

jection takes place because there is a regressive accumulation of narcissistic libido, or an unsurmountable fixation of the same. According to this assumption the projection of the patient's own body could be a defense against a complete return to a libido position corresponding to the foetal and beginning of the extra-uterine development. This viewpoint permits the explanation of various schizophrenic symptoms. For example catalepsy, *flexibilitas cerea*, etc., may be considered to correspond to those developmental stages in which the person does not yet realize that his organs are his own and is impelled to leave them to the power of foreign agents. In contrast to these conditions would be the symptom that the person's limbs are actually moved by outside forces. The catatonic condition would be the stage in which there is complete renunciation of the external world, corresponding to regression to the level of existence in the mother's body.

These regressions of the libido often extend to the period before there is centralization in the genitals, to the prenatal and early postnatal period when the whole body is diffusely libidinous. The author believes that when these facts are taken into consideration the apparent inconsistency between the dream, where the machine represents the genitals, and schizophrenia, where the apparatus represents the whole body, vanishes entirely. At the level of schizophrenic regression the sexual libido resides in the body as a whole, is diffuse, and belongs to various areas; in the language of later genital differentiation, the whole body is a genital. [C. Willard.]

**Freud, S.** MOURNING AND MELANCHOLIA. [Internat. Ztschft. f. a. Psychoanalyse, Vol. IV, No. 6.]

Freud here compares the normal affect of mourning with pathological melancholy. In descriptive psychology, he says, the idea of depression or melancholia is very indefinite, appearing under a variety of clinical pictures which it seems almost impossible to subsume under a single entity. To gain unity of view he emphasizes the resemblances of the two conditions. The mechanism of mourning may be described as follows: the reality test shows that the loved object no longer exists and gives the command that the libido must be withdrawn from it. This arouses opposition, for human beings do not willingly give up a libido position even when there is a substitute. The opposition may be so strong that there is a pathological reaction—the reality principle is deflected and the object is retained in the form of a hallucinatory wish psychosis. In the normal course, however, the respect for the reality test finally gains the victory. Melancholia may, like mourning, be the reaction to the loss of a real object but in some instances the object lost is not recognized and may be considered unconscious. In mourning there are retardations and loss of interest in the environment for a certain period; in melancholia there are the same retardations and absence of interest, but here seemingly without cause. But the symptom which above all others distinguishes pathological depression from mourning is the prevailing idea of

unworthiness. Depressed patients believe themselves morally lost, reproach themselves with all sorts of shortcomings, and stand in constant fear of punishment. They extend their self-accusations over the entire past and future, believing themselves wholly beyond redemption. They refuse food and achieve the very remarkable conquest of that fundamental instinct which makes all living things hold fast to life. From the analogy with mourning one would be led to conclude that depressed patients have suffered a loss in the form of an external object; from their own statements it would seem that they have suffered a loss in their own ego—a part of the ego seems to have split itself off, to have opposed itself to another part and to be sitting in critical judgment on that part. From close attention to the complaints of these patients, however, it becomes manifest that the reproaches ill fit the patient's self, or that with slight modifications they fit another person better, some one whom the patient loves, has loved, or ought to love. And here we have the key to the disorder. The reproaches are really directed against a loved object. A real injury has been suffered from this object; disillusionment follows; but the result is not the annulment of the libido; it results only in a displacement of the same, not in the direction of a new object, but toward the ego itself, where there is an identification of a part of the ego with the object that has been renounced. The shadow of the object falls athwart an element of the ego, as it were, so that this element is judged by a critical component as an object apart. In this way it is that the loss of the object is transformed into a loss of the ego. The conditions rendering possible this displacement is that the emotional endowment should never at any time have been very stable and that the first choice of the object should have been made on narcissistic grounds. Identification with the ego is the primitive manner of choosing an object and the emotional expression toward the object is originally ambivalent, taking the forms of both tenderness and cruelty, as revealed in the oral or cannibalistic level of the libido connected with taking food. Abraham, therefore, rightly refers to the refusal of food by persons suffering from melancholia to a taboo connected with the cannibalistic level.

The ambivalence solves the riddle of the tendency of depressed patients to commit suicide, which makes this disease so interesting and so dangerous. The analysis of melancholia teaches that a person can only kill himself, when through the recoil of the emotional endowment belonging to the object, the self is valued as an object. In this case sadistic tendencies in the person's self are turned against the ego which has been identified with the object and complete satisfaction of the sadism is found in the self-accusation and attempts at self-injury.

One of the most remarkable peculiarities of melancholia and the one which is most in need of explanation is the tendency to turn into an exactly opposite condition, *i.e.*, into mania. One would be inclined to exclude instances of this sort from psychogenic affections altogether were it not for the fact that psychoanalysis has been successfully used in the

treatment of cases with cyclothymic course, thus not only permitting the extension of the explanation of depression to mania, but making this extension imperative. Both affections are due to the same complex, which in depression has overcome the ego, while in mania the ego is triumphant, in analogy with what happens in alcoholic intoxication when the repressive forces are broken down. The obvious ambivalence in melancholia point to the unconscious system as the theatre of the conflicting affects. There are three conditions connected with melancholia: (1) Loss of sleep. (2) The ambivalence conflict. (3) The regression of the libido to an earlier level. The first two conditions are met with in mourning when pathological features of self-accusation develop, but in these cases the manic phase is never encountered so that this latter reaction must be essentially connected with the third condition, the regression of the libido to the narcissistic level. It may be that the conflict in the ego acts like a painful wound calling for an extreme counteractive energy resulting in the manic phase. The author, however, remarks that more insight must be gained into the economy of the physical processes before they can be used to explain their psychical analogies. [C. W.]