NEUROTIC SUPERSTRUCTURES IN PSYCHOSES.*

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Experience of neurotic patients seeking treatment convinces me that paranoia is by no means so rare a disease as asylum statistics would lead one to suppose. For the purposes of the latter, of course, only fully developed and alienated cases are taken into account. Of the four cases to be discussed here, only one has said or done anything that could be recorded in a certificate, and the delusional picture was only unfolded at the patient's good-will. None of these cases therefore would figure in statistics, yet all four are drawn in a short space of time from a limited section of the community. Paranoid trends, episodes or systems are, I believe, quite common in intelligent, cultured and well-developed minds, and account for a substantial amount of insufficiency and unhappiness. Apart, therefore, from the question of the treatment of the delusional asylum patient, the projected mental clinics will find themselves faced with a formidable problem in regard to the treatment of paranoid conditions. It is from the incipient and partial cases of paranoia that we can gain an insight into the factors which arrest or promote the disease. Only in the most exceptional cases does the fully developed paranoiac admit us within the circle of his fortifications.

Compare in general the placidity of the stable paranoiac who has achieved an emotionally satisfactory compromise between the world of wish and of reality, with the tension, unhappiness and periodic outbursts of the paranoid dementia præcox, who wears out his emotional mechanism without ever reaching such an adjustment. The most superficial comparison of the two cannot allow of any doubt that this internal tension is not only destructive to the patient's mind, but is ruinous to his good relations with his social environment. Failing a harmonious social *rapport*, mind must deteriorate, suspicion and hostility must increase, and at the very least the establishment of a therapeutic *rapport* becomes impossible. Since the tension is not present to an equal extent in all cases, it

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cannot be the essence of the paranoia, and my general thesis is that this tension is neurotic rather than psychotic in nature, and is, therefore, relatively accessible to treatment as distinct from the true paranoiac mechanism, that it arises from the paranoia, *i.e.*, is secondary, or from the paranoid maladjustment to environment, *i.e.*, is tertiary to the true psychotic basis. Without insisting on my personal belief in the curability of the paranoia itself, I am convinced that these secondary or tertiary neurotic tensions can be so treated that their repercussion upon the paranoid isolation can be prevented, with the result that the latter progresses in a benign manner or not at all.

I suggest, therefore, that where you have an early paranoia, you have of necessity an immense amount of tension, dissatisfaction, apprehension and depression of a purely secondary nature, determined at the *neurotic* level, and that by dealing even with this secondary matter you can not only maintain the psychotic as an agreeable and co-operative individual, but you may even keep his psychosis in the form that best lends itself to a natural and social mode of treatment. I personally hold that paranoia in early stages and favourable cases (favourable in intelligence and disposition) is a curable disease. Further I think the cure depends upon dealing with neurotic tensions before the real paranoid structure is challenged. In this way alone does one avoid the risk of the patient's turning against his physician, and in this way alone can one establish a fulcrum from which it is possible to influence the projection defences themselves. The paranoiac will admit that he is in need of health and happiness long before he will admit the need for a sound mind.

Here is a case, A—, that shows quite clear paranoid characters even although the systematized delusions have not appeared. From a very early age there was an unbounded egoism and a fury at being thwarted in any respect. This reached the point in childhood at which he believed he was Julius Cæsar and even avowed this belief, consenting merely to do the necessary school tasks in a make-believe way to humour the authorities until such time as he should be " big Cæsar." As a child he made two quite serious homicidal attempts, one upon his rival brother, another upon his nurse. He further believed that he was able to move inanimate objects, to levitate himself, and to compel other people to do his will by spells and a magical exercise of will. The objective certainty of these beliefs was, until recently, absolute. He thought himself in communication with God, and believed he was able to read the thoughts of his elders. At any rate he recollects being put out of the room for announcing the results of his thought-reading,

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and held that this was a pretty good proof of the correctness of his announcements—a typical paranoid paralogism, of course.

