References

Gunther, M. S., & Trosman, H. (1974). Freud as Expert Witness; Wagner-Jauregg and the Problem of the War Neuroses. *23*-23.

Freud as Expert Witness; Wagner-Jauregg and the Problem of the War Neuroses

Meyer S. Gunther, MD, author; Chicago
Harry Trosman, MD, author

A brief note delineating the link between Freud and Julius Wagner von Jauregg, Professor of Psychiatry at the University of Vienna during Freud's time, may serve to introduce what follows.

I. Introduction—Freud and Wagner-Jauregg

Although Julius Wagner von Jauregg was one year younger than Sigmund Freud, he finished his medical studies at the University of Vienna a year earlier. As a student he had worked with Salomon Stricker, Professor of Experimental Pathology, through whom he probably met Freud, who was similarly employed. The two knew each other well and even addressed each other by the familiar "*du*," although they never became close friends (Jones, 1957). Wagner-Jauregg became a privat-dozent in neuropathology the same year as Freud, and three years later, in 1888, his privatdozentship was also extended to psychiatry. In 1889 he was appointed Extraordinary Professor of Psychiatry in Graz, and in 1893 he became Titular Professor of Psychiatry at the University of Vienna.

Wagner-Jauregg's primary contribution to psychiatry consisted of the discovery of the cure for general paresis of the insane by malaria therapy. He was active in advocating the widespread application of iodized salt as a prophylactic measure for cretinism. He was effective in the field of forensic psychiatry, particularly in the reform of Austrian law with regard to mental patients. In 1927 Wagner-Jauregg was awarded the Nobel Prize, the first and only psychiatrist ever to have achieved this distinction (Ellenberger, 1970).

Although Wagner-Jauregg was fully appreciative of the work of Freud in neurology, he did not accept as scientifically valid Freud's psychoanalytic work. In spite of this, however, it was Wagner-Jauregg who wrote the report recommending Freud's nomination for the title of Ordinary Professor in 1920. Ellenberger points out that in this report Wagner-Jauregg made a slip of the pen recommending Freud's

appointment as Extraordinary Professor, striking out the prefix "Extra." He suggests that this may indicate that Wagner-Jauregg was ambivalent about supporting Freud's candidature but did so out of professional solidarity. In spite of their professional antagonism and despite some evidence that Freud felt animosity toward Wagner-Jauregg, they exchanged congratulations on their 80th birthdays "in an almost royal manner" (Ellenberger, 1970p. 470).

As part of the aftermath of World War I, much dissatisfaction was expressed in the Austrian Parliament about the handling of psychiatric casualties by military surgeons. A Commission of Inquiry was appointed, and a number of complaints were received from former mental patients against a half-dozen psychiatrists, one of whom was Wagner-Jauregg. A hearing took place from October 15-17, 1920, in the presence of many neuropsychiatrists and journalists. Freud was appointed by the Commission to give an expert report on the electrical treatment of war neurosis. The report was written February 23, 1920, and read by him at the inquiry the following October (Jones, 1957). The published version appears in the *Standard Edition* as "Memorandum on the Electrical Treatment of War Neurotics" (Freud, 1920a). Following the reading of the report there was a discussion, which appears below.

II. Freud's Testimony as Expert Witness1

CHAIRMAN: Excuse me for making some preliminary remarks. Does Professor [Freud] stand in basic opposition to Prof. Wagner and the Vienna school on many points?

PROF. WAGNER: Would you please tell me why [you ask]? Did I ever write anything about that?

PROF. FREUD, expert witness: There is no opposition between us in our conception of these conditions; in this we are in complete agreement. I would only venture the opinion that he draws the boundaries of simulation a little too large. With regard to many of these cases, I would have seen fewer malingerers and more neuroses, but this is not a difference of principle. I know, as he does, that all these neuroses are a flight from the conditions of war into illness. This term originated with me, and medical science has accepted it. The concept of purposefulness was first applied to neuroses of peacetime.[2] Every neurosis has a purpose; it is directed toward certain persons and would disappear at once on a South Sea island or in a similar situation, for there would no longer be a reason for it. I am happy to be able to affirm that complete agreement exists between us about the understanding of neuroses, and I can only underscore the evidence Hofrat Wagner has presented.[3] It is very curious that such neuroses do not occur during imprisonment. There are two reasons for this. First, the motive of extricating oneself from danger does not exist, and, second, the neurosis would do no good: one would not thereby escape from prison. Thus the motivation is missing. All these neurotics are, in our estimation, fugitives from war. The number of those who feigned illness should be small.

PROF. WAGNER: [There have been] confessions!

PROF. FREUD: I will not argue about that. Most of these conditions were induced by strong unconscious intentions; among these, the intent to restore personal independence has not been mentioned as yet. For many educated people, it was dreadful to have to submit to military treatment, and poor treatment by their superiors had an influence on many in our army and that of Germany. In our attempts to heal neurosis by psychoanalytic methods, we have found that rage against superiors was often the principal motive of the illness; many cases which did not originate at the front but in hospitals behind the front line provided this elucidation. Upon reflection, I have had to admit that this is one of the cases in which a general misconception predominates, where there are things to be said on both sides of the question. There is some truth in saying that the newspapers agitate in an ugly manner out of sensationalism, out

of a feeling of vengefulness against the old system. But it is also true that we had a people's army, that men were forced into military service, that they were not asked whether they liked to go to war, and that is why one has to understand that people wanted to escape. The physicians had to play a role somewhat like that of a machine gun behind the front line, that of driving back those who fled. Certainly, this was the

intent of the war administration. Individual physicians may have coped with this role in different ways. For the medical profession, this was a task really quite unbecoming to its standards. The physician should be the advocate of the ill first of all, not that of another. His function is impaired as soon as he starts serving someone else; at the moment he undertook the obligation of rehabilitating people for war duty as quickly as possible, there resulted a conflict for which the medical profession cannot possibly be made responsible. No compromise can be effected between submission to humane values and compulsory military service. There may have been some physicians who forgot their humanitarian duties and responded to the pressures put upon them by passing them on in an elastic manner. They allowed the sense of their power to make an appearance in a brutal fashion. Although I have no knowledge of everything that took place in Vienna, I am fully convinced that it is impossible that the accused could be persons of this type; nor could Hofrat Wagner, whom I have known for 35 years; I know that the motivating force in his treatment of patients is his humaneness. I have listened to Mr. Kauders and to the history of his illness. He believes that he has been wronged. I cannot quite agree with the assertion of Hofrat Wagner, however, that these grotesque phenomena came about principally through conscious malingering. I know the kinds of things that come to the surface in neuroses in peacetime. It is perhaps too hasty to assume malingering. This man does not give the impression of malingering. First he had something, I don't know what; an injury was confirmed.

