A PSYCHO-ANALYTIC APPROACH TO THE CLASSIFICATION OF MENTAL DISORDERS.*

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DURING a symposium on the psychotherapy of the psychoses held under the auspices of this Section,† I took occasion to point out that, owing to the nature of their case material, many psycho-analysts had been forced to undertake this branch of treatment, whether they liked it or not. In the case of psychiatric classification the position is somewhat different. However much the psycho-analyst may choose to procrastinate, he cannot postpone indefinitely the task of correlating psychiatric data with his own systematic formulations on mental development. The more precise and dogmatic these formulations become, the more incumbent it is on the psycho-analyst to test them in the psychiatric field. Already some ventures have been made in this direction, notably in the work of Rickman,‡ Schilder,§ Stärcke‖ and others. The main justification for a renewal of these attempts lies in the fact that during the past four or five years, appreciable advances have been made in the psycho-analytic understanding of early stages of ego development. A great deal has been achieved by the analysis of small children, largely under the inspired stimulus of Melanie Klein, and already this work has produced reverberations in other directions. I am constrained to make this preliminary explanation in the hope of mitigating an impression which I fear still prevails in some quarters, namely, that in its relations to psychiatry, psycho-analysis displays the dogmatic over-compensation of an ignorant and none-too-welcome parvenu. Indeed, I should like to take this opportunity of stating that psycho-analysis, if even on the barest grounds of

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† Glover, "The Psychotherapy of the Psychoses," *Brit. Journ. Med. Psych.*, 1930, x, No. 3, p. 226.

‡ Rickman, *Psycho-analytical Theory of the Psychoses*, 1928.

§ Schilder, *Entwurf zu einer Psychiatrie auf psychoanalytischer Grundlage*, 1925, Vienna.

‖ Stärcke, "Psycho-analysis and Psychiatry," *International Journal of Psycho-analysis*, 1921, ii, p. 361.

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economy of effort, looks forward to an increasingly close alliance with pure psychiatry. And I hope to be able to indicate in this paper some problems on which the co-operating energies of the two sciences might well be concentrated.

It may occur to you to ask why psycho-analysts are not content to mould their formulations to existing psychiatric classifications. A satisfactory answer would involve a lengthy digression on the nature of psycho-analytic method and, apart from a few preliminary comments, I can only hope that the reply will be apparent from the nature of the considerations brought forward. It would, of course, be idle to pretend that psycho-analysts do not find some psychiatric classifications unsatisfactory from their point of view, but again I shall refrain from entering upon a lengthy argument on this matter. In any event the onus of criticizing existing classifications has already been shouldered by psychiatrists themselves. Almost all thoughtfully written text-books emphasize the difficulties and confusions of clinical classifications and endeavour to overcome them. This endeavour takes the form either of simplification, which does manifest injustice to clinical detail, or of further elaboration, which is apt to confuse the student. Terminology apart, when one reads of various "mixed forms" included within the great groupings—schizophrenic, paranoid or melancholic—or when one thinks of complicated transitional groups lying between these main divisions, the ultimate impression is one of matted complexity. Not that complexity of itself is a valid reproach against any classification. It has always been preposterous to suppose that the complications of mental development could be adequately reflected in a simple tripartite division of the psychoses. Serious objection can be taken only when the degree of complexity is in inverse ratio to the fundamental understanding achieved. And the most sympathetic reading of much descriptive psychiatry can scarcely remove the impression that the three most important fragments of the jig-saw puzzle are firmly adherent to all the complementary pieces. Moreover, it appears reasonable to suppose that the rigid interlocking which hampers one system of classification may prove to be the firm groundwork of an unknown grouping. For example, if we find a delusional element common to schizophrenia and paranoia, or an affective system common to schizophrenia and melancholia, it is always possible that the common element should have been the main factor in classification.

Before expounding the principles governing psycho-analytical

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classifications of the psychoses, we may inquire to what general conditions an adequate system of classification should conform. Presumably it should be sufficiently elastic and skeletal in outline to permit of subsequent modification; it should not crack under the strain of new or awkward data. Not only ought it to leave gaps free, but its very outline should indicate the possibilities of future research. Like the early schemata of atomic weights, it should encourage us to presume the existence of undetected "elements," or, alternatively, assist us to isolate illuminating "syndromes" from existing undifferentiated symptom-complexes. Obviously it should present existing data in as comprehensible a light as possible, but there should be no attempt to reduce comprehensibility from fear of refractory exceptions. If, for example, we find it difficult to say what exactly is the *rôle* of a phobia in the psychoses, there is no reason why we should force a square peg into a round hole. The phobia problem can wait.

This is all very plain sailing. Complications arise when we condescend to the details of psychiatric terminology. Should we, for example, be content with a purely clinical and descriptive method? Convenient as such a system may be in the case of organic disease, there is no doubt that it is a dangerous and retrogressive procedure in the case of the psychoses. Owing to the existence of unconscious mental processes, it is unlikely to be either an accurate or even a practical method. We would not trust a cartographer very far if, having told us that all solid objects surrounded by water are islands, he could not say whether the solid object in question was dry land or the dorsum of a whale. As we know, an apparently simple phobia may be a transient neurotic manifestation or the peak of a concealed paranoid construction. The term "melancholia," too, with its emphasis on the depressed, inhibited and lifeless features of a regression, completely ignores the fact that during this phase, the mind is practically white-hot with excessive charges of hate and aggressive energy. To call the delusions of paranoia a symptom of disease, is as complete a reversal of the psychological truth as to call granulation-tissue an abrasion. It is no more illuminating to talk of catatonia in severe regressions than to use the term "sleep" in describing uræmic coma. Even in organic medicine it would scarcely promote free exchange of ideas, if we labelled certain cardiac and renal conditions together with cystitis and urethritis under the common heading "albumen in the urine." An "end-product" classification in psychiatry is equally inadequate, and must give way to a more "functional" approach.

