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Selected Writings

EDITED WITH AN INTRODUCTION
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PENGUIN BOOKS

15.

Two Types of War Neuroses[1] (1916)

It is very far from my intention to say anything final about the important subject of war neuroses after studying them for so comparatively short a time. I have been in charge of the section for nervous diseases in this hospital for only two months, and have had about two hundred cases under observation. This number is too great, the time for observation has been too short. Psychoanalysis has taught us that progress is to be expected not from the statistical turnover of many cases, but from the intensive exploration of individual ones. These are, therefore, only preliminary communications, and merely reproduce a psychoanalyst's impressions on observing war neuroses in the mass.

The first impression that the ward full of war neurotics made on me was one of bewilderment, and if you glance at the groups of patients standing, sitting, and lying about before you, you would probably share this impression. You see here about fifty patients, who almost all give the impression of being seriously ill, if not of being crippled. Many are incapable of moving about; for most of them the attempt to move causes such violent tremors of knees and feet that my voice cannot be heard above the noise of their shoes upon the floor.

In most of the cases, as I said, the tremor affects only the feet, but there are a few in whom – as you see – every intended movement is accompanied by tremor of the whole body musculature. The gait of the trembler is most remarkable; he gives the impression of spastic paresis; but the varying mixture of tremor, rigidity and weakness occasions quite peculiar gaits, possibly only to be reproduced by cinematography. Most of the patients say they became ill after a shell explosion near them, a fairly large minority blame severe and sudden

chill (a plunge into ice-cold water, getting wet in the open) as a cause of their illness, the remainder experienced accidents of other kinds, or fell ill apparently merely from over-exertion in the field. Those who were concussed by a shell explosion speak of the 'air pressure' that knocked them down; others were partly buried by masses of earth thrown up by the exploding shells.

This correspondence of the symptoms and causes of disease in so many patients would probably have suggested to everyone an organic injury to the brain or spinal cord. I too had, at first, the impression that this peculiar symptom-complex, hitherto unknown to pathology, would be referable to some organic change in the central nervous system, to a central paralysis and irritation which had hitherto never been observed, because concussions such as soldiers are exposed to in this war had not occurred in peace time. I did not dismiss this possibility for a long time, not even when I was able to convince myself by the examination of individual cases that the symptoms never wanting in central organic lesions, and particularly the signs of a lesion of the pyramidal tract (spastic knee jerks, Babinski's sign, ankle-clonus), are not here distinguishable.[2] I had finally, however, to acknowledge to myself that not only the absence of these characteristics but the general picture of the individual cases, especially the extraordinarily variable and unusual disturbances of innervation, were powerful arguments against an organic, even if only a 'molecular' or 'micro-organic', change in the nervous reticulum.

The impression of peculiarity and oddness cleared up only after I had more closely examined a smaller group of patients in whom not the whole body, but only individual parts of it, seemed affected by the disease. The correct nosological classification of the whole disease group is possible only after an understanding of these *mono-symptomatic* cases.

Here you see two patients. In both, besides the not very marked disturbance of gait (the description of which I pass over meantime), the constant oscillating tremor *of the head*, caused by the alternating rhythmic contraction of the neck muscles, is very striking. This third patient keeps *his right arm contracted at an obtuse angle* at the elbow joint; this limb is apparently incapable of active movement; any attempt at

active or passive movement sets up the most violent tremor in the arm muscles and at the same time an increased pulse rate. Pain sensibility is lowered in the arm; the hand is cyanotic. There is no trace of paresis in either the facial musculature or in the lower extremities. If the patient makes a great effort, he can alter the rigid position to some extent, but this is accompanied by violent tremors. Very similar is the case of this other patient, only that *his right arm seems contracted at an acute angle at the elbow, and the upper arm adducted spastically against the thorax.* In another patient the morbid symptom shows itself in the region of the shoulder. You observe the *right shoulder permanently raised*, as well as the tic-like twitching of this shoulder from time to time.