PROF. WAGNER: No.

PROF. FREUD: But that is in the patient's history.

CHAIRMAN: There was a shock?

PROF. FREUD: It was established that there was a sensitive spot.

PROF. WAGNER: That is a sensitive spot and not an injury!

PROF. FREUD: Then he had a slowed pulse, etc. But that is non-essential. The injury was only the grain of sand; a neurosis later developed from the small injury, and at the time he was at the Wagner Clinic, he was evidently neurotic. That this was taken as malingering did him an injustice. It was this injustice that the patient especially felt and that so deeply upset him. All neurotics are malingerers; they simulate without knowing it, and this is their sickness. We have to remember that there is a big difference between conscious refusal and unconscious refusal. The conscious and the unconscious are always conjoined in an individual, however, and if I confront a neurotic who claims and believes that he is organically ill with a statement that he is not, he will be offended, because it is partially true. People are only offended about things which happen to be true. So it irritates neurotics to be informed that we do not believe they have an organic illness. I have the impression that here we have one of those numerous cases in which a neurotic has been

intensely irritated by the information that he is a malingerer and is not sick at all. Thereafter, he developed hostility against the physician and a misconception of the latter's intentions. The patient has

collected all of the material that could be used to support his hostility. This is the source of these numerous pointless actions, the partly comic, partly grotesque interpretations of phenomena at the clinic which, in reality, must be viewed more gently. That is my impression. I also believe that Hofrat Wagner caused this, in part, by reason of the fact that he did not avail himself of my therapy. I don't demand of him that he do so; I cannot possibly demand it of him; even my own students cannot do it.

PROF. WAGNER: I used disciplinary treatment, which was very much recommended, instead of persuading him that he is not ill.

PROF. FREUD: Your treatment had no success here; it only brought him to misunderstand the doctors' intentions. Well, I have overstepped my duty as an expert witness, but I have stated the impressions I gained from the deliberations.

CHAIRMAN: The expert expresses the point of view that he would have found it correct to give psychoanalytic treatment.

PROF. FREUD: In this case, yes.

CHAIRMAN: And the Hofrat did not find it correct, not even in this case. With all respect and esteem for each personal opinion, the question now arises whether these are differing scientific views of a kind that one can follow without committing malpractice, or whether it is clear that not to act in accord with one particular theory is to commit malpractice.

PROF. FREUD: The second alternative, that it constitutes a violation of duty, is out of the question. How far the psychoanalytic treatment of these illnesses is justified is to be determined by science, as an internal affair. Such treatment is not generally accepted. I was not offended that my friend Wagner decided not to choose it. I have never demanded that the ill have to be treated that way; there cannot be any question of violation of duty. Before the war ended, it was deemed necessary in Germany to treat in that way some refractory cases which could not be affected by the usual method. This was done by Prof. Schnee and his assistant Siegel. This method had an extraordinary therapeutic success. That is how we really found out how much we can accomplish. This was, so to say, the beginning of its general use. This experience in treating war neuroses was going to be expanded at the time the collapse of the Central Powers occurred. There was a Psychoanalytic Congress in Budapest to which the Austrian government sent a medical officer of the Army General Staff in order to find out what was going on, because they too wanted to set up these psychoanalytic stations for the treatment of such patients. This shows that no treatment for these patients had been provided for previously.

CHAIRMAN: Dr. Kaufmann in Germany propagated a method of trying to force a cure in one sitting by the use of strong electric currents;

it was practiced for a long time in the German army. That method was apparently much more brutal than the sled apparatus [variable resistance] using 1-2 elements of carbonic acid. Is this sled apparatus used in medical practice?

PROF. FREUD: It is part of the equipment of every practitioner.

CHAIRMAN: Would you please say a word about apomorphine and asafoetida?

PROF. FREUD: I do not have anything to add to what Prof. Wagner said. There cannot be any question of any intent to torture the patients. When new methods are used, it is always the experience that the patients mistrust them and say that they are terrible. When hydropathy came into use in my time, the public was full of terrible news about it. This was caused by the fact that some patients came in the early stages of very serious diseases which could not be arrested and, naturally, later became worse. When I started my treatment, it was said that it made people crazy, that they got into all sorts of states. Colleagues endeavored to spread these ideas, most likely only because it was something new.

CHAIRMAN: So these are completely harmless remedies. Are they also used in private practice?

PROF. FREUD: In private practice one tries not to be disagreeable; otherwise one is replaced by a colleague who is less so. Naturally, this motive does not operate for physicians employed by government.

CHAIRMAN: I have heard that these remedies are also used in private practice.

PROF. WAGNER: Concerning malingering, I would like to say without being presumptuous that I am a little more competent. No malingerers come to Prof. Freud for treatment, whereas in my profession I have had occasion to treat many malingerers. On top of that, during the war I had some rich experience which Prof. Freud has not had. Where Mr. Kauders is concerned, I have explained it all: the trip to Heidelberg of a man who cannot go to Vienna, etc. It is evident that this cannot happen in unconscious mental life. Concerning psychoanalysis, I would like to state that this type of treatment often takes God knows how long, and that is why this method is not usable in war. The motive of speaking another language has been admitted by Prof. Freud.

CHAIRMAN: According to Prof. Freud, treatment needs individualization.

PROF. FREUD: It has been carried out even in war.

PROF. WAGNER: But only in singular cases.

PROF. FREUD: In large numbers. But it was shortened by hypnosis. It took extraordinary pains, but it would have been worthwhile in especially difficult cases.

CHAIRMAN: These are questions for the future. Science will decide which opinion is correct. But you cannot claim malpractice, though you are of a different scientific opinion. Physicians have stressed repeatedly

that the tremendous difference between private and military practice consists in the fact that, in private practice, people who wish to be cured of illness do so even in their subconscious, while the people who came from the battle field with these war neuroses did not wish to be healed, partly subconsciously, partly in full consciousness, as long as the war went on. This is one question I would like to have elucidated.

