Notes on the Psycho-Analytical Investigation and Treatment of Manic-Depressive Insanity and Allied Conditions (1911)

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Essential Papers on Depression

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Whereas states of morbid anxiety have been dealt with in detail in the literature of psycho-analysis, depressive states have hitherto received less attention. Nevertheless the affect of depression is as widely spread among all forms of neuroses and psychoses as is that of anxiety. The two affects are often present together or successively in one individual; so that a patient suffering from an anxiety-neurosis will be subject to states of mental depression, and a melancholic will complain of having anxiety.

One of the earliest results of Freud's

investigation of the neuroses was the discovery that neurotic anxiety originated from sexual repression; and this origin served to differentiate it from ordinary fear. In the same way we can distinguish between the affect of sadness or grief and neurotic depression, the latter being unconsciously motivated and a consequence of repression.

Anxiety and depression are related to each other in the same way as are fear and grief. We fear a coming evil; we grieve over one that has occurred. A neurotic will be attacked with anxiety when his instinct strives for a gratification which repression prevents him from attaining; depression sets in when he has to give up his sexual aim without having obtained gratification. He feels himself unloved and incapable of loving, and therefore he despairs of his life and his future. This affect lasts until the cause of it ceases to

operate, either through an actual change in his situation or through a psychological modification of the displeasurable ideas with which he is faced. Every neurotic state of depression, just like every anxiety-state, to which it is closely related, contains a tendency to deny life.

These remarks contain very little that is new to those who regard the neuroses from the Freudian point of view, although surprisingly little has been written in the literature of psycho-analysis concerning the psychology of neurotic depression. But the affect of depression in the sphere of the psychoses awaits more precise investigation. This task is complicated by the fact that a good part of the diseases in question run a 'cyclical' course in which there is an alteration between melancholic and manic states. The few preliminary studies[1] which have hitherto been published have only dealt with one of these two phases at a time.

During the last few years I have met with six undoubted cases of this kind in my practice. Two of these were light manic-depressive cases (so-called cyclothymia), one of whom I treated only for a short time. The third, a female patient, suffered from short but rapidly recurring states of depression accompanied by typical melancholic symptoms. Two more had succumbed to a depressive psychosis for the first time, but had previously shown a tendency to slight changes of mood in a manic or depressive direction. The last patient had been overtaken by a severe and obstinate psychosis at the age of forty-five.

Most psychiatrists, following Kraepelin, do not consider states of depression as belonging to manic-depressive insanity if they come on after the patient's fortieth year. Nevertheless, as the analysis proceeded this last case disclosed such a marked similarity in its psychic structure to those

cases which did undoubtedly belong to the manic-depressive insanities that I should certainly class it in that group. I do not, however, intend this as a statement of opinion concerning the line of demarcation between the two psychoses. And I do not wish to discuss states of depression occurring in dementia praecox.

Even in my first analysis of a depressive psychosis I was immediately struck by its structural similarity with an obsessional neurosis. In obsessional neurotics[2]—I refer to severe cases—the libido cannot develop in a normal manner, because two different tendencies—hatred and love—are always interfering with each other. The tendency such a person has to adopt a hostile attitude towards the external world is so great that his capacity for love is reduced to a minimum. At the same time he is weakened and deprived of his energy through the repression of his hatred or,

to be more correct, through repression of the originally over-strong sadistic component of his libido. There is a similar uncertainty in his choice of object as regards its sex. His inability to establish his libido in a definite position causes him to have a general feeling of uncertainty and leads to doubting mania. He is neither able to form a resolution nor to make a clear judgment; in every situation he suffers from feelings of inadequacy and stands helpless before the problems of life.

I will now give as briefly as possible the history of a case of cyclothymia as it appeared after a successful analysis had been made.