Here is a patient sitting perfectly still; on his being asked to get up, violent clonic contractions develop in his *left leg* – and only in the left one. When he is stripped, the only indication of disease is *a permanent cramp in the musculature of the left calf* like a persistent contraction. The clonic twitchings, which, however, have not the character of a typical ankle-clonus, occur only on attempting to change the position of the foot actively or passively getting up. The other symptoms of a pyramidal lesion are also lacking. The duration of the cramp could be observed for weeks; a (waking) remission was never observed. This other patient has contractures and tremors of *both right extremities*, the left half of the body is spared.

The exact anamneses of these cases and their relation to the individual symptoms permit their being recognized with more certitude as 'functional', or more precisely, as psychoneuroses. Let us ask this man with the contracture of the left half of the body how he came by his injury; he will tell us that a shell landed on his left and exploded, so that he was struck on the left side by the 'air pressure'. Had the air blast really caused an organic change in the soldier's brain, it would (if we disregard the occurrence of contre-coup) have affected the left cerebral hemisphere at the least more powerfully, but then the symptoms must certainly have been more marked on the contralateral (right) side, which has entirely escaped. A much more plausible assumption is that we are dealing with a psychogenic condition, with the traumatic fixation of the psychic investment on one part of the body, that is, with *hysteria.*

This hypothesis becomes a certainty when we take into account the anamneses of all the cases just presented. The soldier whose right arm is contracted at an obtuse angle was concussed by the shell just as he was sliding his rifle into *the 'stand easy' position*. This position corresponds exactly with that imitated by the contracture. The other one who has his shoulder pressed to his side and the elbow fixed at an acute angle perpetuates in the same way the situation in which he was caught by the explosion; he was lying down at the time with *the rifle at his shoulder, and taking aim* – for this he had to press his arm to his side and bend the elbow at an acute angle. In these cases it is impossible that the central organic lesions are the results of commotion. It is inconceivable that in comparatively so many cases a cerebral lesion could affect the centres for just those muscles that were in action at the moment of the trauma. Much more probable is the assumption that in these cases we are dealing with a fixation of the *innervation predominating at the moment of the concussion (of fright)*. The soldier with the one-sided contraction persistently maintains the innervation of the half of the body which was most endangered, which we can interpret as probably a flight reflex. Both the others preserve the position of the arm that immediately preceded the concussion ('stand easy' position, firing position). In support of the correctness of this conception I can cite a well-known fact from everyday life and a less familiar one from psychoanalysis. In a sudden fright one can often notice that one's feet become 'rooted' in the position accidentally assumed at the moment, that indeed the last innervation of the whole body, the arms, the facial muscles, remains rigidly fixed for a while. Actors know this 'means of expression', and employ it successfully for the representation of the emotion of fear.

There is, however, a less well-known variant of these expressive movements. We know from Breuer and Freud that the essence of hysterical manifestations of excitement or paralysis consists in the *conversion* of an affect into a bodily innervation. Psychoanalysis can trace every such case of *conversion hysteria* back to one or more affective experiences that remain unconscious or forgotten (or, as we say today, repressed), but their energy is lent to certain bodily processes associated in thought with these experiences, which project into the present

like memorial stones of deeply buried reminiscences as rigid and unchangeable as such a memorial. This is not the place to discuss the conditions which are necessary in addition to the *psychic trauma* described before the symptomatic picture of a conversion hysteria can occur (sexual constitution); it suffices to remark here that the cases of war neuroses just presented are, from their anamneses, akin to *conversion hysterias* in the sense of Breuer and Freud. Here, too, the *trauma* is caused by a sudden affect that could not be psychically controlled (fright); it is the innervations dominant at the moment of trauma that become permanently retained as morbid symptoms and indicate that undischarged parts of the affective impulses are still active in the unconscious. In other words, such patients have not yet recovered from their fright, even if they do not consciously think of what they lived through and may indeed at times be cheerful and good-tempered, as though their soul were in no way tormented by any such terrible memory.

