PSYCHOLOGICAL DIFFERENCES BETWEEN THE PSYCHOSES, PSYCHONEUROSES AND CHARACTER FORMATIONS.*

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PSYCHO-ANALYSTS and other psychiatrists agree, I take it, that there are multiple causes for every mental breakdown. The exciting cause may not always be discoverable, but would be sought, if wanted, in the period immediately preceding the onset. Contributory causes can occur throughout life, from birth to the date of onset. It is agreed, also, that in addition there must be a predisposition (though the strength of this as a causal factor varies, roughly, in inverse proportion to the others). It is in the localization of the predisposing (and specific) factors that authorities differ. The older psychiatrists confined it to the lifetime of the ancestors; psychoanalysts accept, in general, what they have been told about ancestral responsibility, but have focused attention, as regards predisposition for subsequent breakdown, on a later period, namely the first five or six post-conceptional years. This they regard as the developmental period of the psyche, and they consider that influences at this time modify the organization in process of formation in a way that cannot occur later, but is not entirely predetermined in the germplasm. The difference is not merely temporal but also qualitative, for while other causes are mainly general (with perhaps some exception as regards heredity), the infantile predispositions are specific. That is, they not only partly determine liability to a breakdown under stress, but play the chief part in determining the kind of breakdown to be expected should one occur, and also the basic layers on which various character formations are built, although the superstructures may be very varied.

The organism at birth has, as a rule, completed physical development in certain respects, *e. g.*, heart and lungs. As regards psychic organization, this, according to analysts, is not so. Tendencies are inherited, but the psyche is not complete for a few years, first placed

* An opening paper (somewhat abridged for publication) read at a Study Group Meeting held on May 7, 1929, under the auspices of the Psycho-therapy and Psychopathology Sub-Committee.

https://doi.org/10.1192/bjp.75.311.671 Published online by Cambridge University Press

by Freud at five, though opinion seems likely to place it earlier rather than later. We do not know the exact physiological equivalents—cortical association tracts, endocrine habits, etc.—to this organized psyche. During the formative period the child reacts to stimuli, often received in the form of conflicts, some of which are biological and unavoidable and some of which are accidental, and by the way in which he does so, acquires certain characteristics and susceptibilities. If the psyche is weakly organized it will break down easily; if it is strong, it will withstand much. In either case the way in which it will behave if it breaks down is thought to be determined by the primitive conformation and developmental fixations, as well as the broad lines on which character peculiarities are based. An analogy might be found in a melanotic sarcoma developing, owing to irritation, from a pigmented mole. But the psychic "mole" is partly a post-natal growth. The mole does not determine malignancy, but determines that the malignant tumour will be melanotic. Perhaps the above shows that there is much agreement as well as divergence between the various schools. These primitive organizations formed before the latency period are not easily changed, but they are not immutable. Psycho-analytical therapy is a method of changing them through regression under control. This can never occur from intellectual introspection, but I wonder if in the occasional cases where after recovery from a psychosis there is better internal and external harmony than before the attack, there may not have been a process of re-living going on in the unconscious, comparable to a partial self-analysis?

Psycho-analysts would, I think, agree that our three groups are modes of combating disturbance. Without encroachments on passivity, or the power to make psychic adaptations in response (as in the low-grade idiot whose defences are confined to reflex movements repeated without change) I cannot conceive of any psychic organization occurring.

The nature of the stimuli does not determine specific differences in the eventual outcome. That is to say, not that these stimuli are identical, nor unimportant for a full knowledge of the psyche, for the prediction of future danger-points, or for the cure of disease, but that we cannot tell by knowing them what types of disorders or developments are most probable. It is knowledge of the particular mode in which the individual has reacted that helps to give us this information. Everyone has to overcome or compensate for the problems of adjustment to the environment represented by the Œdipus situation and the fear of deprivation comprised in the castration conflict. The different ways in which this is done may be partly determined by inheritance, and greatly, I think, by the

developmental stage with which the psyche is preoccupied at the time of disturbance.