The patient remembered that his sexual instinct had shown itself very precociously—before he was in his sixth year—and had set in with great violence. His first sexual object at that

time had been a governess whose presence had excited him. She still figured very vividly in his phantasies. His emotional excitement had led him to practice onanism, which he had done by lying on his stomach and making rubbing movements. He had been discovered doing this by his nurse (formerly his wet nurse), who expressly forbade him to do it, and whipped him whenever he disobeyed her. She also impressed upon him the fact that he would suffer for it all his life. Later, when he was at school he had been attracted in an erotic way by a school-fellow for a period of several years.

In his childhood and later he had never felt satisfied at home. He always had the impression that his parents favored his elder brother, who was unusually clever, while he had only an average intelligence. He also believed that his younger brother, who was delicate, received

greater attention from his mother than he did. The result of this was that he had a hostile attitude towards his parents, and one of jealousy and hatred towards his brothers. The intensity of this hate can be seen from a couple of impulsive acts which he carried out in his childhood. On two occasions when quarrelling over trifles he had become very violent towards his younger brother, and had knocked him down and seriously hurt him. Such violence is particularly remarkable when we learn that at school he was always the smallest and weakest among his contemporaries. He never made any real companions, but generally kept to himself. He was industrious, but had little to show for it. At puberty it became evident that his sexual instinct, which at first had shown itself so strongly, had become paralyzed through repression. In contrast to his attitude in childhood he did not feel attracted to the female sex. His

sexual activity was the same that he had carried out in childhood; but he did not perform it in the waking state but only in his sleep or half-asleep. He had no friends. He was quite aware of his lack of real energy when he compared himself with others. He found no encouragement at home; on the contrary, his father used to say contemptuous things about him in his presence. Added to all these depressing factors he suffered a definite psychic trauma; a teacher had the brutality to call him a physical and mental cripple in front of the whole class. His first attack of depression appeared soon after this.

Even later on he made no companions. He kept away from them intentionally, too, because he was afraid of being thought an inferior sort of person. Children were the only human beings he got on well with and liked, because with them he did not have his usual feeling of inadequacy. His life was a

solitary one. He was positively afraid of women. He was capable of normal sexual intercourse, but had no inclination for it and failed to obtain gratification from it. His onanistic practices in his sleep were his chief sexual activity even in later years. He showed little energy in practical life; it was always difficult for him to form a resolution or to come to a decision in difficult situations.

Up to this point the patient's history coincided in all its details with what we find in obsessional neurotics. Nevertheless, we do not find obsessional symptoms in him but a circular parathymia that had recurred many times during the last twenty years.

In his depressive phase the patient's frame of mind was 'depressed' or 'apathetic' (I reproduce his own words) according to the severity of his condition. He was inhibited, had to force himself to

do the simplest things, and spoke slowly and softly. He wished he was dead, and entertained thoughts of suicide. His thoughts had a depressive content. He would often say to himself, 'I am an outcast', 'I am accursed', 'I am branded', 'I do not belong to the world'. He had an indefinite feeling that his state of depression was a punishment. He felt non-existent and would often imagine himself disappearing from the world without leaving a trace. During these states of mind he suffered from exhaustion, anxiety and feelings of pressure in the head. The depressive phase generally lasted some weeks, though it was of shorter duration at times. The intensity of the depression varied in different attacks; he would have perhaps two or three marked states of melancholy and probably six or more slighter ones in the course of a year. His depression gradually increased during the course of an attack until it reached a certain height, where

it remained for a time, and then gradually diminished. This process was conscious to him and perceptible to other people.