After these considerations, it no longer surprised me, nor will it surprise you, that the other 'mono-symptomatic' cases shown here became comprehensible upon a more thorough inquiry into their anamneses. This soldier with the permanent contracture of the left calf recounts how he was cautiously descending a steep mountain in Serbia, and, while stretching *his left leg* downwards to find support, was concussed by an explosion and rolled down. Here, too, therefore, there was a 'petrification' due to shock, in the attitude that he had adopted in that moment. Of the two patients with tremor of the head, one tells us that at the critical moment he struck his head against the wall of the shelter, the other that as he heard the characteristic whistle of the approaching shell he 'ducked'. The patient with the constant tremor to the left shoulder was *slightly wounded* at the explosion on the part of the body which is now in spasm (the scar is visible).

When I first obtained these anamnestic data of from the patients, I did not know anything of their significance for symptom formation, so that suggestive questions on my part were excluded. Later, of course, I deliberately drew the patients' attention to the circumstances of their concussion, without indicating, however, what meaning I attributed to their replies.

I expect that you will raise objections to this attempted explanation. You will say, the patient could not have noted the actual situation so clearly at the critical moment; these anamnestic data, therefore, are perhaps, only subsequent attempts at explanation by the patient himself which we have simply 'swallowed'.

My reply is as follows: the soldier was certainly fully conscious immediately *before* the concussion; he may also have been aware of the approaching danger (this is acknowledged by many who remained well in spite of the proximity of the explosion). He may then have lost consciousness at the moment of the concussion, and later even have developed retrograde amnesia; the memory trace of the situation before the concussion was already fixed, and might have, in the unconscious, influenced symptom formation. The suspicion of being 'misled' by the patient, and the distrust of his statements, were the causes of the profound ignorance prevailing until recently among doctors concerning all matters pertaining to the psychology of the neuroses. Only when Breuer, and more particularly Freud, began to *listen* to neurotic patients were they able to find access to the secret mechanism of their symptoms. Even in case the patients had subsequently invented the situation present at the concussion, this 'invention' may have been determined by the memory traces of the real circumstances which have become unconscious.

The possibility in these cases that, besides the trauma, any other 'somatic compliance' acted as a predisposing cause could only be excluded by a systematic psychoanalysis of each individual. It is quite possible to imagine that at the moment of concussion, it is precisely the active innervation which plays the role of a 'predisposing factor', of a 'somatic compliance', and brings about the fixation of the affective excitement (which, on account of its strength, is relegated to the unconscious) to just that part of the body then being innervated. Such 'displacements of affect' on to an indifferent but, just at the critical moment, accessible bodily innervation are well known to us from the psychoanalyses of conversion hysteria.

Unfortunately, I am not in a position to support these particular points by the psychoanalyses of the different patients concerned. I

must confine myself, therefore, to grouping these 'mono-symptomatic' war neuroses with conversion hysteria.

Let us now turn to the second and, as you see, much larger group of patients, those with *generalized tremors* and *disturbances of gait.* Here, too, if we wish to understand the complete picture we must start from the main symptom, the *disturbance of gait.* Look, for instance, at this quietly recumbent patient; as soon as he attempts to rise, his lower limbs begin to tremble, first at ankle and knee joints; the tremor then increases more and more, its excursions become continuously greater till finally the static balance of the body is so disturbed that the patient would fall if he were not caught; if he sits or lies down the tremor ceases at once of itself. (I repeat, signs of organic illness are completely lacking.) This other patient can walk supported on two sticks, but his gait is uncertain, and we hear a reduplicated sound when he puts down his right foot; his right heel touches the floor twice at each step before he has the confidence to support himself on it completely. A third has a wide-base gait like a tabetic, the fourth one beside him walks as though he were completely ataxic – and yet in a recumbent posture they show no trace of a real ataxy, much less can any disease of the spinal cord be demonstrated. The gait of two of the patients shown here can only be described as a 'thrusting gait': they lift the leg without flexing the knee and let it come down with a loud noise. This man here is probably the most severely affected; on his attempting to walk the intention tremor passes into a generalized spasm of the entire body musculature, at the acme of which the patient's consciousness is disturbed.