PROF. FREUD: The difference is not that sharp; it is more quantitative. There are no neuroses without a will to be sick; that means without a will to maintain themselves. There are no neurotics who wish to be that sick without a certain motive. When one treats people, one starts to notice it as a resistance against getting well. The neurotic condition persists because there are reasons for it. On the other hand, for different motives, people wish to get well. These intentions exist side by side, and it is the task of

psychoanalytic treatment to reconcile these contradictions. This is the case in peacetime neuroses. It is correct to say that in war neuroses the intention to stay sick is much stronger—not for pleasure, but to escape military service. One ought not to forget that, in addition to strong motivation against it, motivation for health also exists; otherwise these people would all be malingerers. I admit that Prof. Wagner has seen all the malingerers; I have not. But I believe that he has overestimated their number. These are quantitative differences. Among the people who get sick, there are also heroes who serve, who want to excel, who are not all cowards, but who come to this out of curious motivations. Often this becomes the stronger, the deciding, motive. For example, the behavior of a superior whose esteem was valued becomes an effective motive if the superior mistreats a man. The basis of our opinion is this: there are no neuroses without conflict, and from that it follows that a sharp differentiation is impossible.

The next witness is called.

III. The Problem of the War Neuroses

Preliminary Considerations Of Freud's Testimony

Freud's testimony before the Inquiry Commission not only constitutes a rich expression of his thinking on a complex clinical problem, but also provides us with an opportunity to examine the fascinating interplay of metapsychology, ethics, and politics. In this commentary on his testimony I shall describe some of the features of war neuroses as they constitute a special form of the larger clinical entity, traumatic states. Freud's testimony will then be summarized, with emphasis on the relation between his positions on the key issues of the argument and their background in his metapsychological thinking of that period. A description of further developments in the continuing ethical and conceptual problems during the 50 years since his testimony will conclude the commentary.

The war neuroses of World War I had been puzzling to psychiatrists and, in subtle ways, problematic for psychoanalysts of that time. Typically, the patient with a war neurosis, as with any traumatic disorder, experiences the sudden onset of a variety of apparently unrelated symptoms, such as conversion hysteria, severe anxiety, depression, somatization, phobias, or disorders of consciousness, thought, or sensation—all following some relatively acute trauma for which the individual has had little adequate psychical preparation. The typical traumas in civilian life are such things as mechanical accidents, natural disasters, fires, and, occasionally, social catastrophes. Traumas in military life, in addition to the preceding, involve experiences such as being trapped under increasingly deadly enemy fire, or near terrible explosions, with the inevitable, imminent threat of one's own death or the actual death of one's close comrades. Victims frequently report having felt intense helplessness at the moment of the trauma, and their symptoms reflect, symbolically and dramatically, this frightening helplessness. Such patients frequently relate to the clinical observer with behavior and attitudes that indicate the occurrence of a significant structural regression along narcissistic lines. In these disorders, repetitive symptoms such as nightmares, excessive sensitivity or reactivity to ordinary daytime stimuli occur, suggesting that the individual is attempting to master, through re-experiencing it in a smaller dose, some aspect of the original traumatic situation. As a final characteristic, there is a tendency for these disorders to be resolved, at least symptomatically if not structurally (Archibald and Tuddenham, 1965; Wexler, 1972), over the course of time, after some simple psychotherapeutic procedure such as support, catharsis, or rest.

In 1920, as today, both the intrapsychic-conflict theory of symptom formation and the instinctual theory of motivation were held by certain scientific circles to be inapplicable as explanations for the occurrence of war neuroses. In addition, a psychoanalytic physician's responsibility for treating these problems, as

Freud indicates in his testimony, raises conflicts, culminating in a fundamental question about the ethics of treatment in civilian life as well as in war time: is treatment for the individual a natural right of human beings, or is it a moral responsibility determined by society and conferred conditionally by that society onto the physician—or is it a mixture of both?

Freud's testimony is a rich, succinct vignette, illustrative of his qualities as scholar, scientist, and intensely humane friend. In his role as scholar, Freud hints of many new ideas, not yet formally presented, particularly those having to do with the structure of the mind. He takes a stand on the side of the ultimate incompleteness of any scientific hypothesis and the necessity for openness for future discovery. He leans toward a multivariable theory of the origin of emotional disorders, and he emphasizes that the goal and framework with which one views the treatment of psychopathology will influence one's theoretical thinking regarding models of etiology. Freud indicates the necessity in psychiatry for individualization—especially the individualization of understanding of the patient. He states unequivocally his skepticism over the dubious methods employed to establish the reliability of a particular treatment procedure.

As mature friend and humanist, Freud treads carefully around the issue of Wagner-Jauregg's responsibility as well as his motivation for his questionable therapeutic activity. This treatment activity had involved the use of strong, physically painful shocks to the body with electric current to "cure" war neuroses. Freud refrains from making absolute moral judgments, although this might have been very tempting in light of the issues. He is empathic with the dilemma of the physician who, under the duress of social demands, is caught in a conflict of his own values. He takes a stand which minimizes rather than emphasizes basic differences among dedicated physicians in the discharge of their professional responsibilities.

The Testimony Itself

I should like to summarize the argument Freud presents in the testimony so that the theoretical background of the thinking which shaped it may then be outlined.

At the very beginning, Freud sets out several basic dilemmas. He suggests that Wagner-Jauregg misunderstood the difference between psychoneuroses and malingering, noting that psychoneuroses involve unconsciousprocesses and motives which have a social expression and function, even though such motives may be unredeeming in the moral sense. He suggests that the desire to escape from military service may arise from such normal feelings as humiliation, mortification, rage, resentment, reactions he considers to be inevitably inherent to the very nature of military service. He suggests that these may lead many soldiers to a basic conflict in motivation, i.e., the desire of the ego to preserve itself safely and comfortably versus the desire to do one's duty according to one's own or society's standards. This may be experienced as a split between a sense of helplessness in the service of preserving one's own life versus a wish to be aggressively active and masterful in the service of fulfilling one's ideals. Freud goes on to the dilemma posed for the military physician: whether to serve the patient's needs and goals, or to serve his military superiors. Thus, the conflict within the individual soldier has a counterpart in the dilemma of the physician. Freud suggests that all too frequently the solution of this conflict lies in the physician's becoming merged with the power and goals of state authority as if he were identifying with the aggressor.