He started treatment with a history of having become more and more seclusive, so that he would not leave his house even by the back gate without looking round to see if there were anyone watching. He believed that a certain lady was in love with him, and was pursuing him. I must say that I think this belief, though perhaps exaggerated, had substantial foundations, but his terror was morbid. He had invented and made a secret machine for forecasting the course of prices on the Stock Exchange. It was, as far as I can make out, a very ingenious "averages" calculator, but his expectations from it were decidedly mystical and exalted. He considered that in many ways he was very peculiar, had a specially intimate relationship with God and was probably intended for something great. He felt in himself a great sense of devotedness, though what his mission was to be was as yet obscure. He also had from the earliest age a power of defying all disagreeable circumstances by what he variously described as "getting into his shell" and "coming to an end." Apparently this was a kind of hysterical "feint." He believed that there was something wrong with his genital organs, and went to several physicians in succession; each was able to reassure him for a time, but in each he quickly lost faith. Finally an eminent surgeon made a very exhaustive examination and diagnosed a slight cicatricial thickening round the edge of the levator ani, possibly due to pelvic cellulitis. Diathermy was prescribed, but without either mental or physical benefit, and he began to go to pieces emotionally. He came under my notice as apparently a hypochondriac with, perhaps, a basis of conversion hysteria. His general nervousness and anxiety, unhappiness and inefficiency were extreme. As he himself put it, he felt he was going off his head. There was extreme apprehension and excitement though these were well-controlled, with very marked physical symptoms of anxiety and neurasthenia.

Confidential relations were fortunately quickly established and he confessed that he had been a practising homosexual all his adult life, with apparently no capacity at all for heterosexual feeling. He very quickly discovered the knack of "free association" in a way I have never seen equalled, for, without really becoming inaccessible to stimuli, he was able to transport his whole attention into the past and to follow out threads of the most distant memory. It was really a sort of auto-hypnosis and it worked extremely well, so that for long periods—on one occasion six weeks—I did not require to address a single question or comment to him. Aided by this exceptional advantage we very quickly got an almost perfect

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anamnesis, and he began to see the development of his life, as it were, in serial section. His dreads, doubts and inhibitions fell off him rapidly, the homosexual compulsion lost its hold over him and he experienced heterosexual impulses and hopes. The relief was so intense, the revulsion from anxiety, bewilderment and helpless compulsion so great that for months he skirted an attack of mania. He was, in fact, frequently hypomanic, with the wide-opened palpebral fissures, the facies and raised metabolism, the talkativeness and divertible interests all quite well-marked, though without incoherence or loss of control. Whenever his interviews were intermitted for a short period this excitement and exaltation almost got out of hand; he felt such an enormous superiority to the "dull, blind people" he passed in the streets, people who had never had the spiritual experience which he had surmounted. He fell in love—another factor in his exaltation—and his sense of mastery led him to feel that he would easily supplant any authority, that he could influence people's thoughts, and that anyone who was not doing as he wished was afraid of him. In this phase he made a very alarming impression upon several people, including his own doctor. He was enormously self-confident, and intended when his treatment was finished to set up a school of his own, where things would be done properly: he even contemplated taking charge of his own treatment. Under the influence of this exaltation his former paranoid belief in his supernatural powers over people and objects and over the force of gravity returned in full force, but he was in some apprehension of a radical change in himself that he felt to be impending.

Though he often suggested that he had nearly reached full self-knowledge, he never actually threatened to break off treatment except when he gave himself a holiday for a period of three days once, and at a week-end on one or two occasions. In these intervals he always became much more exalted and erratic, and it would seem as if the self-criticism and discipline of daily self-study was an indispensable outlet for his excitement and served also to re-enforce his self-control. The most serious break-away that occurred was a reversion to the literal and absolute belief in his past power and potential future power of moving external objects by the direct action of his will. This reversion is very interesting technically, because he had been uncovering the infantile origins of his homosexuality and meeting the most paralysing resistances as he did so. His little pseudo-trance began now to terminate before the end of the interview; he showed an increasing disposition to talk about his illness rather than to seek to recover and observe more material. When he entered the consulting-room he would sit in any place