This last symptom warns us to bestow more attention upon the manifestations accompanying the disturbance of gait. On attempting to walk or to walk without support, all these patients without exception suffer from palpitations and increased pulse rate, most of them sweat profusely, especially at the armpits, also on the forehead, and they have an anxious expression. Thus, if we watch them more closely, we see that besides the disturbances of gait other permanent symptoms are present as well. There is hyperaesthesia of almost all the senses;[3] hearing is especially affected in most of the cases, but also sight. As a

result of this hyperacusis and photophobia they are very timid; most of them complain of very light sleep that is disturbed by anxious, terrifying dreams. The dreams for the most part repeat the dangerous situation experienced in the battlefield. Almost all of them complain as well about their quite inhibited or much reduced sexual libido and potency.

Before we decide how to classify these symptoms for diagnosis we must here, as previously for the 'mono-symptomatic' cases, consider the anamneses very closely. Most of the patients say they were affected by a 'shell explosion', some that they were also covered with earth. They lost consciousness immediately, and only came to themselves again in a hospital behind the line. Then they were completely 'paralysed' for days, mostly weeks on end – a few for one or two months. *The tremor appeared on the first attempts at walking*, after the power of mobility had long been established in bed, and apparently no further paralysis had occurred. In a few cases the soldier continued on duty after the shell explosion and fell ill later in consequence of a quite negligible, purely psychic, shock. This volunteer, for instance, was sent out on advance guard at night after a shell concussion; on the way he stumbled over a ditch, got a fright, and only fell ill after this experience. Still more striking is the 'summation of the pathogenic causes' in those very frequent cases in whose anamnesis the cause of the illness is to be discovered in general, not in the shell explosion but in terrible experiences of other kinds, indeed in the superhuman effort and deprivation and the constant anxious tension of the war. According to the information provided by the anamnesis, one encounters with the same frequency commotions through sudden or frequently repeated, sometimes unbearably prolonged, chills (a plunge into ice-cold water, especially on crossing rivers in winter, rain and snowfalls when camping in the open). Twelve soldiers from the same regiment were admitted to our hospital on one day, all presenting the symptoms previously described as incapacity to walk; all of them fell ill from the same cause, a river crossing after marching all day in snow and rain. In these cases, too, the present condition was preceded by a 'period of paralysis' that passed fairly quickly, to make way, *on the first attempt at walking*, to the present state of things.

I probably do not need to repeat that here, too, I have sought carefully, and without any result, for organic symptoms.

In many of these cases of chill, one learns that the condition was improving spontaneously until they began to be treated for their supposed 'rheumatism' with hot baths, or were sent for after-treatment to one of our natural hot springs (Trencsén-Teplitcz, Pöstény), where they relapsed.

Let us sum up what has been said: soldiers fall ill after a sudden concussion or after repeated smaller or greater concussions. On loss of consciousness (not always present) there follows a stage resembling paralysis, which passes off spontaneously after a longer or shorter period to give place on the first attempts at walking, or, on certain therapeutic efforts to a chronic condition. This last state is composed of certain general phenomena and of a disturbance of gait without any organic basis. There is a distinct relation between the disturbances of innervation on attempting to walk and the general phenomena, in that the latter are increased by the attempt to walk, are partly indeed only brought about by these attempts. Certain permanent symptoms also occur, of which hyperaesthesia of all the senses is the most prominent.