Attention is directed to three parts of the mind which supply the elements of the earliest conflicts. There is the *id*, the source of primitive instincts; the *ego*, which regulates both instinct discharge and response to external stimuli, stands between the id and the outer world, is the storehouse of memories and is capable of feeling instinct tension and also of being modified by external environment; finally there is the *super-ego*, formed by introjection of parental characteristics from the environment.

Conflict may arise between the pleasure-principle of the id, the reality principle of the ego, and moral pressure from the super-ego. Within the id there may be conflict between hate and love and between different modes of instinct gratification, particularly the conflicting aims of pre-genital libido trends if these do not fuse harmoniously, and of the desires aroused by the development of object-relationship from the auto-erotic stage, through the narcissistic, on to the outer world.

To regard our three categories as modes of solving conflict is somewhat contrary to the ordinary social attitude. Clinically mental derangements are maladaptations, and the more pronounced the worse. But to the individual suffering from psychic conflict they are attempts to cure internal anxiety and distress, and the further advanced and stable the condition, however socially abnormal, the more complete the cure from this aspect. The psyche must be enabled to endure the environment, or the environment must be shut out. The "cure," *i.e.*, disorder, may be painful, but the unsolved conflicts are dreaded more.

To sum up: *Primitive* conflicts lead to a psychic organization which may be healthy or distorted by various degrees and types of fixation and lop-sided development. *Later* conflicts which give rise to mental abnormality do so by disturbing this organization, and causing the individual to regress psychically to an extent determined by the primitive fixations, and to put up various other defence mechanisms, such as dissociation, projection, etc. These together constitute the symptoms. The later conflicts to which the subject is most susceptible are those which are most closely associated with such primitive conflicts as have been incompletely solved.

A completely developed *normal character* I conceive, roughly, to imply internal and external adaptability, harmony between and within the three constituents of the psyche, an ego capable of enjoying full gratification or tolerating tension and frustration, and a fully mature libido able to give the ego love satisfactions in object

relationships, either direct or in sublimated form, without fixation or ambivalence. While this is the most stable solution and the one best able to adapt to new situations, character formations which cannot rightly be called pathological may include derivatives from lower stages of libido organization which have been satisfactorily sublimated.

Where the primitive organizations formed in response to early biological and environmental pressure break down, new defence mechanisms are required, and these bring about the symptoms of psychoneurosis or psychosis or the peculiarities of abnormal characters.

In differentiating, then, we have to consider the psychic organization to which infantile occurrences acting on inherited predisposition have given rise, and, in addition, the defence mechanisms used when this breaks down—such as repression, displacement, dissociation, projection, introjection, condensation, phantasies, etc.

I think the accepted psycho-analytical position might be summarized thus: As regards libido *aim*, the fixation is at a lower developmental stage in the psychoses than in the psychoneuroses, (Psychoses: first and second oral and first anal; psychoneuroses; second anal, phallic, genital. This means predominance quantitatively, and never involves every scrap of libido.) In *object*-relationship dementia præcox may regress almost to an auto-erotic stage, and in other psychoses narcissism (hyper-cathexis of the ego) is prominent as compared with the psycho-neuroses. Differences in libido aim or object do not differentiate the character groups from the others, as this category includes fixation at any of the levels. Another distinction is that the destructive impulses (whether directed against the self or the environment) are as a rule stronger in the psychoses than in the psychoneuroses. As regards localization and mechanisms, *ego* changes predominate in the psychoses, *id* changes in the psychoneuroses. This means, roughly, that in the psychoneuroses the repressed material returns in a distorted form which has made it acceptable to the ego, while in the psychoses the ego is so changed that it will either tolerate uncritically, or not recognize as arising from itself the previously repressed impulses and phantasies. There are also important *transference* differences involved in the predominating narcissism of psychotics.

In considering the subject, the question arises whether a broad distinction in psychiatry between so-called psychoses and psychoneuroses is justified, apart from clinical diagnosis. I mean, after having diagnosed a case as predominantly of the species paranoia, and not dementia præcox, hypochondria, hysteria or obsessional

neurosis, are we further justified in saying that the first three have psychological features which distinguish them from the last two? I think we are, though perhaps we exaggerate the distinction. But it seems rather strange that we should be, for our classification of psychoses follows in the main that of Kraepelin, based on clinical observation of end-products, while with the psychoneuroses, most follow one derived from considering psychological processes.