Freud's analysis of Wagner-Jauregg's specific "errors" constitutes the body of the early portion of his testimony. He acknowledges that the patient who brought charges against Wagner-Jauregg apparently had some real though minor physical injury, which became a nidus for the crystallization of a variety of

trends in his personality, particularly his hidden resentment of his subservience to military authority as well as his humiliation and anger at being accused of malingering. He implies that Wagner-Jauregg might be criticized for not maintaining the essence of a positive (therapeutic?) alliance with the patient, but he cannot hold Wagner-Jauregg guilty for not utilizing psychoanalytic procedures.

In the major portion of the testimony, in which he deals with the problem of treatment, Freud begins by holding that using milder types of aversion therapy is simply a lesser form of the same sin, i.e., the sin of ignorance. At the chairman's insistence, Freud indicates somewhat hesitantly that modified psychoanalysis had been used with limited success for the treatment of war neuroses. However, since he believes there are no absolute truths in medicine or science, he would be loathe to see the authorities decree which form of treatment is the correct one to use. This would be especially troublesome in psychiatry, where a belief in the efficacy of a particular treatment is often a function of popular whim. Under direct questioning, Freud avoids the trap of attempting an absolute answer to the problem of ultimate motivation. He suggests that all patients with war neuroses, regardless of premorbid personality traits, have mixed motives for becoming ill or for remaining ill. Ultimately, however, since there are conflictual motives in those who fall ill as well as in those who do not, no absolute differentiation is possible. “There are no neuroses without conflict.”

Some Metapsychological Considerations

It may be useful to contrast Freud's presentation of his ideas on the nature of war neuroses in this testimony with several of his pertinent writings of that period. This comparison may serve not only to highlight the carefully focused, qualified argument he offered in his testimony, but also to demonstrate the manner in which differing ideas are integrated around a series of understated central themes.

A word of background is in order regarding Freud's personal situation and the general state of psychoanalytic metapsychology at that time. Although Freud was not directly involved as a military officer in the treatment of war neuroses, he certainly had considerable peripheral contact with them. His sons fought throughout World War I, and, in addition, he corresponded actively with many of his intimate followers who were in service (Jones, 1955). This was particularly true of Ferenczi, who had significant influence on Freud's own thinking, partly as a result of Ferenczi's very extensive experience with war neuroses.

Freud's thinking during this period was undergoing major reorganization on a number of matters that bear indirectly on war neuroses. The years 1916 through the early 1920's, when several writings having to do with war neuroses appeared, was the period during which the structural model of the mind evolved (Jones, 1955). The unconscious operation of defensive processes, the revision of the instinct theory, the description of differentiated agencies of the mind, the problems of narcissism and signal anxiety—all these might well have been in the background of his thinking about war neuroses.

Pertinent to the metapsychology of war neuroses was the opportunity these disorders offered to the opponents of psychoanalysis. Among the many nonpsychological etiologies suggested to explain the symptoms were such phenomena as nervous exhaustion, physical concussion, and even petechial hemorrhages of the nerves, implying a variety of physical changes in the nervous system. In lay parlance, this was “shell shock.”

In his Introduction to *Psychoanalysis and the War Neuroses*, a small volume of papers published in 1919 by Abraham, Ferenczi, and Simmel, Freud (1919) attacked this argument, pointing to the many lines of evidence suggesting that war neuroses, like all other psychoneurotic symptoms, serve the function of

primary gain for an obvious intrapsychic conflict, for instance, a conflict over the desire to preserve one's life versus a variety of other motives. Furthermore, the presumption of a psychogenic etiology is made more convincing in retrospect by successful psychotherapeutic resolution of the symptoms. Freud summarized his thinking with respect to several of the dilemmas as follows: "The war neuroses … are to be regarded as traumatic neuroses whose occurrence … has been promoted by a conflict in the ego…. The traumatic neuroses of peace will also fit into the scheme as soon as a successful outcome has been reached of our investigations into the relations which undoubtedly exist between fright, anxiety and narcissistic libido" (pp. 208-210).[4] Further on, Freud notes, "In traumatic neuroses and war neuroses the human ego is defending itself from a danger which threatens it from without or which is embodied in a shape assumed by the ego itself…. the ego is afraid of being damaged … by external violence" (p. 210). In ending the paper, Freud makes a scholarly effort to distinguish the war neuroses from ordinary traumatic neuroses by suggesting that in the case of war neuroses, "What is feared is nevertheless an internal enemy" (p. 210). He does not elaborate this thesis further, although the implications for the structural theory are apparent.

In *Beyond the Pleasure Principle* (1920b) wherein he introduces the concept of the repetition compulsion and the death instinct, Freud explores an economic viewpoint to explain the method by which the mind handles excessive stimuli that threaten to overwhelm it. He notes that victims of traumatic neuroses tend to re-experience aspects of the initial trauma in the form of night terrors and hyperreactive responsiveness to ordinary daytime stimuli. When this occurs they break down with fresh anxiety and new hysterical-like symptomatic episodes. He suggests that these dreams and experiences are not antithetical to the wish-fulfillment concept of dreams, but rather represent an effort to reconstruct retrospectively the damaged *Reizschutz*, that protective shield lying on the surface of the mind which guards its deeper layers from excessive external stimulation. Although this *Reizschutz* is hypercathected by the ego in response to some signal (anxiety?) of imminently occurring, excessive stimulation, this protective barrier must be malfunctioning at the moment of the traumatic experience. As a consequence, too much stimulation is let into the mind, as if a dike had broken and the mind were flooded. The mental apparatus is temporarily overwhelmed, the pleasureprinciple is set aside, and the mind becomes fixated to a situation of trauma. He points out that this is not the same as the old shock theory, but rather it is built upon a fundamentally different premise: lack of opportunity for ample preparation of the mental apparatus leads to a failure of appropriate cathexis of the receptive system, making inevitable the resultant experience of paralyzing fright. Therefore, "These dreams are endeavoring to master the stimulus retrospectively, by developing the anxiety whose omission was the cause of the traumatic neuroses" (1920bp. 32). In addition, in this paper he presents an idea which has not proven consistently reliable, namely, "… a gross physical injury caused simultaneously by the trauma diminishes the chances that a neurosis will develop" (p. 33).