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On the other hand, in the absence of general agreement on the ætiology of the psychoses, a classification based solely on alleged genetic elements would be a legitimate source of exasperation as well as of confusion. As a temporary measure, therefore, a descriptive factor, even if inadequate, seems unavoidable, and may be laid down as a first factor in classification. The problem arises: Can this descriptive factor be combined with criteria which will promote genetic understanding, aid differential diagnosis and prognosis, accentuate the essentially psychotic nature of the psychoses, and yet establish some intelligible relation between the phenomena of psychiatry and the psychological phenomena of everyday life?

This last condition is essential. A classification which cannot relate the psychoses to mental phenomena as a whole has foundered in the dock. In this one respect the term "melancholia" justifies itself. The man in the street, familiar with his own transient states of depression, is encouraged to assume that he can himself be mad at times. And his assumption is correct. Not only can he be mad at times, but all the time he is a little mad. Still further he passes through a protracted phase of severe madness in his infantile years. Only the consensus of social opinion and valuation entitles him to call his nursery and adult madness normality. This matter can easily be put to the proof. Let anyone maintain a complete system of "nursery madness" during the period when "adult madness" only is expected of him; in other words, let any adult adopt the ideology, language and behaviour of an infant of 18 months, and he will promptly be certified by two "normally mad" doctors. Here we make our second practical contact with the problem of classification. A sound classification must somehow relate the psychoses to normal development. But to do this we must realize just how psychotic normal development is. Converted into systematic terms, a classification of psychoses must be built up in close relation to the historical modifications of ego-structure. And if we do not know all that is to be known of this structure, we must simply leave empty niches in the classification.

In establishing the nature of this second factor, we have at the same time opened the way to discovering a third factor. Granted that we must relate the psychoses to normality, we must not abuse this necessity. Although the community calls on us to diagnose and treat psychoses, it certainly does not want us to call normality madness. So we must check the second factor by a third, representing some specific or almost specific psychotic mechanism.

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At the risk of neglecting other important specific factors, I shall maintain that loss of reality sense is one of the most striking features of the psychoses, and provides us with an adequate correction for error. We must, of course, lay down some fairly precise definition of this third term. For the moment I shall neglect this obvious precaution; it will be easier to arrive at a definition of reality once we have studied the backbone of the classificatory system, viz., the nature and order of ego modifications.

Doubtless other criteria could be substituted for or added to these three factors. It is partly a matter of convenience, and partly a question of the depth of psychological knowledge and understanding. Obviously we are not debarred from adding alternative labels where this course seems desirable. And in any case the psychiatrist has a long leeway to make up before his psychic systems approach the degree of complexity already regarded as essential in classifications of organic disease. In the meantime let us see what can be done with the three suggested criteria: (*a*) a descriptive, clinical standard, (*b*) a systematic ego standard by which psychiatry can define its relation to other psychological data, and (*c*), a qualitative standard which, by virtue of specific or almost specific relation to the psychoses, acts as a check on the systematic standard.

With regard to the descriptive standard, I have already suggested that owing to differences of academic opinion I am compelled to borrow from existing psychiatric terminology. I shall limit my indebtedness to three or four terms. To begin with, although I have no preference as between the terms "schizophrenia" and "dementia præcox," I am bound to borrow one or other in order to suggest a main division characterized by deep and extensive regressive features—a group in which the wholesale detachment of interest from the world of objects is quite unmistakable. In the second place, I would borrow the term "paranoia" to denote a group in which the relation to the external world is much less limited, but which nevertheless shows a more or less characteristic impairment of reality sense—to wit, the delusional system. Lastly, I would adopt a melancholic group to indicate a regressive system, less extensive than the præcox regressions, associated with a marked degree of inturned psychic scrutiny, together with a characteristic affective state, *viz.*, depression. That there are depressions in other groups is one of the inadequacies of existing descriptive criteria.

With regard to the second criterion, I ought to say that my

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views on ego organization are derived from purely psycho-analytic sources, in most instances from the writings of Freud. In the simplest terms of structure the ego is regarded by psycho-analysts as an organized system of psychic impressions ultimately expressed in terms of memory-traces. From the dynamic point of view, however, it can be regarded as a psychic organ of adaptation. This organ is, one might say, bounded on one side by perceptual consciousness, and on another by instinctual impulse. Perceptual consciousness is, however, more than a boundary; it is a psychic window system. Using this system the ego not only samples the stimulations of the external world, but, provided unconscious barriers do not interfere with the view, takes measure of an inner world of instinct derivatives. These derivatives are either ideas or affects. The function of the ego as a whole is to effect a compromise between the demands of instinct and the amount of gratification possible in the external world. Strictly speaking, the external world in this sense includes the individual's own body. As, however, only a few component instincts are capable of gratification apart from an external object, we may say roughly that the ego lies between instinct and an external world of objects—in other words, environment. The "signal" system by means of which the ego tests the success or failure of its manœuvres is anxiety. If ego manœuvres are unsuccessful, frustrated instinct will induce anxiety; if in its attempt to gratify instinct the ego attacks the world more than immediate human representatives will endure, an environmental embargo or threat ensues; if the original impulses are exorbitant or impossible of gratification, they frustrate themselves; and if an unconscious guilt system has been established, all impulses counter to the existing unconscious codes of the ego are frustrated from within, and the result is once more anxiety. In 1877 a German psychiatrist said that anxiety was the Alpha and Omega of psychiatry. Psycho-analysis, having traced innumerable indirect signs of anxiety in conscious and unconscious territories, is prepared to say that anxiety is the Alpha and guilt the Omega of human development. Spurred by anxiety the ego makes fresh attempts at adaptation. But there are only three main lines of action possible; (*a*) inhibition, repression or deflection of instinct, (*b*) less exorbitant demands on environment (courses which presuppose some tolerance of frustration-anxiety), and (*c*) a pathological distortion of the ego. This third group is then subdivided into two: cases in which the consequences of ego distortion are roughly limited to the mind or body of the subject (autoplastic), and cases where impairment of

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reality relations is an outstanding feature. The psychoses represent an extreme example of the third method. The neuroses, too, belong to the third group in so far as a degree of localized ego distortion occurs; but except in some socially unimportant respects, there is in the neuroses no grave interference with "reality testing."