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rather than his own, light a cigarette and begin a sort of general psycho-pathological discussion. Finally during his introspection he suffered anxiety attacks so severe that he had to stop several times in the hour and then to abandon the interview. It was during this phase that he suggested his three-day rest. On resuming after a four-day interval he instantly challenged the physician on the objectivity of his paranoid beliefs, and was met with the statement that that was totally irrelevant to our inquiry, and that in any case the evidence did not justify him in demanding that the physician should violate his own whole system of beliefs and experiences in order to accept those of an individual patient. He admitted both these points as well as many other considerations of a more purely pathological nature, but still felt he could not work for the physician but must do it himself. It was then pointed out to him how opportunely this objection of his had occurred: that it enabled him to cease controlled introspection just at a time when this was becoming intolerably terrifying, and further that the argument diverted his attention from the painful and arduous study of himself and his own psychological mechanisms to objective supernatural speculations about the possible mechanisms of these " remembered miracles." Such speculations could never be conclusive, as he clearly saw, but what influenced him most was the physician's explanation of the hedonic, economic convenience of " exteriorizing " or " projecting " the whole interest. The motive for this projection he quickly came to realize was an escape from an apprehended self-discovery. The mechanism, in fact, as was pointed out to him, is identical with that of phantasy formation generally and served an identical purpose. After a night's reflection he announced he saw that it was so, and resumed his original method of work, with the result that he quickly made most startling and disagreeable discoveries which were in every sense relevant to the content of his delusions. The excitement subsided immediately a subjective interpretation of all these paranoid ideas was adopted and his personal relations to the physician immediately became most cordial. Incidentally the last vestiges of his homosexual leanings and the inhibitions on his heterosexual wishes very speedily cleared up.

I do not intend to deal with the actual content of his conversations, though some of his recollections were astonishing examples of infantile memory. I merely adduce the case as showing how a steady attack upon the neurotic, rather than upon the psychotic, features of an illness will hold the patient friendly and co-operative where a direct frontal attack upon the psychosis would merely evoke antagonism. This patient could not have tolerated a direct

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challenge to any of his beliefs, yet he opened up his mind completely in order to secure an understanding of the neurotic strains and disabilities which he readily admitted. His hypochondriacal beliefs vanished in a month or two, his homosexuality gave place to strong heterosexual emotions within four to six months, and his paranoid beliefs, with the exception of this last flare-up, simply attenuated themselves and lost meaning for the patient. From a morose and irritable recluse he became sociable, courteous and friendly, while his overbearing self-confidence seems to have dissipated itself completely on his discovery of its infantile basis. Whatever the permanent results, the day-to-day effect and the total change achieved by this method of approach was most striking.

It will be said that it is more than doubtful that this case is or would have become one of paranoia, notwithstanding the objective delusions, mental attitude, mode of life, homosexuality and the typical mechanisms that I have adduced. A second case, B—, however, should be accepted as paranoia without difficulty. In B—'s case I had only a matter of four months of effective treatment, and though this naturally did not allow of anything like a complete result, yet it so altered the neurotic superstructure of the disease that he ceased to be an invalid, the tension, anxiety, irritability and despair were substantially removed, and an insight was acquired which I believe will keep him oriented to his social world for an indefinite period. B— was sent to me as a case of anxiety neurosis with chronic hypochondriacal ideas. Bit by bit, as he acquired confidence, he unfolded what he had concealed from the specialists—a complete paranoidal system taking briefly the following form: Whenever he was in company some word, innocent enough in itself, was used by someone in his hearing; this instantly caused in him a facial reaction, which was noticed and commented on by women in particular. This word—whatever it might be—was intended to make him betray himself, and the whole neighbourhood was seething with scandal about his sexual habits. Among the words that most uniformly produced violent reactions were the following: Back, hole, finger, "put up his hand," "both ways," "it is true," cunning, suction, boys, liar, low, dirty, filthy, tragedy, brother, dying, weakling. When any of these occurred in the most casual conversation, he insisted that in a mysterious way an influence beyond his control radiated from himself that produced a most painful state of electrical tension in everybody present with a subsequent depression. Even without a signal word he would suddenly get the idea that somebody suspected him of something and he then felt compelled to betray his awareness of this suspicion. His own thought, conveying itself supernaturally to the other

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person's mind, naturally served to confirm this suspicion even although it was unjust. These will serve as examples of his beliefs. His impulse to self-betrayal and self-thwarting led to a remarkable tissue of suspicions, interpretations, watchfulness and self-control. His face was wooden, like the *Gefägnisblick* of the jail-bird that betrays nothing of the internal thought. In spite of all these false ideas, however, he had a most remarkable power of handling men and of understanding what they were really intending. He would exercise endless trouble and skill in unravelling social situations, so that in addition to being a skilled technician and an able business man, he was an exceptionally good organizer and employer of labour.