When the patient was about twenty-eight years old a condition of hypomania appeared, and this now alternated with his depressive attacks. At the commencement of this manic phase he would be roused out of his apathy and would become mentally active and gradually even over-active. He used to do a great deal, knew no fatigue, woke early in the morning, and concerned himself with plans connected with his career. He became enterprising and believed himself capable of performing great things, was talkative and inclined to laugh and joke and make puns. He noticed himself that his thoughts had something volatile in them; a slight degree of 'flight of ideas' could be observed. He spoke more quickly, more forcibly and louder than usual. His frame of mind

was cheerful and a little elevated. At the height of his manic phase his euphoria tended to pass over into irritability and impulsive violence. If, for example, someone disturbed him in his work, or stepped in his way, or drove a motor-car quickly past him, he responded with a violent affect of anger and felt inclined to knock the offender down on the spot. While in this state he used often to become involved in real quarrels in which he behaved very unfeelingly. In the periods of depression he slept well but during the manic phase he was very restless, especially during the second half of the night. Nearly every night a sexual excitement used to overtake him with sudden violence.

Although his libido had appeared very early and with great force in his childhood, the patient had for the most part lost the capacity for loving or hating. He had become incapable of loving, in the

same manner as the obsessional neurotic. Although he was not impotent, he did not obtain actual sexual enjoyment, and he used to get greater satisfaction from a pollution than coitus. His sexual activities were in the main restricted to his sleep. In this, like the neurotic, he showed an autoerotic tendency to isolate himself from the external world. People of this kind can only enjoy pleasure in complete seclusion; every living being, every inanimate object, is a disturbing element. It is only when they have achieved the complete exclusion of every external impression—as is the case when they are asleep—that they can enjoy a gratification of their sexual wishes, by dreaming them. Our patient expressed this in the following words: 'I feel happiest in bed; then I feel as though I were in my own house.'[3]

At puberty in especial the patient was made aware that he was behind his companions of the

same age in many important respects. He had never felt their equal physically. He had also been afraid of being inferior mentally, especially in comparison with his elder brother. And now the feeling of sexual inadequacy was added. It was precisely at this time that his teacher's criticism ('a mental and physical cripple') struck him like a blow. Its great effect was explained by the fact that it recalled to his memory the prophecy of his wet-nurse, when she had threatened him with lifelong unhappiness because of his masturbation. Just when he was entering upon manhood therefore, and ought to have had masculine feelings like his companions, his old feelings of inadequacy received a powerful reinforcement. It was in this connection that he had had the first state of depression he could recollect.

As we so often see in the obsessional neuroses, the outbreak of the real illness occurred when the

patient had to make a final decision about his attitude towards the external world and the future application of his libido. In my other analyses a similar conflict had brought on the first state of depression. For example, one of my patients had become engaged to be married; soon afterwards a feeling of incapacity to love overcame him, and he fell into severe melancholic depression.

In every one of these cases it could be discovered that the disease proceeded from an attitude of hate which was paralyzing the patient's capacity to love. As in the obsessional neuroses, other conflicts in the instinctual life of the patients as well can be shown to be factors in the psychogenesis of the illness. I should like to mention especially the patient's uncertainty as to his sexual role in this connection. In Maeder's case[4] a conflict of this kind between a male and female attitude was particularly pronounced; and

in two of my patients I found a condition surprisingly similar to that described by him.

In their further development, however, the two diseases diverge from each other. The obsessional neurosis creates substitutive aims in place of the original unattainable sexual aims; and the symptoms of mental compulsion are connected with the carrying out of such substitutive aims. The development of the depressive psychoses is different. In this case repression is followed by a process of 'projection' with which we are familiar from our knowledge of the psychogenesis of certain mental disturbances.

In his 'Psycho-Analytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)' Freud gives a definite formulation of the psychogenesis of paranoia. He sets out in short formulae the stages which lead up

to the final construction of the paranoic delusion. I will here attempt to give a similar formulation of the genesis of the depressive psychoses, on the basis of my analyses of depressive mental disturbances.

Freud considers that in a large portion at least of cases of paranoic delusions the nucleus of the conflict lies in homosexual wish-phantasies, *i.e.* in the patient's love of a person of the same sex. The formula for this is: 'I (a man) love him (a man)'. This attitude raises objections in the patient and is loudly contradicted, so that the statement runs: 'I do not love him, I hate him'. Since internal perceptions are replaced by external ones in paranoia, this hatred is represented as a result of the hatred endured by the patient from without, and the third formula is; 'I do not love him—I hate him—because he persecutes me'.