It says much for the genius of Kraepelin that when we seek to study deeper psychological mechanisms in psychotics, we are able to do so to such a great extent within the framework of his classification, showing that his observations, for the most part, emphasized types of behaviour that were the product of deep divergences. There will, naturally, be some changes, but to consider these would, I think, rather side-track the present discussion.

On clinical grounds alone the distinction, though useful in practice, would be difficult to maintain. We could not do so in the matter of gravity of behaviour disturbance. In all large mental hospitals, I suppose, the certified cases include some hysterics and obsessionals, and certainly in private practice we find uncertifiable cases, both early and advanced, that are genuinely psychotic. For example, mild, chronic cases of dementia præcox that drift aimlessly through life. Prognosis is also no sure ground, if we leave aside our own power impulse which seeks to modify. If we consider spontaneous recovery without specific treatment of, say, cases of simple mania, melancholia, or acute confusional as compared with anxiety hysteria or obsessional, the balance of probability as regards completeness of recovery is surely with the psychoses. (I wonder whether the appearance of normality during the intermissions in manic-depressives may be connected with a close relationship to character construction with which it fuses? This is merely a passing idea.)

Psychotics, then, have more effective mechanisms for protecting themselves from disturbers while absorbed in their psychosis (though we may learn to pierce the armour), but are not necessarily more firmly or permanently entrenched.

The terminology is admittedly unsatisfactory, and perhaps instead of calling them psychoses and psychoneuroses, Adolf Meyer's "reaction type" would meet the case, with an appropriate adjective, *e.g.*, ego reaction types, libido, narcissistic, projection, transference, etc., depending on what basis of distinction was adopted.

Another clinically distinguishing feature is said to be *insight*, supposed to be present in psychoneurotics and absent in psychotics —and I would add, following Ferenczi, in character formations. (We may admit to having a troublesome symptom, but our

characters are just ourselves, what we are!) The distinction is only partially true. Insight is often very superficial in psychoneurotics, while most early psychotics know at least that they are mentally ill, while some, especially among manic-depressives, retain a detailed insight into the clinical processes going on (and yet some of the same species are entirely without). I remember one whose recurrent mania had necessitated confinement for many years, who retained it to a remarkable degree. In discussing, during a mild depressive phase, a homicidal outbreak in which she had attacked another patient and was only prevented from injuring her by "*force majeure*," she raised the point of her legal position had she succeeded, remarking, "I knew what I was doing and I knew that it was wrong." Surely this is insight? Moreover, sometimes it appears in curious flashes where least expected, only the patients use their own methods of telling one that they recognize the pretence. Such, I think, was the intention of the patient who remarked that it was a good thing she journeyed every night to the beautiful places she had just been describing, as otherwise she might find life in hospital very dull. Still, I admit that insight is less often present consciously in psychotics than in others. Naturally there can, by definition, be no conscious, critical insight into well-formed delusions. This absence of criticism is the result of the alterations in the ego to which I have referred, and to which I shall return again later.

I am not emphasizing diagnostic points, because I think the pigeon-holing and labelling part of psychiatry is rather a clinical than a psychological matter—a study of visible results rather than of underlying mechanisms which take so much longer to discover. In practice one switches one's mind from one to the other, and I am not sure that they are mutually helpful. Personally I have never regained the diagnostic confidence I had during my first few weeks at a psychopathic hospital at which this was stressed, when I was quite inexperienced, and was not distracted by other interests from observing the differentiating signs I had read up. However, in early cases, if we would recognize tendencies before outspoken manifestations have occurred, we must rely chiefly on psychological investigation. It is useful, too, in the matter of prognosis and in deciding whether a psychotic case is one in which psychotherapy is worth attempting. In this I think one would be inclined to attend more to the possibility of engendering some insight to work on, conscious or preconscious, than to the transference, provided that that were not too hostile or suspicious, because it is on the ego that the brunt of the disturbance falls.