Now from psychoanalysis we know of a condition in which the attempt to perform certain actions evokes a generalized phenomenon. This is Freud's *hysterical anxiety*, which is characterized in many cases by the fact that the attempt to move, the voluntary innervation in getting up or walking, is linked to an intense *anxiety* which forces the patient to avoid certain movements and to transform his entire way of life in this direction. Neurologists have long known of these avoidances which they call *phobias* without, however, having understood them. The disturbance of innervation was called *astasia* (incapacity to stand), or *abasia* (incapacity to walk) and the various avoidances were named according to certain inessential superficialities (agoraphobia, claustrophobia, topophobia, et cetera).

Only psychoanalysis first threw any light on this peculiar morbid condition. It appeared that these patients had repressed into their unconscious the affective reaction to certain *psychic traumata*, for the most part experiences that were adapted to diminish their *self-confidence*,

repressed in the unconscious from where they continued to influence their activities, and on any threat of repetition of the pathogenic experience led to a development of anxiety. The patient then learns to escape these anxiety states by avoiding any activity that would in any way lead to the repetition of the pathogenic situation. *Astasia–abasia* is only the final stage of this system of avoidance; it prevents locomotion in general in order all the more surely to avoid one definite situation. I can only mention here that the root of every neurotic fear is a sexual one (Freud) and also that there is a constitutional predisposition for topophobia (Abraham).

Now the 'general' symptoms also correspond completely with the clinical picture of *anxiety*. I have said that, for our patients, every attempt to overcome the apparent paralysis and to move about may induce palpitations, increased pulse rate, sweating, grimaces, even a condition similar to a fainting fit. This picture corresponds in every way with that sudden development of anxiety, as well known to us in daily life as it is in the histories of patients suffering from *anxiety neurosis*. The hyperaesthesia of all the senses, which was described as a permanent symptom, and the disturbance of sleep by anxiety dreams, corresponds to the constant anxiety expectation from which the neurotic suffering from anxiety complains. The disturbance of the sexual libido and potency can assuredly be considered as neurotic.

I believe that after all this we have the right to regard every case belonging to this group of war neuroses as *hysterical anxiety*, and to consider the motor disturbance as an expression of *phobia* that serves the purpose of preventing an outbreak of anxiety. In particular, then, we can give the name of hysterical '*astasia–abasia*' to most of the cases here shown; for the case where you see there exists a complete inability to sit, we should have to coin the term '*hysterical anhedria*'.

We shall now endeavour to picture to ourselves how the concussions, on which stress is laid in the anamneses, were able to cause such types of illness. This attempt can only have a very partial success, for we cannot conduct a systematic psychoanalysis. Nevertheless, daily contact with the patients and brief psychoanalytic questioning of a few of them furnished me some material that I can employ meanwhile in answering this question.

It struck me that many of the anxiety-smitten soldiers had obtained high distinctions for previous services, and for gallantry against the enemy. To the question as to whether they had been frightened, previous to this, they usually answered that neither now nor previously had they felt any alarm. On the contrary, some of them told me, 'I was always the first to volunteer when there was something dangerous on.' I can only tell you a little about the cases that I analysed rather more thoroughly. A Hungarian peasant, orphaned of his father at a very early age, had very early been obliged to do the work of the 'grown-ups' on the farm. For reasons that it was no longer possible to examine analytically, he became very ambitious, wanted to do everything just as well as the grown-ups, and was very touchy if any fault was found with his work, or if, as often happened, any one actually made fun of him. Later he had to put up many a fight with his neighbours and also with the local police; ultimately, as he said, he 'was afraid of no one'. On the battlefield, he had a shell concussion and had fallen from a great height; since then he experienced tremors in walking (and a conversion symptom as well, a cramp in the calf), is emotional, weeps easily, but has occasionally outbursts of rage – for instance, when he learnt that he must remain under treatment for a further period. The other patient whom I was able to interrogate at some length was a Hungarian Jewish engineer; he had always been very assiduous at school, had great schemes in his head (discoveries, acquisition of riches, et cetera); previously religious, he gradually came to getting along without God, and was also in the process of breaking off his engagement of six years' standing to a girl because he had come to the decision that he was no longer bound by a promise given in early youth, and that this marriage would have imperilled his career. He entered the war as a volunteer and remembers the details of his falling ill quite well. His company on one occasion was exposed to severe shelling; when he heard the whistling of the shell that fell beside him, he vowed to himself to marry his bride if nothing happened to him, and he also muttered a Hebrew prayer ('Schema Israel'). He recovered his senses after being stunned for a short time, but soon noticed that he had become incapable of walking. As a matter of fact, his gait is peculiar; he takes quite short steps (without any tremor),