In the psychoses with which we are here concerned a different conflict lies concealed. It is derived from an attitude of the libido in which hatred predominates. This attitude is first directed against the person's nearest relatives and becomes generalized later on. It can be expressed in the following formula: 'I cannot love people; I have to hate them'.

The pronounced feelings of inadequacy from which such patients suffer arise from this discomforting internal perception. If the content of the perception is repressed and projected externally, the patient gets the idea that he is not loved by his environment but hated by it (again first of all by his parents, etc., and then by a wider circle of people). This idea is detached from its primary causal connection with his own attitude of hate, and is brought into association with other —psychical and physical—deficiencies.[5] It seems

as though a great quantity of such feelings of inferiority favoured the formation of depressive states.

Thus we obtain the second formula: 'People do not love me, they hate me…because of my inborn defects.[6] Therefore I am unhappy and depressed.'

The repressed sadistic impulses do not remain quiescent, however. They show a tendency to return into consciousness and appear again in various forms—in dreams and symptomatic acts, but especially in an inclination to annoy other people, in violent desires for revenge or in criminal impulses. These symptomatic states are not usually apparent to direct observation, because for the most part they are not put into action; but a deeper insight into the patient's mind —as afforded in the catamnesis, for instance—will

bring a great deal of this kind of thing to light. And if they are overlooked in the depressive phase there is more opportunity for observing them in the manic one. I shall have more to say about this subject later on.

It is more especially in regard to such desires to commit acts of violence or revenge that the patients have a tendency to ascribe their feelings to the torturing consciousness of their own physical or psychical defects, instead of to their imperfectly repressed sadism. Every patient who belongs to the manic-depressive group inclines to draw the same conclusion as Richard III, who enumerates all his own failings with pitiless self-cruelty and then sums up:

> And therefore, since I cannot prove a lover. . .
> I am determined to prove a villain.

Richard cannot love by reason of his defects which make him hateful to others; and he wants to

be revenged for this. Each of our patients wishes to do the same, but cannot, because his instinctual activity is paralyzed by repression.

New and morbid states, such as feelings of guilt, result from the suppression of these frequent impulses of hatred and revenge. Experience so far seems to show that the more violent were the person's unconscious impulses of revenge the more marked is his tendency to form delusional ideas of guilt. Such delusions, as is well known, may attain enormous proportions, so that the patient declares that he alone has been guilty of all sins since the world began, or that all wickedness originates from him alone. In these persons an insatiable sadism directed towards all persons and all things has been repressed in the unconscious. The idea of such an enormous guilt is of course extremely painful to their consciousness; for where there is a great degree of repressed sadism

there will be a corresponding severity in the depressive affect. Nevertheless the idea of guilt contains the fulfillment of a wish—of the repressed wish to be a criminal of the deepest dye, to have incurred more guilt than everyone else put together. This, too, reminds us of certain psychic processes in obsessional neurotics, as, for instance, their belief in the 'omnipotence' of their thoughts. They frequently suffer from anxiety lest they have been guilty of the death of a certain person by having thought about his death. The sadistic impulses are repressed in the obsessional neurotic also: because he cannot *act* in conformity with his original instincts he unconsciously gives himself up to phantasies of being able to kill by means of *thoughts.* This wish does not appear as such in consciousness but it takes the form of a tormenting anxiety.

As a result of the repression of sadism,

depression, anxiety, and self-reproach arise. But if such an important source of pleasure from which the active instincts flow is obstructed there is bound to be a reinforcement of the masochistic tendencies. The patient will adopt a passive attitude, and will obtain pleasure from his suffering and from continually thinking about himself. Thus even the deepest melancholic distress contains a hidden source of pleasure.