In 1926, in *Inhibitions, Symptoms and Anxiety*, he returns briefly to the problem of traumatic neuroses, this time with a well-organized structural theory. To the question of how a threat to the instinct of self-preservation "could by itself produce a neurosis without admixture of sexual factors," he notes that there is no contradiction here because "any such contradiction has long since been disposed of by the introduction of the concept of narcissism, which brings the libidinal cathexis of the ego into line with the cathexes of objects and emphasizes the libidinal character of the instinct of self preservation" (1926ap. 129). He speculates that "it would seem highly improbable that a neurosis could come into being merely because of the objective presence of danger, without any participation of the deeper layers of the mental apparatus." Since the deepest layers of the unconscious have no knowledge of death as such, he states, "I am therefore inclined to adhere to the view that the fear of death should be regarded as

analogous to the fear of castration and that *the situation to which the ego is reacting is one of being abandoned by the protecting super-ego—the powers of destiny—so that it has no longer any safeguard against all the dangers that surround it*" (p. 130; italics added). Finally, he suggests that in addition to the protective shield's failure of function, a situation that permits excessive excitation to enter the mind, there is another explanation for the fright, "anxiety is not only being signalled as an affect but is also being freshly created out of the economic conditions of the situation" (p. 130), i.e., out of the quantity of excitement contained in the experience itself.

Some of Freud's ideas regarding the narcissistic basis for the conflict in war neuroses may relate to Ferenczi's ideas (1916b) which emphasized the quality of unexpectedness of the actual physical trauma and the mind's inability to make any adequate preparation for it. Ferenczi suggested that the individual's former successful self-preservative and, at times, heroic behavior had little prophylactic value. Furthermore, he notes that the very unexpectedness of the experience "may well have shaken their self love to its foundations.... The result ... may well have been a *neurotic regression*, that is, the relapse into a phylo- and ontogenetic stage of development long outgrown [namely] ... the infantile stage of the first year of life" (pp. 136-137). He argues that many of the specific symptoms, such as incoordination, tremors, inability to stand or walk, altered sensations, phobias, overexcitement states, represent a return to childlike or primitive stages of development of psychic structure. Finally, he suggests, "... As a preliminary explanation ... we are dealing in these traumata with *an ego injury, an injury to self love, to narcissism*, the natural result of which is the retraction of the range of object cathexes of the libido, that is, the cessation of the capacity to love anyone other than oneself" (p. 141)

In a related paper entitled "Disease—or Patho-Neurosis" (1916a), Ferenczi again refers to a related area in which Freud's concurrence is implied.

In his essay on narcissism, Freud (1914) mentions ... my suggestion that the peculiar changes in the love life of the physically sick (the withdrawal of objectlibido and the concentration of all egoistic as well as libidinal interest in the ego) support the view that, concealed behind the object-love of a normal adult, a great part of the earlier narcissism continues to exist, only waiting for the opportunity to make itself felt. A bodily illness or injury can therefore quite well result in regression to so-called traumatic narcissism and even to its neurotic variants [p. 81].

Further on he asks the following crucial question: "Under what circumstances, however, will the illness or injury be followed by a farreaching regression into narcissism and evoke a 'disease narcissism' or a true narcissistic neurosis ... ?" He answers:

(1) If the constitutional narcissism—even if it be only latent—was already too powerful before the injury, so that the slightest harm to any part of the body affects the ego as a whole; (2) if the trauma endangers life or is thought to do so, that is to say, threatens existence (the ego) in general; (3) if one can imagine the formation of a narcissistic regression or neurosis of this kind as a result of an injury to a part of the body especially powerfully charged with libido, with which the ego as a whole easily identifies itself [p. 83].

Freud summarized his final thinking about several of the issues related to the problem of war neuroses with a decisive but strikingly pessimistic judgment in 1926 in *The Question of Lay Analysis*.

All our social institutions are framed for people with a united and normal ego, which one can classify as good or bad, which either fulfills its function or is altogether eliminated by an overpowering influence.

Hence the juridical alternative: responsible or irresponsible. None of these distinctions apply to neurotics. It must be admitted that there is difficulty in adapting social demands to their psychological condition. This was experienced on a large scale during the last war. Were the neurotics who evaded service malingerers or not? They were both. If they were treated as malingerers and if their illness was made highly uncomfortable, they recovered; if after being ostensibly restored they were sent back into service, they promptly took flight once more into illness. Nothing could be done with them. And the same is true of neurotics in civil life ... [1926bpp. 221-222].

The Next Fifty Years

Over the course of the 50 years since Freud's testimony, what has happened to the central issues with which he was concerned? With respect to the metapsychology of war neuroses, in a period between the two World Wars and perhaps including most of the experience of World War II, the dominant authors (Grinker & Spiegel, 1945; Institute for Psychoanalysis, 1944; Kardiner, 1947; Menninger, 1948; Miller & Crichton-Miller, 1940) conceived of the framework of war neuroses, their dynamics, and their treatment in terms similar to those of Freud and Ferenczi. For instance, Kardiner: "There is a change in the concept of oneself in the outer world which is responsible for the catastrophic drama.... The structure of the ego has been altered ... the endopsychic perception of a hostile world and an impoverished self' (p. 325).

Grinker and Spiegel (1945) refer to the significant role of helplessness in predisposing one to a traumatic reaction when one is threatened with the loss of something which is especially valued, be it part of oneself, a friend, an abstract idea, or an inanimate object. In these authors' judgment, the soldier's precipitous regression, introversion, and withdrawal following such a loss seems to relate to his inability to anticipate or prevent the calamity, or to devise some protective solution for himself after it has occurred. Grinker and Spiegel concur with most authors in accepting a general framework of treatment based upon viewing the individual soldier in his group milieu, with considerable effort to understand both. Rest, reassurance, and a modified form of catharsis (narcosynthesis) were the principal forms of therapy. The social bases for viewing these problems were clearly evident, i.e., maintenance of relation to one's unit, preservation of group identifications and ideals, and treatment close to the front. However, the fundamental focus was still an effort to understand and treat him in individual terms, albeit limiting the therapeutic involvement to the immediate situation of the soldier's breakdown, the primary goal being restoration of military function and competence.