Once again this is all very plain sailing; indeed, many psychological schools accept these views without qualification. Disagreement makes its appearance when the psycho-analyst refuses to accept the conscious adult ego as the most important model, and insists on regarding the ego-organizations of the first five years of life as key patterns. Following this line of approach the psychoanalyst first of all inquires what exactly is the nature of instinct in these years, and proceeds to answer his own question with a formulation which at one time aroused either scepticism or disgust or anger in a majority of his hearers. He says in effect that the child is endowed with impulses of a primitive, aggressive and libidinal type, frustration of which produces a vicious circle. The sequence is as follows: Frustration of primitive impulse, anxiety, hate, projection, additional frustration of hate and now guilt; still more frustration of the original impulse and now inhibition; ending once more on a note of frustration. The first mechanism to break the vicious circle is repression, which abolishes *all* representation of the impulses in question. He proceeds then to classify the original libidinal tendencies, and says that the first five years are governed by certain primacies associated with certain erotogenic zones; to wit, an oral libidinal primacy, where the attitude to objects is almost undifferentiated cannibalism; then an excretory libidinal primacy accompanied by intense sadistic attitudes to the world, but with an increase in capacity to master instinct and endure frustration; and finally a less sadistic infantile genital primacy of instinct which, though foredoomed to frustration, and therefore to induce a characteristic anxiety (*i.e.*, castration anxiety), can in most cases be successfully repressed, leaving a residue to be deflected into the affectionate family relations of childhood. With regard to the aggressive impulses employed in attitudes of hate, although the ultimate aim of this group is to destroy all sources of tension, and in that sense does not alter, the technique of destruction is to a large extent determined by the libidinal interest governing successive stages.

If we take this view of infantile history, it is obvious that not only the adult ego but the ego of a child of five, however well organized, is essentially a composite. This can be supported by

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theoretical considerations which I have elaborated elsewhere,* *viz.*, that any psychic system which (*a*) represents a positive libidinal relation to objects or part objects, (*b*) can discharge reactive tension (*i.e.*, aggression and hate against objects), and (*c*) in one or other of these ways reduces anxiety, is entitled to be called an ego system or ego-nucleus. Thus an oral system gratifies instinct on a part-object (mother's nipple); it can exert aggression towards the nipple (sucking, pulling, biting), and it is able to prevent some degree of anxiety. This is the model or prototype of an independent autonomic primitive ego-nucleus. Applying this system to the conception of a series of primacies, it seems reasonable to conclude that the primitive ego, from at any rate the age of one year onwards, is polynuclear, in the sense of a *series* of comparatively independent organizations; also that the more primitive the ego formation, the more primitive the part objects with which it is concerned.

For a long time psycho-analysis was content with the idea of a consecutive series of fixations, described these mainly in terms of libidinal organization, and applied this system in tracing the ætiology of the psychoses. Thus paranoia was related to the early phase of anal-sadistic organizations, and schizophrenia to the oral phase. But I have long felt that the idea of a *consecutive* series of nuclear fixations was applicable only from the anal stage onwards, by which time the ego is more coherent and organized. For one thing melancholias obviously derive their character from the oral phase, thus necessitating ætiological differentiation from the schizophrenias. In short, we are driven to conclude that the ego of the five-year-old is not only polynuclear, but that the earliest nucleus is itself a polymorph; or, in other words, that the earliest ego tendencies are derived from numerous scattered instincts and *converge* gradually until, probably about the age of two, a coherent anal-sadistic organization is established. No doubt oral elements dominate what has been called the oral stage, and justify the term "oral primacy," more particularly since they constitute a model "autonomic" ego-system. But oral primacy is only relative.

What, then, are the other elements of the first primitive nucleus? The answer is theoretically easy. We have only to collect all the observed and discoverable libidinal relations or erotogenic zones together with all the systems which can be employed to discharge aggression during the first year or eighteen months of life. Any

* "The Ætiology of Drug Addiction"; appearing shortly in the *International Journal of Psycho-analysis.*

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two representative elements which exist in close association could theoretically represent a nuclear formation.*

Thus, for example, an oral libidinal system, together with a muscular aggressive system (clawing, tearing, kicking and biting), can be observed in close relation in the child, and could theoretically represent an ego-nucleus. And when we find in schizophrenia that catatonia is sometimes associated with active oral symbolism, the question arises whether this is more than a coincidence. Again, oral incorporation and excretory ejection is a commonplace of the first year, whilst the oral and anal habits and interests of the schizophrenic are not difficult to detect in close association, although frequently anal stereotypies conceal the oral components. Here, at any rate, is a promising field for research. The raw material of possible early ego formations is easy to collect: on the one hand, various erotogenic zones in active function, oral, skin, respiratory, alimentary, excretory and muscular; on the other hand, the reactive systems that discharge aggression. The latter appear to have one element in common, *viz.*, the musculature, but if one thinks more closely it is apparent that the most important erotogenic systems, with the exception of the skin, are also capable of expressing destructive impulses. A small child, for example, can phantasy destroying the world with his urine. I believe it will soon be possible to establish with some exactitude various nuclear combinations of libidinal and aggressive interest which, marshalled under the relative primacy of oral impulse and aggression, give rise to the omnibus fixation-point of schizophrenia. In the meanwhile, one can say with certainty that the fixation-point of melancholia is still essentially an oral fixation-point, one in which oral aggressive function has dominated all other contemporary modes of destruction, has been turned in on itself mainly for purposes of mastery, and has warped the psychic organization in a characteristic way.

To sum up at this point, the primitive structure of the ego might be figured as a kind of skeletal system. At the beginning is a cluster formation of ego-nuclei converging on a consecutive series, the elements of which show an increasing degree of organization. The cluster and the first few nuclei that follow represent the fixation-points of the psychoses; the last organized nuclei represent the

* It need hardly be repeated that the nucleus in question is a psychic nucleus. It represents a closely knit psychic system of impressions, which can not only be reanimated, but can contribute to later ideational processes (unconscious or conscious phantasies).

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fixation-points of the neuroses. The image is of pictorial value only, and expresses a time dimension (see Figs. 1, 2 and 3).