Before the actual state of depression sets in many patients are more than usually energetic in their pursuits and manner of life. They often sublimate in a forced manner libido which they cannot direct to its true purpose. They do this so as to shut their eyes to the conflict within them, and to ward off the depressive frame of mind which is tending to break into consciousness. This attitude often succeeds for long periods, but never completely. The person who has to combat

disturbing influences for a long time can never enjoy peace or security within himself. Any situation which requires a definite decision in the field of the libido will cause a sudden collapse of his psychic equilibrium which he has so laboriously kept up. When the state of depression breaks out his previous interests (sublimations) suddenly cease; and this leads to a narrowing of his mental outlook which may become so pronounced as to attain to monoideism.

When the depressive psychosis has become manifest its cardinal feature seems to be a mental inhibition which renders a *rapport* between the patient and the external world more difficult. Incapable of making a lasting and positive application of his libido, the patient unconsciously seeks seclusion from the world, and his auto-erotic trend manifests itself in his inhibition. There are other means, it is true, by which neuroses and

psychoses can give symptomatic expression to an autoerotic tendency. That it should be inhibition rather than some other symptom that appears in this case is fully explained from the fact that the inhibition is able to serve other unconscious tendencies at the same time. I refer in particular to the tendency towards a 'negation of life'. The higher degrees of inhibition in especial—*i.e.* depressive stupor— represent a symbolic dying. The patient does not react even to the application of strong external stimuli, just as though he were no longer alive. It is to be expressly noted that in the foregoing remarks only two causes of the inhibition have been considered. In every case analysis revealed still further determinants, connected with the individual circumstances of the patient.

Certain features commonly present in states of depression become comprehensible if we accept

the well-founded conclusions of psychoanalytic experience. Take, for instance, the frequent ideas of impoverishment. The patient complains, let us say, that he and his family are exposed to starvation. If a pecuniary loss has actually preceded the onset of his illness, he will assert that he cannot possibly endure the blow and that he is completely ruined. These strange ideas, which often entirely dominate the patient's thoughts, are explicable from the identification of libido and money—of sexual and pecuniary 'power'[7]—with which we are so familiar. The patient's libido has disappeared from the world, as it were. Whereas other people can invest their libido in the objects of the external world he has no such capital to expend. His feeling of poverty springs from a repressed perception of his own incapacity to love.

We very frequently meet with fears or pronounced delusions centering round the same

idea in states of depression connected with the period of involution. As far as my not very extensive psycho-analytical experience of these conditions goes, I have reason to believe that it is people whose erotic life has been without gratification who are liable to such delusions. In the preceding decade of their life they had repressed this fact and had taken refuge in all kinds of compensations. But their repressions are not able to cope with the upheaval of the climacteric. They now pass in review, as it were, their wasted life, and at the same time feel that it is too late to alter it. Their consciousness strongly resists all ideas connected with this fact; but not being strong enough to banish them completely, it has to allow them entrance in a disguised form. They are still painful in the form of a delusion of impoverishment, but not as intolerable as before.

Viewed externally, the manic phase of the

cyclical disturbances is the complete opposite of the depressive one. A manic psychotic appears very cheerful on the surface; and unless a deeper investigation is carried out by psychoanalytic methods it might appear that the two phases are the opposite of each other even as regards their content. Psycho-analysis shows, however, that both phases are dominated by the same complexes, and that it is only the patient's attitude towards those complexes which is different. In the depressive state he allows himself to be weighed down by his complex, and sees no other way out of his misery but death;[8] in the manic state he treats the complex with indifference.

The onset of the mania occurs when repression is no longer able to resist the assaults of the repressed instincts. The patient, especially in cases of severe maniacal excitation, is as if swept off his feet by them. It is especially important to notice

that positive and negative libido (love and hate, erotic desires and aggressive hostility) surge up into consciousness with equal force.