His illness, however, for a year or so before I saw him had made a sinister advance. In the presence of a company of men he would feel compelled to betray the idea of erection and ejaculation although nothing of the sort had occurred. The others would instantly be aware of his mental processes and all sorts of curious responses and provocations occurred, which not only enormously embarrassed his own business discussions, but made him believe that his sexual peculiarities were a subject of universal scandal. Women also became intensely excited in his presence, but the principal trouble was with men. These provoked or at least afforded an occasion for his self-betrayal, and when finally this self-betrayal assumed the form of emitting an odour which he insisted was felt by everybody and could never be eradicated from clothing, his capacity for carrying on an ordinary life was at an end. He now regarded himself as a pariah, a "bad joke"; he felt that everybody was waiting for "it" to happen and either giggling at it or regarding him with the strongest disgust. He had only to wear a suit of clothes once for it to become intolerable; no washing or deodorizing had the smallest effect, and he could never tell at what moment this purely odorous emission would occur, or be wantonly provoked. The world suddenly became for him hostile, derisive, and contemptuous, and no expedients on his part had the least ameliorative effect. He went to endless physicians about it and they all assured him there was no objective basis for his belief; he thereupon decided they were making a fool of him. The whole world in fact had entered into a conspiracy of silence and a secret understanding against him.

I think that it will be admitted that this is a case of systematized delusional insanity, and that the organization and fixation of his beliefs was progressing literally from day to day. There was not a trace of hallucination (beyond that of smell), of weakening of judgment, of deterioration of affect or of character. The patient

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was a man of the highest resolution and intelligence, yet totally convinced of the objective reality of these beliefs. The first two months of the treatment were spent in a philosophical discussion of reality, and of the distinction between the various kinds of reality and the limitations of social and individual beliefs. A philosophical interest in his situation and problems was thus established in his mind so that he could discuss the whole matter with some degree of detachment, and in this way he could enter into some confidential relationships with his physician. His contact with his physician and with one other person to whom he had a strong father transference really represented his whole social *rapport*. It proved sufficient to begin an analysis, though at first of a scope limited by his interests and suspicions. He retired as it were from a universally hostile world to the hobby of systematic self-study. He had, moreover, a tremendous load of secondary neurotic inhibitions, including impotence and *ejaculatio præcox*, which were made our avowed therapeutic objective, and which therefore he was willing to discuss and study without any psychotic restrictions. It was cut off in his opinion from the question of the validity of his beliefs, any challenge to which he could not tolerate. Yet these neurotic disabilities were sufficiently urgent to command his interest. The analysis of the neurotic mechanisms proceeded rapidly and favourably. The patient's intelligence and strength of character and the enthusiasm with which he made the inquiry his own very quickly gave him a complete insight into the hitherto unconscious mechanisms of his *neurosis*. From this point he quickly made the, to him, remarkable discovery that in all the *psychotic* situations his own involuntary impulses had not only played a responsive part, but had even planned and initiated the "betrayals." He was enormously impressed with his own discovery, and the next day added the significant commentary that he now recalled that a couple of years before he had had the idea that the whole thing came from himself, but that more recently he had forgotten all about this feeling. He now re-embraced the view that the trouble started in and from himself, and though still tending to mystical and supernatural explanations, he progressed steadily towards an understanding of the utility of these manifestations to himself. He grasped for the first time the passive homosexual factor in himself, and saw how this involuntary self-exhibition served the purposes of these morbid and dissociated impulses. He saw further how the subsequent projection of the responsibility for these social occurrences served to rid him of all self-reproaches. It was now clearly grasped that the original sequence of guilty conscience, fear of self-betrayal, apprehension

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of blame, self-consciousness, became by degrees changed by his imagination into unjust accusation, wicked thoughts implanted in his mind by others, compulsory self-consciousness leading to compulsory self-betrayal, and thus to the confirmation of other people's (supposed) evil and unjust suspicions.

When he had realized how, owing to this mechanism, his passive homosexuality, masochism, etc., were involuntarily and unconsciously given free play, while the whole blame for every evil thought or wish was successfully projected upon other people, he grasped the astonishing fact that from a certain primitive pleasure point of view the whole catastrophic series of happenings were of value to him and were of value to no one else. At this point objective criticism was brought to bear upon the reality of his beliefs, the original discussion about the kinds of reality and their relative importance was gone over again, and the patient was progressing very rapidly, I think, towards complete recovery, certainly towards a functional readjustment, when considerations of time and money put an end to treatment. He was completely incapacitated when he began treatment; at the end of six months he resumed exceptionally heavy duties successfully and has married.

In any case, from the administrative point of view the treatment was successful. Instead of being hostile, suspicious and miserable, the patient became enthusiastic and co-operative after the first few weeks, and would have remained so, I am certain, even had the treatment been continued to a conclusion. This is in itself quite important.