Psychological considerations, also, would be used to recognize a combination of psychotic and psychoneurotic components in

the same case, as well as deciding whether this is a possibility. That is a matter about which opinions differ among psychoanalysts as well as other psychiatrists. I hold that such a combination is both possible and not uncommon, and that the same patient may at one time show a predominantly psychotic, and at another a psychoneurotic type of reaction, while sometimes the disturbing factors may be repressed or neutralized by sublimation or other phenomena of character-formation without symptoms. Mixed cases imply libido-fixation at more than one level. This is discovered by analysis in many patients, especially in their character components. It must be distinguished, however, from regressive re-cathexis (re-charging) of early developmental layers which occurs in various conditions (*e.g.*, physical illness), and always during the progress of an analysis which is at all deep. Examples of combined types are: Manifest tic with latent paranoia, conversion hysteria in combination with various psychotic conditions, an anxiety neurosis developing from the suppression of manic outlet. True, tic has some psychological characters in common with paranoia and the last is not a good example, for anxiety does not denote any special fixation, and symptoms in general are employed to quiet it. I quote it because in the case I am thinking of the changed condition was so clear and occurred under the influence of transference.

The contrary view would, I fancy, hold that the indications of psychoneurosis in a psychotic (or *vice versâ*) are apparent only—just as a hysterical paralysis may ape a peripheral nerve lesion. This is indubitably true sometimes—for example, the behaviour of a a dementia præcox may look very obsessional without his having obsessional neurosis, and both use ceremonials. Moreover, when we diagnose early præcox as hysteria, it is not usually that a hysteria has changed into a præcox, but that we have made a mistake.

Admitting true combinations, they might be explained from the libido side metaphorically somewhat as follows: An early fixation involved some libido, but a certain amount escaped. This did not all reach complete development, but some got caught up at a higher stage and is producing symptoms at that level. It should be remembered that fixation points are not absolute developmental blockings, but exaggerations or "sticky places," to which the organism regresses under stress; also that libido is conceived quantitatively as well as qualitatively. We have no means of measuring it, but by long analysis we get an impression of its intensity and concentration.

Among the psychoneuroses and between character and symptom formation (in both groups) mixed cases are commoner than pure cultures, so that the same is theoretically possible between the

psychoses and neuroses. It is rarer because, possibly, of the greater amount of libido which seems to be involved in a psychotic fixation, and the more massive and relatively "all or none" mode of reacting. This might be a point worth going into.

To return to the question of insight from which I digressed, its absence from consciousness depends, I think, on a change in the critical ego, but this conscious blindness seems sometimes to be combined with preconscious or unconscious sensibility. Some paranoids possess a good deal of intuition. They often consult doctors spontaneously about their troubles, which, rightly, according to them, should concern lawyers. Some, too, seem to have insight into the psychology of others, and a power to interpret symbols and dreams of other persons which is very interesting. Psychoneurotics on the other hand, may be very blind to what goes on below the surface. Though I would not go so far as to bring forward this matter of conscious insight with preconscious lack and *vice versâ* as a distinguishing feature between our classes, it does seem that the whole question of insight is more complex than at first appears.

A difference I would suggest as generally characteristic is that, in the psychotic changes in the ego permit repressed matter to be manifest for external inspection, such as symbols and other mechanisms, that in psychoneurotics are hidden, and only discoverable by the laborious method of analysis of dreams and phantasies, and thus arouse incredulity in non-analysts. It would be extremely interesting if some *verbatim* reports could be made of the contents of hallucinations and delusions to compare with dream analysis. I will quote two short examples. Freud describes the use of puns in unconscious associations. I remember a chronic melancholic who maintained that she caused the war because her name was Mrs. Germany. Moreover germs cause disease, and she was "Germ Annie."