This manic state, in which libidinal impulses of both kinds have access to consciousness, once more establishes a condition which the patient has experienced before—in his early childhood, that is. Whereas in the depressive patient everything tends to the negation of life, to death, in the manic patient life begins anew. The manic patient returns to a stage in which his impulses had not succumbed to repression, in which he foresaw nothing of the approaching conflict. It is characteristic that such patients often say that they feel themselves 'as though new-born'. Mania contains the fulfillment of Faust's wish:

> Bring back my passion's unquenched fires,
> The heavenly smart of bliss restore;
>
> Hate's strength—the steel of love's desires—

Bring back the youth I was once more.

The maniac's frame of mind differs both from normal and from depressive states, partly in its care-free and unrestrained cheerfulness, partly in its increased irritability and feeling of self-importance. The one or the other alteration can predominate according to the individuality of the patient or the different stages of the disease.

The affect of pleasure in mania is derived from the same source as is that of pleasure in wit. What I have to say about this is therefore in close agreement with Freud's theory of wit.[9]

Whereas the melancholiac exhibits a state of general inhibition, in the manic patient even normal inhibitions of the instincts are partly or wholly abolished. The saving of expenditure in inhibition thus effected becomes a source of pleasure, and moreover a lasting one, while wit

only causes a transitory suspension of the inhibitions.

Economy of inhibition is, however, by no means the only source of manic pleasure. The removal of inhibitions renders accessible once more old sources of pleasure which had been suppressed; and this shows how deeply mania is rooted in the infantile.

The technique of the manic production of thoughts may be regarded as a third source of pleasure. Abolition of logical control and playing with words—two essential features of manic ideational processes— indicate an extensive 'return to infantile freedom'.

Melancholic inhibition of thought finds its reverse in the manic flight of ideas. In the melancholic phase there is a narrowing of the circle of ideas, in the manic phase a rapid change

of the content of consciousness. The essential difference between flight of ideas and normal thinking is that whereas in thinking or speaking the healthy person consistently keeps in view the aim of his mental processes the manic patient very easily loses sight of that aim.[10] This differentiation serves to characterize the external aspect of the flight of ideas, but not its significance for the manic subject. It is especially to be noted that the flight of ideas offers the patient considerable possibilities for obtaining pleasure. As has already been said, psychic work is economized where the abolition of logical control is removed and where the sound instead of the sense has to be considered. But the flight of ideas has yet another function, and a double one: it makes it possible to glide by means of light allusions over those ideas that are painful to consciousness, for example, ideas of inadequacy;

that is to say, it favours—like wit—transition to another circle of ideas. And it also permits of playful allusion to pleasurable things which are as a rule suppressed.

The similarity between the mind of the maniac and that of the child is characterized in a number of ways of which only one need be mentioned in this place. In the slighter states of manic exaltation the patient has a kind of careless gaiety which bears an obviously childish character. The psychiatrist who has had much to do with such patients can clearly see that his *rapport* with them is the same as with a child of about five years of age.

The severer forms of mania resemble a frenzy of freedom. The sadistic component-instinct is freed from its fetters. All reserve disappears, and a tendency to reckless and aggressive conduct takes

its place. In this stage the maniac reacts to trifling occurrences with violent outbursts of anger and with excessive feelings of revenge. In the same way, when his exaltation had reached a certain height, the cyclothymic patient mentioned above used to feel an impulse to strike down anyone who did not at once make way for him in the street. The patients often have an excessive feeling of power, measuring it not by actual performance but by the violence of their instincts, which they are now able to perceive in an unusual degree. Fairly frequently there appear grandiose ideas which are very similar to children's boasts about their knowledge and power.

Arising from the case of cyclothymia already described at length, there is one important question which I cannot attempt to answer definitely. It remains to be explained why, when the patient was about twenty-eight, states of

manic exaltation should have appeared in addition to the depressive state which had already existed for a long time. It may be that it was a case where psychosexual puberty followed a long time after physical maturity. We often see the development of instinctual life delayed in a similar manner in neurotics. On this hypothesis the patient would not have experienced an increase of his instinctual life at puberty but have been overtaken, like a woman, by a wave of repression; and it would only have been towards the end of his third decade that a certain awakening of his instincts would have occurred in the form of the first manic state. And in fact it was at the age that his sexual interests turned more to the female sex and less towards auto-erotism than before.