In case C—, one of depressive psychosis, success was not nearly so great. Hostile projections and egocentric suspicions were indeed a feature here also and were comparatively early and easily dispelled. The recurrent depression, however, directly interfered with the investigation in a way there was no evading, automatically inhibiting the patient's intellectual processes: it brought the therapeutic discussion to a standstill by rendering him almost mute. Inaccessibility of any sort is of course an absolute bar, and particularly so in the presence of massive emotion.

Taking these three cases as examples, I would offer some suggestions as to the potentialities and limitations of psychotherapy in dealing with "projection" symptoms, delusional or obsessive. I would prefer to have based my remarks upon a larger number of cases, but I have only one more strictly comparable in regard to exhaustiveness of study, responsiveness of patient, etc. A— and B— received over 200 hours of clinical study, C— nearly 400, while none of the three, had reached the stage of "broadcasting"

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their paranoid ideas. Cases so early as this are, of course, not easily obtainable for study. The first dilemma that confronts the psychotherapist in treating such cases is that of reaching and retaining, for the necessary length of time, the requisite confidence of, and intimacy with the patient, without being drawn into the circle of his psychotic system. This problem I propose to leave for later consideration. The second difficulty is to avoid joining issue with the patient on the question of the objectivity of his projections until the latter (*a*) has established a strong *rapport* with the physician, (*b*) is aware of the subjective utility of his beliefs, and (*c*) has been so educated in epistemology and the social meaning and conditions of thinking as to be capable of at least a formal criticism of his own thought-processes. The patient will raise the issue as soon as he can, and attempt to force the physician to declare his own point of view. The more suspicious and antagonistic the patient is, the more insistently will he obtrude his delusions and other projections, once these are revealed at all, because these are his defences; they form a "red herring" to draw off attention from his own endopsychic conflicts, and in his opinion they constitute an excellent test of the friendship and sincerity of the physician. I repeat that any argument, rational dissuasions or any attention whatsoever, prematurely devoted to projection symptoms of any kind is simply "playing into the hands" of the psychosis, developing and confirming the patient's paranoid tendencies and rendering the real pathogenic mechanisms ever more and more inaccessible to treatment. Subtlety and dexterity are of little avail in postponing this issue. To acquiesce in his delusions, to dispute them, to quibble or shirk the discussion are all equally disastrous either by irritating the patient, reinforcing his suspicions of conspiracies of silence, confirming the delusions or rivetting his attention upon his projections. Nor is it possible to fob such patients with the tale that they are ill; that is the point at issue, and they are too acute to yield to a *petitio principii*. No evasiveness, lack of interest nor attitude of superiority is tolerated by these patients. I repeat that the only way I have found, or can so far conceive, for deferring the critical attack upon projection symptoms, until this has a chance of success, is by explicitly insisting upon a preliminary discussion of the theoretical foundations of belief in general, and of the meaning to be attached to the ideas, truth, proof, etc., in fact to arrive at a common understanding as to the theory of knowledge and of the social functions and conditions of thought—a psychobiological critique of the powers and limitations of mind, and an agreement as to rules and methods of discussion.

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The third difficulty is to break the vicious circle between secondary neurotic thwartings and psychotic regressions. This, as I have suggested earlier, if it can be achieved, at least prevents adding fresh fuel to the patient's dissatisfactions and tensions, and if any success can be gained along these lines it directly distracts the patient's attention from his projection symptoms, it promotes his insight into the duplicities and irrationality of unconscious thinking, and it helps more than anything to maintain the correct *rapport* with the physician. Although these neurotic symptoms are secondary to the patient's affective mal-adaptation to his environment and the concomitant thwartings and dissatisfactions of interest, and although this maladjustment itself is secondary to the psychotic fixation, the neurosis, superficial and secondary as it is from the standpoint of mental development, is the real channel of traumatic energy for the further progress of the psychotic regression. All thwarted interest, dissatisfaction, etc., is caught up in the neurosis, and from this level repercusses upon the psychotic fixations and reinforces indefinitely their deeper-seated regressive tendencies; it is, in fact, to this tension that the rapid progress of the psychosis is due. It is responsible also for any violent hostility and anti-social conduct that may appear, and contributes very largely to the well-known therapeutic inaccessibility of the psychotic. If, then, any definite neurotic symptom or mechanism can be discovered in the psychotic, this is the strategical point of attack; progress can be made at this point alone; here alone the patient's defences are vulnerable. Success achieved at this point opens the patient's eyes to the fact that if not mentally disordered, he has at least been unnecessarily unhappy from causes within his own mind. The world and his fellows thereupon assume a slightly more favourable aspect, and the *rapport* with the physician is enormously confirmed and safeguarded from the negative psychotic influences that are so apt to destroy it.