I have said that we have here a promising field for research. I should like to add that in this field psychiatrists have unique opportunities to assist and accelerate psycho-analytical research.

FIG. 1.

ORDER OF LIBIDINAL PRIMACIES.
[EARLY VIEWS.]

A. ORAL.

B. ANAL-SADISTIC.

C. PHALLIC.
GENITAL.

FIG. 2.

[ABRAHAM'S SERIES.]

A. ORAL.
- **(1) PREAMBIVALENT.** [SUCKING.]
- **(2) SADISTIC.** [BITING.]

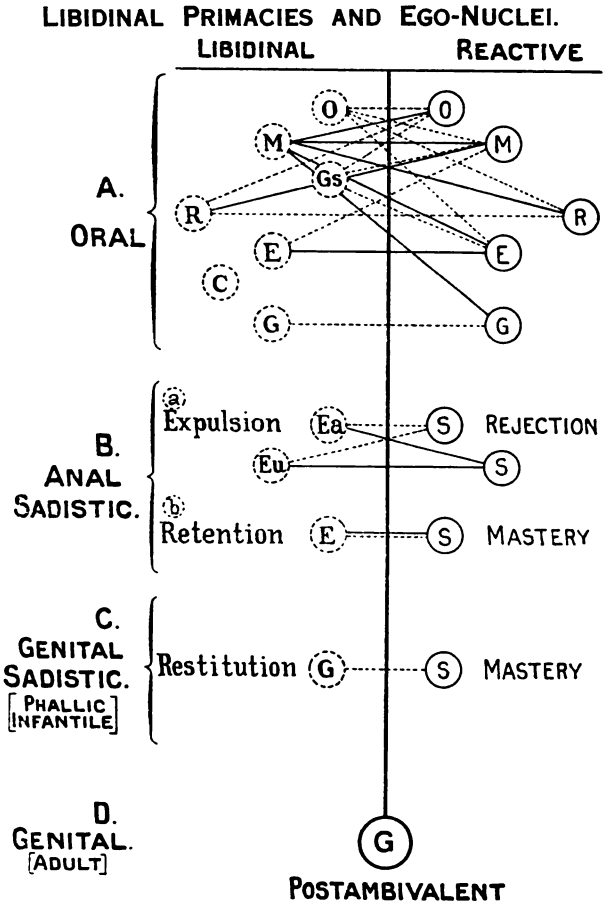
B. ANAL-SADISTIC.
- **(1) EXPULSION—DESTRUCTION.**
- **(2) RETENTION—MASTERY.**

C. GENITAL.
- **(1) PHALLIC.**
- **(2) FINAL—POSTAMBIVALENT.**

There is ample scope, especially in the case of schizophrenia, and the so-called toxic psychoses, for isolating syndromes, the value of which could be tested by analysis of psychotic and non-psychotic types. In this connection the "decomposition products" of schizophrenia require the most careful study and grouping; in the case of primitive ego-nuclei the object is invariably a "part object," and in schizophrenic regression it becomes once more a

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FIG. 3.



Illustrating the relation of libidinal primacies to ego-formations: A view of ego-development in longitudinal section; ego-nuclei bisected and reflected to show libidinal and reactive constituents; note the relative lack of organization of the oral phase, emphasizing the importance of other zonal components during that stage. Inter-relations of different libidinal and reactive zones are indicated by plain and dotted lines.

In stages B, C and D the attitude to the instinctual object (or part-object) is indicated.

Key.—O. Oral. M. Muscular. Gs. Gastric. E. Excretory. Ea. Anal (Excretory). Eu. Urinary (Excretory). R. Respiratory. C. Cutaneous. G. Genital. Oth. Other zonal organizations. S. Sadism.

" part object." A prerequisite of any such work would be common understanding of fundamental mechanisms. Without this understanding many syndromes would go undetected. And in the last

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resort syndrome-hunting is merely a stimulus to ætiological research and formulation, not a substitute for it.

We must now turn to the third factor of our classificatory system, *viz.*, the *qualitative* test of reality. Our first task is the definition of reality. Approaching this problem systematically, there are two obvious lines of investigation. The first is the nature of "objects," and the relations existing between primitive objects and objective reality. The second involves some consideration of the primitive processes of projection and introjection.

Strictly speaking, an "object" is that on which an instinctual impulse is gratified, and may vary from a nipple in the case of oral impulse, to the idea of the solar system in the case of astrophysical curiosity. But the fact of psychical displacement warns us that even the most abstract objects of metaphysical preoccupation can function as substitutes for more primitive part-objects; in fact, that the whole world can be reacted to as if it were an orange to be squeezed, or a nipple to be sucked. As we know, when certain psychotics withdraw their interest from the world of objects and pile up an unmanageable charge of sadistic libido within their own egos, the resulting damage and destruction is sometimes represented by ideas of world destruction.

Now in the case of auto-erotic activities, the "object" on which the impulse is gratified is part of the individual's own body—sometimes an organ, sometimes an organic system. So as far as pleasure experiences have some quality in common, there is evidently plenty of scope for confusion as to ego-object boundaries in the earliest phases. Indeed, Freud believes that there is some advantage to be obtained by assuming a state of "primary identification" between the subject and all instinctual objects. We might say that all the agents contributing to a gratification experience (including the object) are taken to be part of the ego, and secondly, that in so far as gratification experiences at different parts of the body have some psychic quality in common, the contributing agents are liable to be identified. This primitive type of identification is an important element in the process of symbolism.