Another woman gave me in a few short sentences a veritable epitome of Freud's theory of the regression of object libido. She was a deteriorated case who lay on a mattress and was incontinent of fæces and urine, and whom I had never before heard speak. One day she stared fixedly at me and said in tones of increasing ecstasy: "You're my husband. No you're not, you're my Master, Baden Powell. No you're not, you're Myself; I *love* you." She then pointed to her own eyes, nose, mouth and cleft in lip to show how alike we were. Having regressed to a vegetative, auto-erotic existence, she made, apparently, a jump forwards to an adult hetero-sexual attachment, fell back to a father-fixation, and then to a narcissistic homosexual level, at which she stayed for a bit. And all this practically in one breath!

From considering this accentuation of dissociation and projection rather than repression and distortion, I would like to bring forward and compare tentatively, for purpose of the discussion, another aspect of defence apparatus. The defence of the psychotic ego against disturbance caused by readmission of the dissociated or by intrusion from persons or things in the environment seems very strong, almost impregnable—much stronger than any single defence mechanism in a psycho-neurotic or even, though to a less degree, a character. This may be because the ego is too feeble to stand even quite mild tension and shrinks away or because the amount of libido involved at one place is so great that the subject would be overpowered by its release or from both causes together. In addition, it may be—though I suggest it only tentatively—because the mechanisms which the forces of resistance use to defend the ego from being disturbed by what is repressed and unconscious are fewer in number. Hence they must be very strong, for if one gives way, the whole psychotic structure may break down, and the ego be confronted with the original conflicts that caused the trouble without having gained any increased tolerance. (It is as if in the psychoses all the eggs were put into about half-a-dozen iron safes, and in the psycho-neuroses they were divided among more than a score of wicker hampers! I think this aspect of strength *versus* number is well worth thinking about when we study the psychology of various disorders, but it differs in degree among different types and individuals. I feel personally uncertain whether it should be regarded as a factor in our present grouping, or whether, as was suggested at the meeting, a classification on these lines might not cut across our categories. I can only say that the best examples I can think of of the "iron safe" type are among psychotics, and of the "wicker hampers" among the neurotics.)

The contrast was illustrated by two patients, both suffering from anxiety and having other superficial resemblances. Actually they were absolute contrasts. One was probably an early psychotic, and the other an anxiety hysteric who was about as far removed from psychosis as can be. Yet in the content of their mental processes there were striking points of similarity. Both had exhibitionistic tendencies (more repressed in the psychoneurotic than in the other, who had apparently sublimated successfully before his breakdown). Both had urinary phantasies and incest conflicts in the unconscious, and even used a similar phallic symbol (the nose), though in one it formed a delusion and in the other an association to a dream. The delusion always underwent hyper-cathexis after the patient had spoken of some actual sexual worry. In the psychotic these various

themes were evident in his life. There was a gallant, lover-like relationship to his mother, business success and happiness after his father's death and a conscious guilt-feeling about the happiness. The death had occurred shortly before his first breakdown. In his dreams there were manifest, instead of disguised, representations of crude instinct activity, such as urinary exhibitionism and incest, yet in ordinary life he was refined and sensitive, although he had become somewhat careless in his habits. It would have been very difficult for this patient to have been brought to realize interpretations sufficiently gradually to avoid excessive anxiety, and I failed to hold the case. Had I done so he might eventually have made a favourable response. His attitude, however, was one of fear and hostility; he attended very irregularly and soon broke off treatment. The hysteric, on the other hand, has behaved so far almost as a model patient. His difficulties are unfolded gradually, layer by layer, with some emotion, but no very alarming disturbance. His defence mechanisms are not too strong, but they are numerous, and the transference is mainly positive, but not too exuberant.

(The therapeutic test is relative only. "Wild analysis" with too vigorous uncovering is dangerous in all cases, whereas skilful handling may deal successfully with very explosive types. It seems, however, that the margin of safety is greater in some than in others, and I would suggest greater, as a rule, in psychoneuroses than in psychoses.)