supports himself on a stick, is constantly alarmed lest he fall, and therefore whenever possible leans against the wall or a piece of furniture. He has also become rather dejected, is uncommonly modest, his voice is low, his speech short-winded and hurried, his handwriting almost illegible. He has half-heartedly resumed relations with his bride, but (since he has been rather better) he has once more given up his relations to God.

It is not difficult to recognize in these two cases the conditions under which, as previously said, an anxiety hysteria accompanied by phobia may develop. Both these patients have carried their estimation, perhaps their overestimation, of their selves pretty far. The encounter with an overwhelming force, the blast of air from the shell, that hurled them to the ground as of no account may well have shaken their self-love to its foundations. The result of such a psychic shock may quite well have been a *neurotic regression*, that is, a return to a stage of development long outgrown (both onto – and phylogenetically). (Such a regression is never lacking in the symptomatology of the neuroses, as apparently outgrown phases never quite lose their power of attraction and on the occurrence of a more favourable opportunity always reassert themselves.) Now the stage to which these two neurotics regressed seems to be the infantile stage of the first year of life, a time when they could not yet either walk or stand properly. We know that this stage has a phylogenetic model; the being with the upright gait was, after all, a fairly late achievement of our ancestors among the mammals.

It is not absolutely necessary to suppose that the self-love of all these war neurotics was so greatly exaggerated as this. A correspondingly severe trauma can, in so-called normal people, have an equally shattering effect upon their self-confidence and make them so timid that even the attempt to sit, to stand, or to walk, is just as for the child learning to walk, accompanied by an outburst of anxiety. I was strengthened in my assumption by the naïve remark of one of my nurses at the morning round: 'Why, doctor, this man walks just like a child learning to walk.' Besides this regressive trait that fetters the patients to their bed or diminishes their freedom of movement, there may also be at work in many, perhaps in all, of the cases the 'secondary'

function of the neurosis. It is comprehensible that the prospect of being sent back after convalescence to active duty, where things have already gone so badly with them, acts as a deterrent for these patients, more or less unconsciously preventing recovery.

Let us consider a few more of the symptoms described. The most striking of all is certainly the *tremor*, which in most of the cases entirely dominates the clinical picture. The disturbances of gait just discussed are almost always brought about by a slow tremor of the lower limbs. The regressive trait is unmistakable in the symptom of trembling. In the case of these neurotics an extremity provided with manifold innervations and with complicated coordinated movements becomes, on intended effort, an aimlessly trembling bodily appendage at any attempt to move. For the prototype of this reaction we must look – ontogenetically – to the earliest childhood, phylogenetically, far back in the animal ancestral series where the living being did not yet react to stimuli by changing its relation to the external world (flight, approach), but by changes to its own body. I think, too, that in these 'neurotic' tremors we are dealing with the same disturbance of innervation with which we are acquainted in everyday life, the trembling due to anxiety, or rather to fear. Every innervation of muscle can be hindered or prevented by the inhibiting innervation of the antagonists. If this innervation of agonist and antagonist muscles is simultaneous, the result is spastic rigidity; should it occur in a rhythmic alternation, the limb affected will be tremulous. In our cases we find all possible combinations of spasticity and tremor. In this way is brought about the peculiar disturbance of gait in which, in spite of every effort to walk, no change of place is effected, and which might best be described as a being glued to the ground (*piétiner sur place*). This disturbance of co-ordination at the same time becomes a defence formation that will protect the patient from re-experiencing the alarm. It may be mentioned here that this combination of disturbance of gait with tremor is absent in the ordinary astasia–abasia with which we are acquainted in peacetime practice, where topophobic manifestations are occasioned simply by conditions of weakness, by feelings of giddiness, et cetera.