However this may be, the next steps in the differentiation of ego from "object" are fairly clear. Experience of mastery of instinct shows the way. An instinct excitation that can be gratified on the individual's own body is *a priori* to some extent manageable. An instinct that requires a true external object, such as the mother's nipple, is unmasterable unless with the collusion of the real object. Hence psychic pain, that immediate consequence of frustration,

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provides the first great impetus towards the discovery of real external objects. Other experiences contribute to this "object" system. There are certain painful ego experiences which indicate the existence of a painful "not-me"—a pin through the diaper, a hard crumb in the mouth, a hot-water bottle against the ribs. When such stimuli are removed the pain stops. So the "not-me" is gradually reinforced by experience of stimuli which can, as it were, be discarded. But certain "me" stimuli resemble the pins and crumbs of the "not-me." Some colic pains can be eased by the sudden expulsion of wind. So here again we have a source of confusion between the "me" and the "not-me." And here, too, we watch the birth of that great primitive mechanism of projection. If only more enduring colics could be suddenly converted into painful "not-me's" like crumbs, and violently expelled! At the same time the experiences of mouth, hand and stomach are responsible for building up another psychic tendency, which we dimly try to appreciate by the use of the term "introjection." If only the pleasure-producing nipple could be imprisoned in the mouth, the stealing warmth retained in the stomach! Failing these, if we could only make the gesture of holding on with clenched fists, of making pleasurable "not-me's" part of "me," how much safer from anxiety the ego would be! Thus, however long the hallucinatory phase of primary identification may last, it gives place to a phase of adaptation which is nevertheless from the adult point of view a phase of confusion confounded. A pleasure ego that wrongly includes reality objects is set against a painful outer world that wrongly includes parts of the ego. The sequence is therefore acute hallucinatory pan-psychosis, then a part introjection psychosis of the schizophrenic, or at any rate melancholic type contrasted with a part projective psychosis of the paranoic type (Figs. 4 and 5).

The concept of a hallucinatory pan-psychosis is a trifle hypothetical, although during the earliest infantile stage (sucking) there are hallucinatory phenomena and to spare. On the other hand, actual clinical analysis of psychotic children shows that the second main subdivision (introjective and projective psychoses) corresponds with the facts. The same general outline can be demonstrated in the adult psychoses, although the system is covered to a varying extent by complicated processes of object restitution. These bizarre attempts take up the foreground of the clinical picture.

In making these correlations between psychotic states and the systems of primitive experience by which ego differentiation is achieved, I have been tempted rather by the illustrative value of

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FIG. 4.

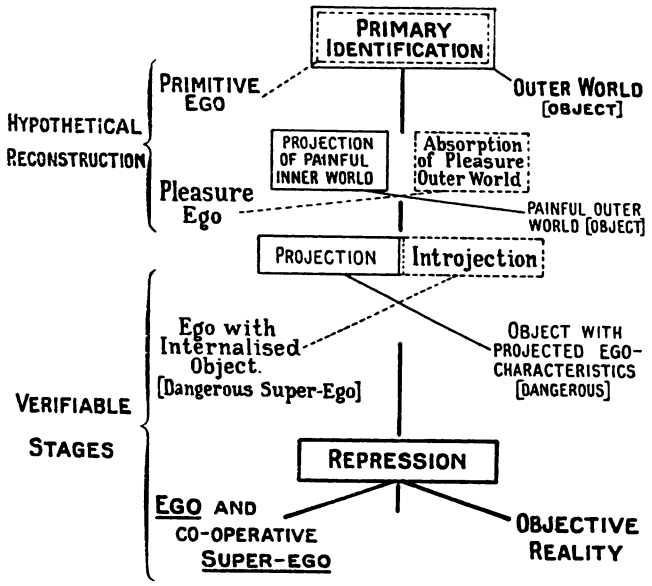
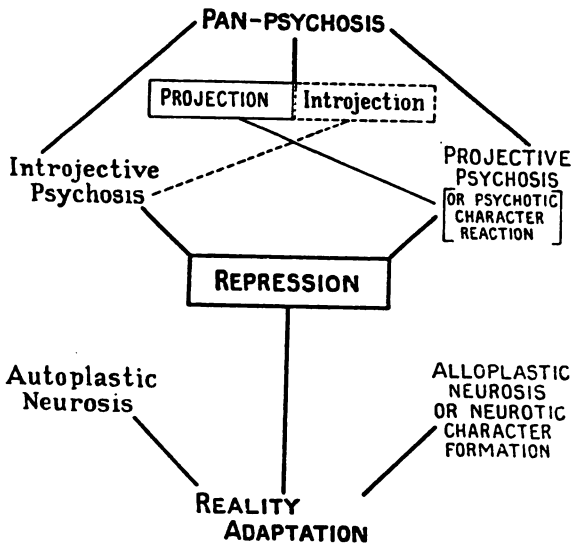


FIG. 5.



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these concrete experiences. Because, of course, the introjections and projections that influence reality sense are not simply sensory, but more complicated psychic experiences. The most painful, persistent and unmasterable stimuli are the psychic stimuli of frustrated instinct. They correspond inside the ego to the pins and crumbs of external life, raised in intensity to the *n*th power.

Now as regards precedence of these mechanisms in the psychic plane, I think it is safe to assume that, in so far as they are not mutually complementary mechanisms, precedence must be awarded to the projective process. After all, the infant's first experience of the world might be regarded as facing massed batteries of excruciating stimuli, and it is clearly important to get these " outside " as soon as possible. This precedence has fateful consequences. So long as the pleasure-producing nipple was part of the self by primary identification, it was part of the pleasure-ego—a " good " nipple-self. When it is found to be an external object, only periodically masterable, the painful tension is projected after this vanishing object, which then becomes a painful " bad " nipple, deserving of hate and destruction. But to destroy it is to kill the goose that lays the golden eggs, *i.e.*, it is a threat to the " good " (gratifying) nipple as well as to the " bad " one. This reaction threat to a gratification system involves renewed psychic pain. And the renewed pain, following close on the heels of projected tension, acts as a boomerang. One projects on to the object, hates it, wishes to destroy it, and the object hits back. The experience is already familiar on the sensory plane. Either in course of casual activity or during a rage, the baby hits itself against the bars of the cot. What do the bars do ? At precisely the same moment, they strike the child smartly and painfully on the head or hands. A painful, malignant and remorseless outer world ! To this mixed phase of sensory and psychic experience we can ultimately trace the roots of persecutory paranoia. But, of course, the purely psychic structure of the persecutory system develops only when the influence of true introjective processes has played its part in the drama.