Another case, not analysed, but reported verbally to me by Ferenczi, was a paranoiac who read something about the relationship of paranoia and homosexuality, and, after a while, apprehended it personally. He was at first pleased and interested, and then suddenly regressed to acute katatonia. Such a result from a merely intellectual approach could hardly occur, I think, in a psychoneurotic. I might mention a rather more fortunate illustration. A paraphrenic, either through the treatment she was having or through the natural course of the disease, seemed to have gained some understanding of and tolerance towards her internal complexes. One day I asked her if the voices she heard were like her thoughts. The effect was dramatic. She burst out laughing and called out excitedly, "Do you mean that they don't come from there at all" (pointing outward), "but from here"? (hitting her chest) And though I expressed myself as uncertain, there was marked improvement followed rapidly by acceptance with cure or recovery.

I now come to the vexed question of *transference*—a phenomenon so common in the psychoneuroses that they have been called "transference neuroses." It is sometimes said that psychotics do not form transferences. I cannot understand this, for that they

do seems obvious. Patients in mental hospitals continually become attached to members of the staff of the same or opposite sex, write them love letters, see resemblances to persons in the past, and so on. There is a difference, however, brought out especially by psychotherapy. In the case of psychoneuroses the conflicts are, by means of transference, worked through in the analytical situation. This seems to happen much less in the psychotics. Two possible explanations occur to me which are not mutually exclusive. First, that much of the transference is in the form of a narcissistic identification, as described by the patient who said, "You are myself; I love you." This is a hindrance to treatment, for the physician is introjected into the mental world of the patient and becomes part of him. Secondly, when real object-love occurs, it may be confined to the utilization of free libido, not involved in the psychosis, and therefore the origin of the symptoms is not discovered by analysing the transference to the extent it is in psycho-neuroses. It is therefore less therapeutically important, though sufficient friendliness is necessary for the patient to discuss his symptoms and perhaps to make some alterations to please the analyst. When mentioning transference in psychotics, it should be noted that their destructive tendencies often make it hostile.

In conclusion I would say a little more about the *character formations*. I have referred to "normal" character as including both those reaching an ideally complete development and those making adequate adjustments at other levels. In addition there are abnormal personalities, perhaps suffering more distress than many with outspoken symptoms, who cannot properly be described as definitely suffering from either psycho-neurosis or psychosis. These abnormal character types are of innumerable varieties, and include, for example, cases of general inhibition or inability to carry through intentions, timorous persons without actual phobias, "difficult" people, paranoid types, cases who repeat throughout their lives the cycle of short-lived success followed by failure (*e.g.*, fortunes or friends made and lost). I do not know whether to include cyclothymia, as it differs only from manic-depressive psychosis in degree. Perhaps the latter might be classed as an extreme character abnormality?

In considering abnormal character formations, the outstanding difference from the other two groups seems to lie in the circumstance that in the latter the trouble is more circumscribed, gathered together and encapsulated as symptoms, while in character states it is diffuse. We can liken symptoms to abscess-formation and the character conditions to a general toxæmia, while multiple symptoms (such as phobias) would be represented by metastases or pyæmia.

In practice we do not find such absolute differentiation as I have imagined for descriptive purposes. No person with pronounced symptoms can have an entirely normal character psychologically, for the existence of deep disharmonies of the instinctive life prevents it, nor is it probable even from a more superficial, pragmatic point of view, nor do we find abnormal characters entirely without circumscribed symptoms. It is not uncommon, however, for a person with serious symptoms to be otherwise pragmatically well adjusted and efficient, or for a pathological character to have few and quite mild symptoms.

As types to illustrate my thesis I quote a patient who had localized her intense conflicts to such an extent that though her phobias (trains, knives, etc.) were very severe and of long standing, the main character was quite exceptionally well adjusted, though some even of the adjustments showed that they had their source in the conflicts. Had she, without resolving her conflicts, failed to segregate the trouble, it is improbable that she would have managed so satisfactorily (when she was not actually in the throes of the anxiety) for herself and others. I compare this case to one who, though she achieved much with her life, was continually up against internal difficulties, disharmonies and fears, and yet was practically without localized symptoms. Among psychotics the most striking examples of localization are seen in paranoia—the "monomaniacs" of popular conception. I compare, for instance, the typical dissatisfied, disgruntled paranoid personality with a lady I saw in a hospital abroad who, though poor and unattractive, was happy in her certainty that she was really a beautiful princess, but spoke of it as little as most people do of their private beliefs. She slept in an asylum, but had parole, and being liked by children, earned a little money by taking them for walks.