However, by the time of the Korean and Vietnam conflicts, the underlying thinking of military psychiatrists had altered dramatically (Bey, 1970; Bourne, 1970; Caldwell, 1967; Glass et al., 1961; Group for the Advancement of Psychiatry, 1960). Primary attention was focused on the social group (military unit) as the entity to be preserved. The individual soldier was viewed in terms of his behavioral contribution to group function. Military psychiatry shifted its strategy to understanding and manipulating those forces responsible for primary prevention, i.e., for preventing or minimizing loss of effectiveness of the military unit. Treatment of the individual soldier, if breakdown occurred, was conceived of almost exclusively in terms of restoration of adaptive behavior. This alteration in concept may be due to the disinterest of dynamically oriented, depth psychiatrists in these two wars, or it may simply be due to a reassertion of dominating influence by the military authorities with their inevitable desire to retain unit strength. Occasional voices of doubt were raised (Friedman, 1972; Gibbs, 1973; Ungerleider, 1963), but the dominant authorities subscribed to the above views, as illustrated by the following quotation:

Mental health and military effectiveness of the individual are related but not necessarily synonymous .... It may be argued that ... indices of effectiveness do not have a specific relationship to mental health, but they do, to a large degree, reflect the effectiveness of a military organization in terms of the individual members and the organization as a social unit ... [Group for the Advancement of Psychiatry, 1960pp. 270-271].

Therapeutic procedures categorized as secondary prevention involved such things as rest or drug-induced sleep, brief freedom from assignment, and group counseling. Such procedures were designed to emphasize the individual's attachment to his unit, to convince him that he would not be gratified for his symptoms through evacuation to the safety of rear areas as a psychiatric casualty, but rather that he would be returned to his unit within a few days.[5] Gross reductions in immediate breakdown rates as well as in long-term or permanent disability rates (compared with World Wars I and II) are cited by proponents as convincing evidence of the success of this orientation of current military psychiatry (Bourne, 1970; Group for the Advancement of Psychiatry, 1960). From the viewpoint of metapsychology, it would appear that once again the nature of the social goal has retrospectively influenced the conceptualization of the workings of the mind and therefore the selection of treatment method. One is reminded of Freud's suggestion in his testimony, "The physicians had to play a role somewhat like that of a machine gun behind the front line, that of driving back those who fled."

There are critical situations beyond the traumatic neuroses which have tended to expand the entire issue of trauma and traumatic states. Survivors of concentration camps or other social catastrophes (Krystal, 1968; Winnick et al., 1968; Lifton, 1968), and victims of natural disasters (Wolfenstein, 1957), have provided psychiatrists with a considerable body of evidence suggesting that massive psychic trauma, with or without physical injury, may produce emotional states resembling traumatic and war neuroses in certain aspects of their symptomatology, underlying structure, and treatment difficulties. All involve some structural regression, particularly with respect to the "self" aspects of personality. Long-term studies suggest that frequently these disorders are never fully healed in the sense of restoration of the patient to his former state of intactness. Recent work with rehabilitation of massively traumatic, life-altering physical injuries (Gunther, 1971), and studies of patients undergoing surgical transformations, losses or replacements of major organs (Abram, 1972; Beard, 1969; Blacher, 1972; Dansk, 1972; Fitzgerald, 1970; Lazarus & Hagens, 1968; Muslin, 1971; Panel, 1974) also document the occurrence of similar extensive damage to personality structures.

As a result of this later evidence, several of the basic concepts referred to by Freud in his testimony and elaborated by him and his followers through the years, may now be viewed as constituting a common core of dynamicprocesses underlying diverse traumatic states, whether the precipitating events are physical or psychical, medical or social. I refer to ideas such as: Freud's theses about the individual's abandonment by his protective superego and the notion of the split in the ego; Ferenczi's and Freud's observation of the relation to narcissistic regression of disappointment over unexpected trauma; Grinker and Spiegel's ideas about the significance of feelings of helplessness in the face of threats of unpreventable loss; and Kohut's (1971, 1972) ideas about the dynamic and developmental aspects of the narcissistic sector of the personality. Taken collectively, these concepts may be integrated into the following explanation:[6]

An event which is not and cannot be anticipated effectively, one with an unpleasant to dangerous quality, provokes a reaction of acute surprise and fright, along with disappointment. This disappointment lies in failure of the person's omnipotent capacity to anticipate the event or to prepare for its consequences to

such things as the integrity of his body, the reliability of his mind, the safety of his loved ones, or the stability of his social world. Similarly, such an event may produce acute doubt in one's certainty of the world as a safe, reasonable, gratifying environment, which operates by predictable laws. This may be illustrated by a remark of Wolfenstein's: "When one is suddenly overtaken by catastrophe, there is an awful feeling of having been deserted by this protective power, 'Why hast Thou forsaken me?'" (pp. 57-58). When one is driving down the expressway at 80 miles an hour and is suddenly made aware of the destructive reality of Newton's First Law of Motion, due to the catastrophic behavior of another driver, one may experience the environment as if it suddenly had become a failed parental function of childhood. This "crisis of reliability" of the knowing personality in relation to its stable world leads to a regression or partial fragmentation in the formerly intact, cohesive adult self and, necessarily, a regression in ego functioning. A person's conviction of his ability to predict and therefore to influence the behavior of the environment and its consequences to his mental or bodily self, his certainty of his ability to survive, let alone to master that environment, may never be quite the same after a major trauma as it was before. The consequences to the mental or bodily self will be especially devastating when they have involved threats of change or loss to core narcissistic structures of the personality, those which stabilize and regulate the underlying self-esteem economy (Gunther, 1971). An essential characteristic of such experiences is that they cannot in the ultimate sense be truly anticipated or prepared for because they are neither part of normal developmental experience nor part of the predictable experience of the adult's "average expectable environment" (Hartmann, 1939).