I must now say a few words about the therapeutic effects of psychoanalysis.

The case I have most fully reported in these pages was so far analysed at the time when I read my paper at Weimar that its structure was apparent in general. But there still remained a great deal of work to be done on it; and therapeutic results were only just beginning to be discernible. These have become more clearly visible during the last two and a half months. Naturally a definite opinion as regards a cure cannot yet be given, for after twenty years of illness, interrupted by free intervals of varying length, an improvement of two months' duration signifies very little. But I should like to record the result up to the present. In the period mentioned, no further state of depression has appeared, and the last one passed off very easily. In consequence of this the patient has been able to do continuous work. During the same period there did twice occur changed frame of mind in a manic direction,

which could not escape a careful observation; but it was of a far milder character than his previous states of exaltation. And besides this, certain hitherto regularly observed phenomena were absent. Between these last two manic phases there has been no depressive one, as was usually the case, but a state which could be called normal, since no cyclothymic phenomena were present. For the rest we shall have to follow the further course of the case. There is only one more thing I should like to add: If the patient succeeds in permanently maintaining a state similar to that of the last two months, even this partial improvement will be of great value to him. In the other case of cyclothymia the period of observation has been too short to permit of an opinion regarding therapeutic results. But its pathological structure was found to be remarkably similar to that of the first case.

The third case described at the beginning of this paper showed the effectiveness of analysis in a striking manner, in spite of the fact that external circumstances obliged the treatment to cease after about forty sittings. Even in the early part of the treatment I was able to cut short a melancholic depression which had just developed in the patient, a thing which had never happened before; and as treatment proceeded its effect became more lasting and expressed itself in a distinct amelioration in the patient's frame of mind, and in a considerable increase of his capacity for work. In the months following the cessation of his analysis his state of mind did not sink back to its former level. It may be noted that in this case the preponderating attitude of hatred, the feeling of incapacity to love and the association of depression with feelings of inadequacy were clearly to be seen.

In the two above-mentioned cases of a melancholic depression occurring for the first time, a consistent analysis could not be carried out on account of external difficulties. Nevertheless, its effect was unmistakable. By the help of psycho-analytical interpretation of certain facts and connections I succeeded in attaining a greater psychic *rapport* with the patients than I had ever previously achieved. It is usually extraordinarily difficult to establish a transference in these patients who have turned away from all the world in their depression. Psycho-analysis, which has hitherto enabled us to overcome this obstacle, seems to me for this reason to be the only rational therapy to apply to the manic-depressive psychoses.

The sixth case confirms this view with greater certainty; since I was able to carry the treatment through to the end. It had a remarkably good

result. The patient came to me for treatment fifteen months after the onset of his trouble. Before this, treatment in various sanatoria had had only a palliative effect in relieving one or two symptoms. A few weeks after the commencement of psycho-analytic treatment the patient felt occasional relief. His severe depression began to subside after four weeks. He said that at moments he had a feeling of hope that he would once again be capable of work. He attained a certain degree of insight and said: 'I am so egoistic now that I consider my fate the most tragic in the world'. In the third month of treatment his frame of mind was freer on the whole; his various forms of mental expression were not all so greatly inhibited, and there were whole days on which he used to feel well and occupy himself with plans for the future. At this time he once said with reference to his frame of mind: 'When it is all right I am

happier and more care-free than I have ever been before'. In the fourth month he said that he had no more actual feelings of depression. During the fifth month, in which the sittings no longer took place daily, distinct variations in his condition were noticeable, but the tendency to improvement was unmistakable. In the sixth month he was able to discontinue the treatment; and the change for the better in him was noticeable to his acquaintances. Since then six months have passed without his having had a relapse.