The practical suggestions I make are, therefore, three: (1) Intensive treatment from the moment the patient comes in contact with his physician, but with no contact between the two other than therapeutic, *i.e.*, no social or administrative relations. (2) A strong attempt to educate the patient in the theory of knowledge and to develop his capacity for formal logical criticism. (3) The concentration of attention upon any neurotic as distinct from psychotic symptoms that may be present, and the postponement of the grand attack upon the psychosis until this has been completed.

In general, cases that are clinically paranoia and yet on investigation show that wish, rather than defence, has been the chief factor in projection, are more accessible to investigation and

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amenable to influence than those in which the fundamental wish is deeply hidden under negative and hostile ideas. To begin with, such simple wish-projections have not nearly the same tendency to become organized into a logical unity, nor are they so apt to buttress themselves upon elaborate misinterpretations of data. It is when the wish is repressed, totally denied and rejected by the patient, and where the repudiation requires the services of indignation, that the hostility of the paranoiac takes its origin. Without hostility and suspicion paranoia should be more easily curable than the underlying homosexuality. There are a number of cases which are clinically chronic systematized delusional insanity and yet respond well to treatment. Wherever the wish has not been too seriously threatened or opposed by external circumstances, wherever the wish is not too obnoxious to the censorship and therefore does not require vehement rejection, wherever, indeed, defences have not been too actively aroused, the mechanism of paranoia can be laid bare. Wholesale delusional states of an evanescent nature are not uncommon for instance at the climacteric, and they occur also at other times of stress. These are wrongly called deliria, but are in fact paranoiac in type and mechanism; they are in reality merely a glorified childish make-believe that, owing to the peculiar temperament and circumstances of the patient, wins acceptance in the place of reality. It has been noticed, for example, by Tanzi that the amorous type of paranoia is far more benign, more tractable and less prone to conflict with society than those in which the delusion comes to take the form of persecution. Probably the most dangerous of all is the paranoiac who believes that his pelvic organs are actually being interfered with. Here we have, generally speaking, a rejection and projection of a wish and a violent reaction against it by the whole censorship. At the other end of the scale we have the woman who believes that a certain man is secretly attached to her; here the projected love-wish, that is if it is not too incompatible with her super-ego, and the resulting romantic situation, may be cherished as a secret solace for many years, and in any case does not have the progressive and malignant tendency of the more pronouncedly defence-hostility paranoias.

Of course it will be observed that the systematized delusions I have characterized as amiable and benign are heterosexual, and the inference will therefore be drawn that it is this circumstance that determines the more favourable character of the systematized delusions. Broadly speaking, I think this is fundamentally true, but I will not on that account deny the title of these amorous paranoiacs to be diagnosed as paranoias. Clinically they are

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unquestionably chronic systematized delusional insanities. In these cases the mechanism of projection is beautifully and predominantly displayed, so that unless we accept the Freudian correlation of paranoia and homosexuality as equivalent to a re-definition of paranoia, we would have to admit that this group is paranoia. Cases of this kind are really much more numerous than certification statistics would lead us to believe. They escape record by reason of their amiable dispositions and reticence. Further, so far as my own experience goes, the unconscious homosexual element in these cases is really very strong, though the delusional attachment is heterosexual. These cases represent intermediate states between the incestuous fixation to the heterosexual parent and transference to the homosexual parent, and though the heterosexual drive is completely goal-inhibited (another reason for the need for phantasy, and for the retarded development of the reality sense), it still acts as a pleasurable inspiration in certain circumstances, particularly where there is no possibility of gratification.

The treatment of such cases of course depends upon the facilities offered by the patient's age, character and circumstances, for the completion of the normal development and direction of libido. Without such a radical constitutional change, real character development is not possible and regression is a permanent gulf at such patients' feet. Moreover, without at least normal sex wishes, the need of such patients for phantasy gratification is absolutely paramount, and the phantasy, of course, affords the nidus for innumerable potential delusional systems. The possibilities of therapeutic interference are therefore strictly circumscribed.

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