From the preceding considerations, two inferences follow. Individual differences in reactions to traumatic experiences may relate (among other variables) to underlying differences in predisposing vulnerability of those personality structures which regulate the narcissistic economy. Secondly, the functions of the array of post-traumatic events, such as anxietylike symptoms, loss phenomena, and working-through burdens, would appear clearer. They are designed not merely to establish retrospectively the failed anxiety signal and the protective alteration of the perceptual apparatus. These various mental phenomena also serve to restore, if only in fantasy, a former state of intactness, the state of the self before the moment of trauma. Ultimately, such processes may constitute an attempt to build a new self, one with a better functioning set of protections and regulators.

Some of the other issues—ethical, philosophical—which beset the medical psychoanalyst in Freud's day have continued to merge with more scientific, metapsychological, and clinical issues. There are good reasons why in psychiatry the interplay of clinical problems with politics leads to unending crises in the role function of the socially responsible physician. After all, disordered personalityprocesses express themselves in disordered behavior, and such behavior has significant social as well as individual consequences. Unfortunately, judgments about social consequences inevitably involve utilization of a culturally relativistic value system, one related to the particular society in which the physician practices. One might cite the chilling behavior of the Nazi concentrationcamp medical scientists, including psychiatrists (Mitscherlich & Mielke, 1949), who not only heartily subscribed to the genocide "solutions," but who viewed them as providing a wonderful opportunity for studying human beings in reaction to stress under experimental laboratory conditions never before available, with an unlimited supply of victims for whom no ordinary human restrictions operated.

Another example: certain medical officers of the Indemnification Board of the Federal Republic of Germany attempted to utilize a variety of misinterpretations of psychoanalytic ideas in their efforts to deny compensation to the very victims of persecution that their predecessors had created (Krystal, 1968). They marshaled ideas related to the role of physical trauma, the presence of demonstrable minor,

pre-existing neurotic tendencies, hypothetical genetic factors, etc., to suggest that the uniquely traumatic, massive psychic traumas of concentration camp experience, never before conceived of, with the resultant massively damaged personality syndromes of its victims could not be the result of their concentration camp experience alone. Instead, the officials persistently looked for other explanations that would validate their notion that the disorders were simply exaggerations of ordinary neurotic problems or, even worse, constituted "malingering" efforts to obtain compensation.

Unfortunately, such behavior is not limited to medical officials in the defeated countries of World War II. There are examples in both Russia (Medvedev and Medvedev, 1971; Tarsis, 1965) and the United States (MacDonald, 1973; Mason, 1973; Stanford, 1972), wherein psychiatrists are called upon by authorities to "treat" imprisoned social malcontents or ordinary criminals. In both countries, apparently, there are psychiatrists available who willingly cooperate with official efforts to restore labeled persons to the role of useful members of society.

Sectors of the academic and scientific communities continue their endless efforts to deny or disparage the essential role of unconsciousconflict in the formation of neuroses (Stoller, 1973). This denial leads theoreticians and planners in the mental health field to call endlessly upon psychoanalysis to turn its energies away from the studies of the mind and its normal and abnormal workings and instead to focus upon developing methods for producing immediate cures for aberrant behavior (Psychiatric News, 1973). Unfortunately, the tyranny of statistics becomes the determinant of the validity if not the rational use of a particular therapeutic procedure to produce such cures.

Freud's discoveries about the unconscious thus continue to reverberate in so many aspects of our individual and social problems. This little vignette of his testimony contains much wisdom that is still pertinent and deals with many dilemmas that continue to await resolution.

Footnotes

[1] The original stenographic transcript of Freud's direct testimony has recently come to light as a result of scholarly research by Professor and Mrs. Joseph Gicklhorn of the University of Vienna into the Archives of the Ministry of War. The Archives Director granted permission for its publication, and the original transcript appeared in German in *Psyche* in 1972. It is published here in English for the first time through the kind permission of the editors of that journal. The translation is by Hilda Spiegel.

[2] Freud's term *Friedensvorstellungen* literally would refer to neurotic presentations during peacetime.

[3] "Hofrat" is an Austrian title from the era of the then recently abolished monarchy: it corresponds to Privy Councilor.

[4] The relations between fright and narcissistic libido have been clarified considerably by the further development of the psychology of the self (see Kohut, 1971, 1972).

[5] See Chapter 7 in Dr. Ronald Glasser's (1971) poignant account of medical service in the Vietnam War for an exquisitely sensitive portrayal of this form of therapy and its misuse.

[6] G. N. Engle (1962), utilizing data derived from a wide range of medical and surgical patients, has evolved a similar explanation built around the concept of illness as stress.

References

[1] Abram , H. S. (1972). The psychiatrist, the treatment of chronic renal failure and the prolongation of life. *Amer. J. Psychiat.*, 128 :84-89.

[2] Archibald , H. & Tuddenham . R. D. (1965), Persistent stress reactions after combat: a 20–year follow-up. *Arch. Gen. Psychiat.*, 12 :475-481.

[3] Beard , B. H. (1969). Fear of death and fear of life. *Arch. Gen. Psychiat.*, 21 :373-380.

[4] Bey , D. R. (1970), Division psychiatry in Vietnam. *Amer. J. Psychiat.*, 127 :228-232.

[5] Blacher , R.S. (1972), The hidden psychosis of open-heart surgery. *JAMA*, 222 :305-308. (PAQ.047.0267A)

[6] Bourne . P. G. (1970), *Men, Stress, and Vietnam*. Boston: Little, Brown .

[7] Caldwell , J. M. (1967), Military psychiatry. In: *Comprehensive Textbook of Psychiatry*, ed. A. M. Freedman & H. I. Kaplan. Baltimore: Williams & Wilkins , pp. 1605-1612.

[8] Dansak , D. A. (1972), Secondary gain in long-term hemodialysis patients. *Amer. J. Psychiat.*, 129 :128-131.

[10] Ellenberger , H. (1970), *The Discovery of the Unconscious*. New York: Basic Books .

[9] Engel , G. L. (1962), *Psychological Development in Health and Disease*. Philadelphia: Saunders .

[11] Ferenczi , S. (1916a), Disease—or patho-neurosis. In: *Further Contributions to the Theory and Technique of Psychoanalysis*. New York: Basic Books , 1952, pp. 78-89.