Only one part of the ego says " Kill the goose." Another part says, " Swallow the eggs and keep them inside." But, alas, the eggs are now addled. They have been poisoned by projective hate. In this phase the conflict is terrific. The nearer the child draws to that final termination of nipple mastery which is called weaning, the more necessary it is to retain the nipple psychically. Introjection is essentially a mechanism for dealing with lost or disappearing objects. The more the ego is threatened with loss, the

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greater the hate; the greater the hate, the greater the projected hate; the greater the projected hate, the more dangerous the world of objects; the more dangerous the world of objects, the more poisonous the effect of introjection.

But if the system has been poisoned, why then continue along the line of introjection? Well, partly because the continued uncertainty of object relations compels it. For a time the ego cannot help itself otherwise. Primitive libidinal need is strong, frustration anxiety intolerable. Partly, too, because swallowing is itself destructive, and is therefore the most natural way of expressing hate of frustrating objects. Moreover, if you really have reason to love an object as well as hate it, perhaps the only way to keep that love alive is to get the object inside. Falling to these additional temptations, the child takes a momentous step; it introjects an object with a persecuting tendency. The immediate result of this manœuvre is disconcerting. The ego achieves some degree of object mastery, but at the same moment its organization is split almost to the roots. It also preserves an object relation, but at the cost of turning aggressive energies on itself. By short-circuiting the object it can now hate successfully, but it must hate itself. The more the ego rages and struggles, the more powerful the grip of the now internalized persecuting tendency which feeds on the hate tension aroused by continued instinct frustration. Hate rages against hate. The infantile prototype of melancholia has been established.

In this impasse the ego once more turns to the external world with a policy of projection. If you cannot control this system you have set up in the mind, eject it. But matters have gone too far; a mental organization once established cannot be summarily ejected. All the ego can do is to continue to project painful impulse. And every projection renders the objects of the external world more dangerous, thereby compelling and at the same time vitiating fresh introjections. For a varying time the ego is in a state of feverish activity, alternating rapidly between policies of introjection and counter-policies of projection. These alternations are reflected in the psychotic "mixed states." A vicious circle in ego-economy is now set up. The great primitive mechanism of projection has lost some of its magical power, and introjection paralyses the ego. That the alternating system does not break down completely is due to two factors. The first and most important is the development of an auxiliary mechanism, *viz.*, primal repression, which is supplemented later by secondary or actual repression. The child

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cannot successfully eject the persecuting instance, but it does achieve a masterly adaptation. By sacrificing (repressing) its primitive instinct it comes to terms with the internal persecutor. And the new institution co-operates by taking on a special function; it acts both as instigator of repression and as detector of dangerous unrepressed impulse. This scrutinizing function justifies a special term. We now call the introjected object the *super-ego*.*

The second factor is more important for our present purpose. It is the re-discovery and increased exploitation of reality. Almost from the beginning there is some degree of reality-proving, however faint. This is immensely increased by the tendencies of libidinal impulse and the processes of symbolism and displacement. These make towards an increasing acquaintance with reality. And now comes a dire necessity to establish and cling to a "real reality," one that is safe from the terrifying elements contributed by projection. Here the actual behaviouristic policies of the parents come into their own. The psychological function of the parents is to act out a reassuring version of external reality, until such time as the child can identify with them more completely and carry on its own reassurance.

The foregoing presentation is inadequate in many respects,† but it will assist us to formulate certain generalizations of importance to psychiatry. In the first place we see that from a purely psychiatric point of view the "normal" infant is in an "acute psychosis." But clinical psychiatry cannot be expected to concern itself with such everyday developmental phenomena. The second formulation is of a different order. *Unless the child comes to terms with reality, he remains in a true psychotic state of anxiety.* Exaggerated manifestations of this anxiety are entitled to be called the "clinical

* Although it has been the custom in psycho-analytic literature to reserve the term "super-ego" for the part of the ego that first instigates repression, there seems to be no logical reason why it should not be applied to earlier, more persecutory differentiations. For descriptive purposes, of course, some such term as "anti-ego" or even "alter-ego," would appear more appropriate to the earlier stages, but it would have no other advantage.

† In particular I have done scant justice to the stabilizing influence of introjections of "friendly" objects. In the phase of primary identification these are simply the result of absorption of gratification experiences. Later they relate to the more obvious attitudes of protection, support and love manifested by the parents. Not only do these "good" identifications and introjections offset the "dangerous" introjections by acting as a compensatory system, they put an additional premium on successful repression, and at the same time encourage the ego in its search for "real" reality. As, however, the "dangerous" introjections have a more direct relation to anxiety, they act as a more urgent stimulus to instinct modification. They are therefore of greater ætiological significance in psychotic exaggerations of normal adaptation. In her book, *The Psycho-analysis of Children* (to be published shortly), Melanie Klein has laid considerable stress on the importance of these early libidinal relations to objects.

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psychoses " of childhood, as distinct from the " normal psychoses " of childhood. Thirdly, the clinical psychoses of adult life are precipitated by a breakdown in the auxiliary repression system. The individual has maintained a comparatively normal *façade* of reality adaptation by dint of repression, on the breakdown of which he is automatically plunged into a true infantile psychotic state of anxiety. The potential psychotic is one who has come to precarious terms with reality with a narrow margin of effective repression, and who is therefore at the mercy of any severe frustration, either actual or the result of internal (libido) changes.

We are now in a position to define reality. From the psychiatric point of view, adult reality sense represents the capacity to maintain psychic contact with the objects in or through which post-infantile modified instincts are or can be gratified. This world of objects includes all substitutions or replacements of primary unmodified objects; indeed, a capacity to substitute is a test of normality. The discovery of a real object world is accelerated or retarded in accordance with the amount of anxiety experienced in mastering primitive impulse. Abnormalities in reality sense may be subdivided into (*a*) shrivelling of this object world due to withdrawal of interest into the ego, and (*b*) distortions of the world of objects due to projection on it of ego content. Without question, a social (ultimately self-preservative) factor enters into the estimations of another person's reality sense. But, roughly speaking, so long as the individual does not attempt to kill his introjected enemies by suicide or his projected enemies by homicide, society is not too exacting in its demands. This is particularly true of remote psychic substitutes for primitive objects. Of course I do not exclude the possibility that normal relations to the world of objects depend in some degree of correspondence between, for example, the projected danger of instinct and the actual danger of environment; but I should imagine that this correspondence is in most cases reduced to the level of unconscious symbolism.