In some cases, such as chronic paraphrenias incessantly preoccupied with their delusions, or even possibly some cases of dementia præcox (though perhaps I am here trying to apply a theory more than the facts warrant), it seems not impossible that the trouble may appear more diffuse than it really is, perhaps because the symptoms are so overcharged with libido that the rest of the personality has become weak and unimportant. When some event such as physical illness alters the centre of gravity striking temporary improvement may appear. There is a further distinction that I would like to bring forward between pathological characters and psychoses, in both of which the brunt of disturbance affects the ego. The character case is in closer touch with reality (and hence more essentially "sane"), and tends to work off his conflicts by outward behaviour, in relation to real life, whether wisely or foolishly.

The psychotic, on the other hand, tends to shut out life and deal with conflict through symbols and phantasy. There are exceptions, as in characters absorbed in day-dreams or aggressive paranoiacs, but it is, I think, true in a general sense. Psychotics often attach to symbols a feeling of objective reality, as in those schizophrenics who play with words as if they were material objects.

May I, finally, draw attention to one more psychological mechanism which interests me, and whose relative importance in our grouping might be worth considering—namely what Freud calls the " Wiederholungszwang," or *repetition compulsion.* It is related to habit and also to repetitions involving part processes such as stereotypy, but the form I am thinking of is not identical with this, nor with the artificially induced repetitions in relation to transference which occur during psycho-analytical treatment. I mean especially those mass repetitions which involve the whole personality. Such, for example, are those cases where new situations evoke the same response which was called up by previous events to which they have some, perhaps quite slight, associative resemblance, with little regard to the present usefulness of the response, although it may have been appropriate at some early time when it was first called forth. It is doubtless related to excessive activity of the simpler conditioned reflex mechanism. It may remain an impediment to cure after the early origins have been uncovered, and, according to my observation, insight into it is usually poor.

Repetition compulsion seems to be more active in abnormal states generally than in the healthy, the latter being characterized by ability to make new adjustments. Whether, beyond this, it fits as a special characteristic into either of our three groups is more doubtful. Personally I am inclined to think that, on the whole, if not actually more prevalent it is of most importance and prominence in ego abnormalities (psychoses and character formations), and particularly in character formations where, indeed, it may form the chief reason for calling the condition abnormal. However, the chief differentiating feature I would bring forward in relation to characters is diffusion and the tendency for mass reaction of the whole ego. In psychoses there is greatest mass or " all or none " reaction as regards libidinal intensity; in characters, as regards extent of personality involvement.

The discussion which followed the reading of the preceding paper raised, among other things, the question of *sublimation*, and it seems advisable to add a few remarks on this. Sublimation, in my opinion, belongs to character formation, and is in itself non-pathological. This does not preclude its being present in disordered

persons, as indeed it often is, just as other non-pathological processes may be going on. The mind is hardly ever so out of gear that every part of the psychic mechanism is involved. Individual capacity to sublimate, however, varies, and if over-taxed this may contribute to breakdown.

Clinically, sublimation is not always easy to distinguish from its opposite, reaction formation, and some confusion between them was perhaps present in the discussion. Reaction formation is closely related to all types of abnormalities, whereas sublimation is not. Sublimation means that instinctive impulses after temporary inhibition are now unrepressed, but are finding their outlet in non-sensual forms approved by the super-ego. Reaction formation implies that impulses are kept unconscious by means of repression, and that the repression is being assisted by the exaggeration in consciousness of opposite tendencies. In the "sane" enthusiasts spoken of in the discussion, the source of the enthusiasm is likely to be chiefly sublimation, and in the fanatics chiefly reaction formation. The career of social worker comprises persons illustrating both types. There are those who have sublimated their love impulses into love of humanity and desire to spread happiness. There are others who have repressed sadistic tendencies and adopted social service as a reaction formation, which yet allows some indulgence of the repressed tendencies in disguised form.