The other striking persistent symptom of these war neuroses is

the more or less marked hyperaesthesia of all the senses, photophobia, hyperacusis, and the dread of passive contact. (This last is not usually associated with hyperaesthesia of the skin; skin sensation may even be lessened or lacking; it is only a matter of over-powerful *defence reactions* against being touched.) We must adopt the following assumption of Freud in explanation of this symptom. If one is prepared for a shock, for the approach of a danger, then the investment of the attention mobilized by the expectation is able to *localize* the stimulus of the shock and to prevent the development of those remote effects which we see in the *traumatic neuroses*. Another means of localizing the effects of shock is, according to Freud, a severe, actual, physical injury proportionate to the psychic shock occurring with the traumatic incident. In the cases here shown of *hysterical anxiety*, none of these conditions are fulfilled; we are dealing with a sudden, mostly unexpected shock without a serious bodily injury. But even in the cases in which the approach of the danger was noticed, the attention mobilized during the wait was not proportionate to the actual stimulus force of the shock and so was unable to prevent the discharge of the excitement along abnormal channels. It is probable that consciousness generally shuts itself off automatically at first from such too-powerful stimuli. We may take it for granted that after the trauma a certain discrepancy exists between consciousness that has been relatively protected from the shock and the rest of the neuropsychic apparatus. An adjustment is here only possible when consciousness too takes on its share of the unpleasant excitations; this is then achieved by a certain 'traumatophiliac' attitude, hyperaesthesia of the senses which in small doses gradually allows just so much anxious expectation and shock to reach consciousness as was spared at the time of the shock. According to Freud, we must consider that every repeated little traumata, the jump at every sudden noise or light, we should see as a tendency towards recovery, a tendency of the organism to re-establish the equilibrium disturbed by the distribution of tension throughout the organism.

Freud interprets in the same way the anxiety dreams of traumatic neurotics in which disasters that have occurred at one time are constantly lived over again. Here the psyche does not even wait for an external stimulus in order to react to it exaggeratedly, but creates for

itself the image at which it can then become alarmed. This unpleasant symptom too, therefore, is at the service of the effort of self-healing.

As a crude example of 'traumatophiliac' hypersensitiveness, I show you this shellshocked man whose whole body, as you see, is in a state of constant muscular restlessness without his being able to carry out any intended movements. His eyes are so hypersensitive that in order to avoid the light of day they are constantly kept rolled upwards; at short intervals, once or twice a second, he turns the eyes downwards far enough to let him obtain a fleeting glimpse of his surroundings, otherwise the pupils are hidden behind the rapidly blinking upper lids. His auditory hyperaesthesia is, if possible, still greater; it reminds one of the hyperacusis of acute mania. He simply cannot exist by day in the general ward on account of the noise, and we had to let him sleep alone in the attendant's room. It was very remarkable that the patient at once requested to be allowed to sleep at night in the general ward. Asked for the reason of his request he immediately replied: '*I certainly do start up often at night in the general ward, but it is worse sleeping alone; I can't get to sleep at all in the absolute quiet, because I always have to listen so carefully to hear whether there really is not some sound to be heard.*' This case confirms the hypothesis suggested above that the repeated affects of alarm and the heightening of the acuity of the senses are things that the traumatic neurotics themselves seek out and maintain involuntarily, because they serve their effort at healing.