It is clear that the " reality sense " factor in classification is very closely bound up with the second " developmental " factor. If you insist on treating a complete object, say, a father surrogate, as if he were a part object, say, the mother's nipple, the result is clinically a " distortion of reality "; psycho-pathologically it is a " regression to a stage of part-object relations." Nevertheless, the reality factor provided us with a control system with which to inhibit any exuberant and unpractical exploitation of systematic views. Taking these two standards together we must now ask whether well-

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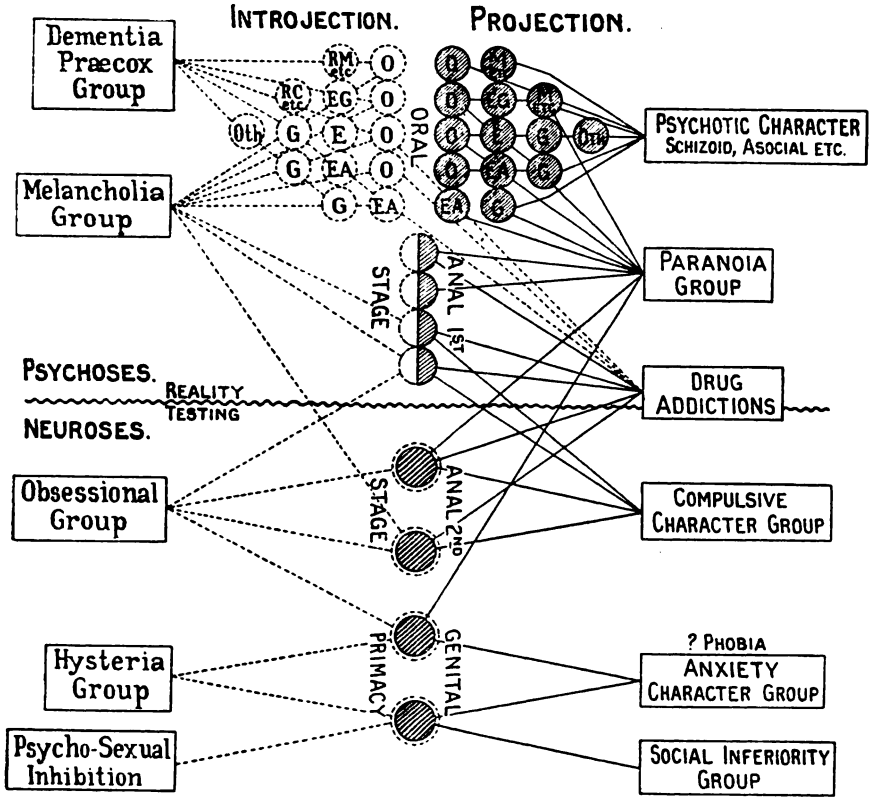
recognized psychotic and neurotic states are capable of orderly presentation. Can we subdivide the main psychoses and neuroses in accordance with ego-object relations? Can we roughly separate out groups characterized by limitation of object relations, by regression to an old ego-system, by processes of introjection, tendencies to retire to primary (hallucinatory) identification? On the other hand, can we distinguish conditions in which the relationship to the external world is distorted or vitiated in some important respect, in which the mechanism of projection is constantly exploited, in which environment is used as an unrealistic defence against ego excitation? Finally, can we, using the reality sense test, subdivide these two main groups sharply, so that the psychoses will fall into a different category from the neuroses? I am going to suggest that in the case of children we can do so quite simply. An adult classification on these lines would, however, be rather amorphous unless we included a number of characterological and other states, some of which are not considered in standard classifications. Most important in this connection are (*a*) schizoid or psychotic character types in general, (*b*) drug addictions, (*c*) obsessional character formations, (*d*) anxiety character formations, and (*e*) mild social inhibitions. An additional advantage of including character states is that we are able to indicate the transitional phases falling between psychotic reactions and so-called normality. And incidentally we are able to grasp the protective possibilities of the neuroses—one might say their potential "buffer" function.

Some rough idea of the interrelations of these factors I have discussed may be gained from the accompanying diagram (Fig. 6). In the first place the nuclear positions of the ego are arranged in vertical order, commencing with a cluster formation representing the most primitive phase of the ego. To indicate the comparative absence of organization during this first phase, I have duplicated this cluster, the unshaded nuclei representing the introjection and identification aspects, the shaded nuclei the projective aspects of the primitive systems. To avoid complicating the diagram too much I have not filled in all the possible nuclear combinations of this phase; and in any case the formations indicated are of a purely provisional nature. I have not duplicated the later nuclei since, from the phase of excretory primacy onward, ego-organization is much more coherent. I have, however, indicated the introjection and projection aspects of these lower nuclei by variations in the shading. By means of arrows I have attempted to indicate possible

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fixation factors for different states; here again, in the interests of simplicity, no attempt has been made to indicate more than a few of the factors.

FIG. 6.



Illustrating the application of three primary factors in classification, (*a*) descriptive, (*b*) degree of ego-development, (*c*) qualitative-reality testing; ego seen in longitudinal section; earlier nuclei bisected and reflected to emphasize (*a*) lack of organization of oral stages, (*b*) relatively independent action of processes of introjection and projection. Approximate fixation points indicated by plain and dotted lines.

The oral "cluster" is represented in five separate layers to suggest a preliminary expansion of ego interest followed by a gradual contraction prior to the establishment of anal-sadistic primacy.

For Key see Fig. 3.

The following points may be singled out for special emphasis:

It will be seen that there is no question of single fixation-points for the psychoses. This is especially true of the dementia præcox

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group, which has a multiplicity of fixations. These have, however, one feature in common, *viz.*, their primitive order. The same is true, but to a less extent, of the melancholias and paranoias. In the case of neuroses the fixation-points are much more localized, although unquestionably earlier developmental experiences are of considerable importance.