[12] Ferenczi , S. (1916b), Two types of war neuroses. In: *Further Contributions to the Theory and Technique of Psychoanalysis*. New York: Basic Books , 1952, pp. 124-141.

[13] Fitzgerald , R. G. (1970), Reactions to blindness. *Arch. Gen. Psychiat.*, 22 :370-379.

[14] Freud , S. (1914), On narcissism: an introduction. *Standard Edition*, 14 :67-102. London: Hogarth Press , 1957. (SE.014.0067A)

[15] Freud , S. (1919), Introduction to Psychoanalysis and the War Neuroses. *Standard Edition*, 17 :205 210. London: Hogarth Press , 1955. (SE.017.0205A)

[16] Freud , S. (1920a). Memorandum on the electrical treatment of war neurotics. *Standard Edition*, 17 :211-215. London: Hogarth Press , 1955. (IJP.037.0016A)

[17] Freud , S. (1920b), Beyond the pleasure principle. *Standard Edition*, 18 :1-64. London: Hogarth Press . 1955. (SE.018.0001A)

[18] Freud , S. (1926a), Inhibition, symptoms and anxiety. *Standard Edition*, 20 :77-175. London: Hogarth Press . 1959. (SE.020.0075A)

[19] Freud , S. (1926b), The question of lay analysis. *Standard Edition*, 20 :179-258. London: Hogarth Press , 1959.

[20] Friedman , H.J. (1972). Military psychiatry. *Arch. Gen. Psychiat.*, 26 :118-123. (PSYCHE.026A.0001A)

[21] Gibbs , J. J. (1973), Military psychiatry: reflections and projections. *Psychiat. Opinion*, 10 :20-23.

[22] Glass , A.J., et al. (1961), The current status of army psychiatry. *Amer. J. Psychiat.*, 117 :673-683.

[23] Glasser , R. J. (1971), 365 Days. New York: George Braziller .

[24] Grinker , R. R., Sr. & Spiegel , J. P. (1945), *Men under Stress*. Philadelphia: Blakeston .

[25] Group for the Advancement of Psychiatry (1960), *Preventive Psychiatry in the Armed Forces: with some Implications for Civilian Use*. Report No. 47. New York: Group for the Advancement of Psychiatry .

[26] Gunther , M. S. (1971), Psychiatric consultation in a rehabilitation hospital: a regression hypothesis. *Comp. Psychiat.*, 12 :572-585.

[27] Hartmann , H. (1939), *Ego Psychology and the Problem of Adaptation*. New York: International Universities Press , 1958. (ZBK.072.0001A)

[28] Institute for Psychoanalysis (1944). *War Psychiatry*. Part I of the Proceedings of the Second Brief Psychotherapy Council. Chicago: Institute for Psychoanalysis .

[29] Jones , E. (1955). *The Life and Work of Sigmund Freud*. Vol. 2 : *Years of Maturity*, 1901-1919. New York: Basic Books . (ZBK.047.0001A)

[30] Jones , E. (1957), *The Life and Works of Sigmund Freud*. Vol. 3 : *The Last Phase*, 1919-1939. New York: Basic Books .

[31] Kardiner , A. (1947), *War Stress and Neurotic Illness*. New York: Paul B. Hoeber .

[32] Kohut , H. (1971), *The Analysis of the Self*. New York: International Universities Press . (ZBK.049.0001A)

[33] Kohut, H. (1972). Thoughts on Narcissism and Narcissistic Rage. *Psychoanal. Study Child* 27 :360-400 (PSC.027.0360A)

[34] Krystal , H. , ed. (1968), *Massive Psychic Trauma*. New York: International Universities Press .

[35] Lazarus , H. R. & Hagens , H. J. (1968), Prevention of psychosis following open-heart surgery. *Amer. J. Psychiat.*, 124 :76-81.

[36] Lifton , R. J. (1968), *Death in Life: Survivors of Hiroshima*. New York: Random House .

[37] MacDonald , M. C. (1973), Patuxent Institution—the problem of direction. *Psychiat. News* (April 4, 1973), 8 : 3 , 35.

[38] Mason . B. J. , (1973), Brain surgery to control behavior. *Ebony* (February, 1973), 29 :62-68.

[39] Medvedev , Z. A. & Medvedev . R. (1971), *A Question of Madness*, trans. E. deKadt. New York: Random House .

[40] Menninger , W. C. (1948), *Psychiatry in a Troubled World*. New York: Macmillan .

[41] Miller , E. & Crichton-Miller , H. (1940), *The Neuroses in War*. New York: Macmillan .

[42] Mitscherlich , A. & Mielke , F. , eds. (1949), *Doctors of Infamy*. New York: Henry Schuman .

[43] Muslin , H. (1971), On acquiring a kidney. *Amer. J. Psychiat.*, 127 :1185-1188.

[45] Psychiatric News (1973), Behavioral shortcuts said ahead for psychotherapy. *Psychiatric News* (March 21. 1973). 8 : 1 , 24.

[46] Stanford , P. (1972), A model, clockwork-orange prison. *New York Times Magazine* (September 17, 1972). pp. 9, 71-76. 78-80, 84.

[47] Stoller , R. J. (1973), Overview: the impact of new advances in sex research on psychoanalytic theory. *Amer. J. Psychiat.*, 130 :3-12.

[48] Tarsis , V. (1965). *Ward* 7 : *An Autobiographical Novel*, trans. K. Brown. New York: E. P. Dutton .

[44] Tourkow, L. P. (1974). Psychic Consequences of Loss and Replacement of Body Parts. *J. Amer. Psychoanal. Assn.* 22 :170-181 (APA.022.0170A)

[49] Ungerleider , J. H. (1963), The army, the soldier and the psychiatrist. *Amer. J. Psychiat.*, 118 :875-876.

[50] Wexler, H. (1972). The Life Master—A Case of Severe Ego Regression Induced by Combat Experience in World War II. *Psychoanal. Study Child* 27 :565-597 (PSC.027.0565A)

[51] Winnik, H. Z. (1968). Psychic traumatization through social catastrophe; a symposium *Internat. J. Psycho-Anal.* 49 :287-329 (IJP.049.0298A)

[52] Wolfenstein , M. (1957), *Disaster, a Psychological Essay*. Glencoe: Free Press .

, 1974; v.2, p3 (21pp.)
AOP.002.0003A