In spite of all its tragedy, this behaviour of the traumatic neurotic recalls the situation of the hotel guest startled out of his sweetest slumbers by his next-door neighbour, who when undressing had flung one shoe against the communicating door. After vainly endeavouring to fall asleep again, he had to implore his restless neighbour to hurl the second shoe against the door in order that he might get to sleep. Many people behave similarly, as Abraham first pointed out, who were victims of sexual assaults in their childhood. Later they have the compulsion to expose themselves anew to similar experiences as though they were trying to control the originally unconscious and uncomprehended experience by a subsequent conscious one.

It is not impossible that the results achieved by many neurologists from treating war neuroses by painful electrical stimuli are due to the

fact that these painful sensations satisfy the patients' unconscious traumatophilia.

Freud's theory, that in the neuroses we are dealing not with disturbances of the balance of energies in the ordinary sense but with a disturbance particularly of the libidinal energies, was rejected by many with the argument that an ordinary trauma 'which certainly causes no sexual disturbance' may evoke a neurosis. Now we see that a shock that in itself can certainly not be called sexual, the explosion of a bomb, results in many cases in the loss of *sexual libido* and in *sexual impotence*. It is therefore not impossible that *ordinary shocks*, too, may lead to the neuroses by *way of a sexual disturbance*. The apparently least important symptoms of traumatic neurosis, namely impotence, may also on a closer examination of the pathology of that condition come to be more highly considered. For us psychoanalysts the assumption serves, as a preliminary explanation, that we are dealing in these traumata with an *injury to the ego*, an injury to *self-love*, to *narcissism*, the natural result of which is the retraction of the range of the 'object cathexis of the libido' – that is, the cessation of the capacity to love anyone else other than oneself.

I do not think that I have awakened in you the expectation of hearing from me a complete explanation of the psychopathological processes of the traumatic or war neuroses. My object is achieved if I have succeeded in showing you that the clinical pictures presented to you really do belong to those two disease groups that psychoanalysis designates by the names of *hysterical anxiety* and *conversion hysteria*. I am also not in a position to explain in detail why in one case a state of *anxiety*, in another a *conversion*, and in a third a mixture of both developed. I have, however, I believe, shown this much, that in these neuroses, too, psychoanalytic research indicates at least the path by which the explanation must be sought, while the rest of neurology exhausts itself in a description of the patients and in empty nomenclature.

16.

Silence is Golden[1] (1916)

An obsessional neurotic patient, otherwise usually taciturn and hesitating in his associations, showed himself to be distinctly chatty during one session. When I drew his attention to this, he acknowledged himself the unusual nature of his garrulousness, excusing it, however, with his usual self-irony, that, of course, 'silence is golden'. In connection with this idea, I pointed out to him the symbolic identity between gold and faeces, and suggested that he was usually as economical with his words as with his money and his fecal matter; was he that day in an exceptionally profligate mood? Moreover, I explained to him the psychological meaning of the proverb. 'Silence is golden', because to not speak represents in itself an economy.

On this, the patient broke into uncontrollable laughter and told me that in general he suffered from constipation, but that day, *exceptionally*, he produced a copious bowel movement. The actual occasion for the expansiveness and the prodigality was the sudden removal of an external constraint: it became possible for him to *avoid* a journey that he would have found very unpleasant.

Another patient (a hysteric) suffers amongst other things from two symptoms that always appeared at the same time: aphasia and a spasm of the anal sphincter. If he was in a good mood, his voice was loud and clear, his evacuation copious and 'satisfying'. When depressed (particularly on the occasion of some inadequacy) or when he had to deal with seniors or superiors, the aphasia and the spasm of the sphincter appear simultaneously.

(Analysis has shown, amongst other things, that the patient was one of those not unusual people who unconsciously retain their faeces because they expect to be 'fortified' physically and psychically from