We can now arrange a rough parallel series in accordance with the amount of ego absorption of conflict and the extent of environmental (object) exploitation. It is not suggested, of course, that the parallelism is exact; in the early stages progress is much more likely to be zig-zag. I have already said that the schizophrenic fixation is an omnibus fixation, and, of course, from the clinical point of view one might regard some schizophrenic states, particularly the paranoid schizophrenias, and their first cousins, the systematized paraphrenias, as precariously balanced between introjective and projective processes. But in the long run breadth and depth of psychic regression prevail, and it is perhaps better to exaggerate this fact in a diagram. Turning to the terms "transitional state" and "mixed states," it will be apparent that from the point of view of nuclear fixations, the first necessity is a closer investigation of the order of progression or regression between different nuclei, and the second an examination of alternating mechanisms. Clinical considerations suggest that the term "transitional" will in any case justify retention, and theoretically it dovetails with the concept of "regression"; on the other hand, the term "mixed states" will give place to a more accurate and detailed terminology once ego-nuclei have been isolated. This will involve a combination of analytic and descriptive (syndromal) methods.

Again, in the case of melancholia and paranoia the main point of contrast lies in their mechanisms. Of course the nuclei from which they are derived are more advanced than in the case of schizophrenia.

Although it is not intended to make this schema comprehensive, or indeed to do more than emphasize a few fundamental considerations, already a significant omission will be noted. In spite of the existence of chronic manias, no attempt has been made to "place" the maniacal states. Superficially regarded, the mpetus towards the object world in many of these states is obvious, but in others maniacal exaltation is accompanied by a disregard of object relations. So the matter is not so simple: and we may well stick to the policy enunciated earlier, *i.e.*, not to force a square peg

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into a round hole. We are, however, not entirely without some orientation in this problem. It is an old observation, first made by Abraham, that the " complexes " of mania are the same as those found in melancholia ; and clinical psychiatrists have noted that melancholics can have dreams with pleasant affect, also that some manic cases exhibit an undercurrent of depression. According to this view mania is only one phase of an extensive process, and is comparable with the restitution phenomena of schizophrenia. It would therefore be regarded as a spontaneous attempt at cure whether a melancholic phase is manifested openly or not. In this case the " placing " of mania in a primary classification is not important. Another possibility which I think is worthy of consideration is the following: Mania may relate to a phase of development which follows the phase giving rise to melancholic systems. It would then have ætiological factors of a specific kind. These would represent an advance on the melancholic system, and would be exploited as a curative or restitutive system. The more pathogenic aspects of the maniacal system would then be derived from an underlying schizophrenic contribution. This would be in keeping with the view of a zig-zag progression in early pathological states representing a gradual increase in anxiety tolerance. According to this view mania would require a special place in a primary classification. Whichever view one takes, it is necessary to emphasize the fact that in the sense of mechanism there is a more dramatic contrast between melancholia and paranoia than between melancholia and mania.

Considerations of space, to say nothing of caution, exclude for the moment any attempt to " place " conditions such as epilepsy or some of the so-called organic reaction types. But even a cursory examination of the psychological phenomena of epilepsy shows an interesting contrast between the regressions accompanying an attack, and the sometimes stereotyped exploitation of the object-world seen in intermissions (the epileptic character). Similarly, even superficial examination of the psychological formations in many organic reaction types suggests that a more orderly systematization of these phenomena is only a matter of time.

Passing over the transverse line which indicates the " reality-proving " boundary, we come to the neuroses. Here the contrast between autoplastic neuroses and character states is much more precise, and the fixation-points indicated may be taken as accurate. The main point of interest is the position of the phobia. Conversion hysterias are quite clearly autoplastic in type, but some phobias

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equally clearly depend on a degree of projection, and in one sense almost caricature the anxiety character type in which there is excessive reaction to all reality sources of danger. Phobias are, of course, more localized constructions. In this connection it is worthy of note that Melanie Klein regards the anxiety phobias of childhood as essentially paranoid in type.

I have given drug addictions a special place in this scheme, not only for clinical reasons, but to bring out some further points in terminology. I have represented the addictions as true " borderline " states in the sense that they have one foot in the psychoses and the other in the neuroses. They have their roots in paranoid states, although occasionally a melancholiac element dominates the picture. Nevertheless, they are sufficiently on the neurotic side of development to preserve a fairly adequate reality relation with the important exception of the relation to drug substances, behind which the paranoid mechanism lies. I find the terms " borderline " or " pre "-psychotic, as generally used, unsatisfactory. If a psychotic mechanism is present at all, it should be given a definite label. If we merely suspect the possibility of a breakdown of repression, this can be indicated in the term " potential " psychotic (more accurately a " potentially clinical " psychosis). As for larval psychoses, we are all larval psychotics and have been such since the age of two.

I have tried to suggest some of the more fundamental considerations to be taken into account in psychiatric classifications. Before breaking off this tentative study, I would add a few comments on the extension and complication of future classifications. Once the main mechanisms and correlations have been established, subsidiary groupings will depend on some compromise between the claims of different schools, *e.g.*, between clinical and psychopathological standpoints. This is already to some extent necessary even in regard to main groupings. I have tried to suggest the possibility of a terminology based on important mechanisms, but others might well suggest that all psycho-pathological states could be accurately named after specific disturbances in the function of the super-ego. Thus melancholia, whilst essentially an introjective psychosis, might well be called a " hypertrophy of the oral super-ego," possibly the " second oral." In fact Schilder has already made an attempt along these lines. Similarly as to possible subgroups. The claims of " isolating " or " circumscribing " psychic mechanisms are certainly very great, as may be seen in the case of drug addictions and fetichisms. And the same is true of the

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spreading mechanisms (displacement). But on the other hand, there might be some advantage in arranging sub-groups by reference not only to the instincts involved in the condition, but the degree of completeness of the object. Conceivably also the example of psycho-analysis may be followed in naming certain instincts after the zonal component chiefly concerned. In their characterological studies, for example, psycho-analysts have not hesitated to describe an "oral," "anal" or "genital character," and there are many character states that might be called "sadistic hyperæmias." In this matter we have the encouraging example shown by organic medicine. It may be accounted to the older physicians for grace that though they wrote professional treatises in a dead language, they were nothing loath to call a spade a spade.

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