirdly, anyone who has had anything to do with such patients will acknowledge that they are distinguished precisely by their inability, {126} certainly in the long run, to accept persuasion [Persuasionen[227]] (defiance!!). We conclude, therefore, that educational measure are always necessary in order to make at all possible the analysis which follows. We must leave open for now the question as to how to prevent the breakthrough of the impulses from being so harmful. We do not yet have sufficient experience to know how they may be safely released. The general rule is that the work of uncovering the unconscious must proceed only very slowly and carefully, and may even have to be interrupted, especially when schizophrenic mechanisms are part of the clinical picture.

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[226]['Psychogogik' was a school of therapy current in Germany in the early 20th century that stressed an educational approach to the therapy of the neuroses. It overlaps to some degree with current psychoeducational, suggestive, and behavioral approaches. See. Kronfeld, A., *Psychotherapie: Characterlehre - Psychoanalysis - Hypnose - Psychagogik* [*Psychotherapy: Characterology - Psychoanalysis - Hypnosis - Psychagogic*], 2nd ed., Springer, 1924, esp. pp. 274-297.]

[227][Reich is probably referring here to the therapeutic school, known in Germany and Austria as Persuasionstherapie, associated with the Swiss psychiatrist Paul Dubois, whose *Les psychonévroses et leur traitement moral* [*The Psychoneuroses and their Psychological Treatment*], Masson, 1904, favorably contrasted rational persuasion ('persuasion rationelle') to the mere passive acceptance of authoritative suggestion. Kronfeld (1924) used Persuasiontherapie as a component of his Psychagogik; see p. 296.

In this part of the chapter, Reich is arguing that psychoeducation, persuasion, and (implicitly) suggestion, are but valuable adjuncts to a psychoanalytic approach, which he considers the definitive treatment for the impulsive character.]

The only conceivable means of dealing with socially dangerous impulsivity does not presently exist: *treatment in a psychoanalytic facility* . Nowadays, with a few exceptions, psychiatric institutions are merely internment facilities set up for the protection of society. The patients themselves are an afterthought. If one follows the fate of people who have been hospitalized psychiatrically one discovers the following: the patients is first hospitalized for a suicide attempt, gets discharged, sooner or later makes another attempt, and gradually develops a curious attachment to the hospital. Each time the suicidal impulses are more intense and more dangerous until either an attempt succeeds or the patient is chronically hospitalized as a 'psychopath' or schizophrenic.

Psychoanalysis has shown how much environment, material want, the poor judgment and brutality of parents, a conflict-ridden upbringing, and surely constitution as well, transform children into antisocial, sick and warped adults. Mankind protects itself from them by interning them, which under present conditions always makes matters worse. But should 'the conscience of humanity {127} awaken'[228], should it wish to make amends for what so many of its representatives have done to such patients, then psychoanalysis will certainly be the first to be called upon, under better conditions than today, to collaborate in the relief of neurotic misery. {128}{129}

[228] [Although in quotes, this phrase appears to be Reich's own.]

NAME AND SUBJECT INDEX

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