From a diagnostic point of view the case was quite clearly a depressive psychosis and not a neurosis of the climacteric period. I am unfortunately unable to publish details of the case; they are of such a peculiar kind that the *incognito* of the patient could not be preserved if I did. There are also other considerations which necessitate a quite special discretion—a fact which is greatly to

be regretted from a scientific point of view.

There is one objection that might be raised regarding the therapeutic results obtained in this case, and that is that I had begun treating it precisely at that period when the melancholia was passing off, and that it would have been cured without my doing anything; and from this it would follow that psycho-analysis did not possess that therapeutic value which I attribute to it. In answer to this I may say that I have all along been careful to avoid falling into an error of this kind. When I undertook the treatment I had before me a patient who was to all appearances unsusceptible to external influence and who had quite broken down under his illness; and I was very sceptical as to the result of the treatment. I was the more astonished when, after overcoming considerable resistances, I succeeded in explaining certain ideas that completely dominated the patient, and

observed the effect of this interpretative work. This initial improvement and every subsequent one followed directly upon the removal of definite products of repression. During the whole course of the analysis I could most distinctly observe that the patient's improvement went hand in hand with the progress of his analysis.

In thus communicating the scientific and practical results of my psycho-analyses of psychoses showing exaltation and depression I am quite aware of their incompleteness, and I hasten to point out these defects myself. I am not in a position to give as much weight to my observations as I could have wished, since I cannot submit a detailed report of the cases analysed. I have already mentioned the reasons for this in one of the cases. In three other very instructive cases motives of discretion likewise prevented me from communicating any details. Nor will intelligent

criticism reproach me for adopting this course. Those who take a serious interest in psycho-analysis will make good the deficiencies in my work by their own independent investigations. That further investigations are very greatly needed I am fully aware. Certain questions have not been considered at all or only barely touched upon in this paper. For instance, although we have been able to recognize up to what point the psychogenesis of obsessional neuroses and cyclical psychoses resemble each other, we have not the least idea why at this point one group of individuals should take one path and the other group another.

One thing more may be said concerning the therapeutic aspect of the question. In those patients who have prolonged free intervals between their manic or depressive attacks, psycho-analysis should be begun during that free

period. The advantage is obvious, for analysis cannot be carried out on severely inhibited melancholic patients or on inattentive maniacal ones.

Although our results at present are incomplete, it is only psychoanalysis that will reveal the hidden structure of this large group of mental diseases. And moreover, its first therapeutic results in this sphere justify us in the expectation that it may be reserved for psycho-analysis to lead psychiatry out of the *impasse* of therapeutic nihilism.

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Notes

1 Maeder, 'Psychoanalyse bei einer melancholischen Depression' (1910). Brill, 'Elin Fall von periodischer Depression psychogenen Ursprungs' (1911). Jones,

'Psycho-Analytic Notes on a Case of Hypomania' (1910).

2The following brief description adheres closely to Freud's characterization in his paper, 'Notes upon a Case of Obsessional Neurosis' (1909).

3 I might remark that the other male patients whose depressive psychoses I was able to analyse behaved in the same way. None of them were impotent, but they had derived more pleasure from auto-erotic behaviour all along, and to have any relations with women was a difficult and troublesome business for them.

4 Maeder, 'Psychoanalyse bei einer melancholischen Depression' (1910).

5 In many cases, and particularly in the slighter ones, the original connection is only partly lost; but even so the tendency to displacement is clearly recognizable.

6 Cf. with this the etymology of the German word *hasslich* ('ugly') = 'that which arouses hate'.

7 [The German word used, *Vermögen*, means both 'wealth' and 'capacity' in the sense of sexual potency.—*Trans.*]

8 Some patients cling to the idea that they can be cured by the fulfillment of some external condition—usually one, however, which never can be fulfilled.

9 *Der Witz undseine Beziehung zum Unbewussten*, 1905.

10 Liepmann, *Über Ideenflucht* (1904).