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SHORT ARTICLES AND NOTES

Bisexual Factors in Curable Schizophrenia *

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Kraepelin, over fifty years ago, gave psychiatry, after a long series of remarkable studies of many psychoses, his famous differentiation of dementia praecox as an incurable, progressively deteriorating, nervous and mental disease, and manic-depressive psychosis as a repetitious, cyclical, autogenously recoverable reaction. Thereafter psychiatry, generally, adopted this concept, particularly for its useful simplification of many legal, administrative, and custodial problems.

Over thirty years ago Freud, Bleuler, and Jung, then the leaders of psychoanalytic methods, reinforced the Kraepelinian theory by arriving at the conviction, from a small number of ineffectually treated cases, that dementia praecox, now renamed schizophrenia, was based on some unknown, constitutional cerebral or other pathology and was incurable by psychoanalytic methods. Unfortunately for thousands of patients, this conviction has continued to influence most psychoanalysts and other psychiatrists to neglect the psychopathology of schizophrenia, although Meyer, White, and Jelliffe had at this time demonstrated the prejudicial unsoundness and injustice of the belief from the evidence of a number of autogenous social recoveries made under intelligent nursing.

In 1912, after reading Freud's *Studies in Hysteria* and White's *Mental Mechanisms* and some papers by Meyer and Jelliffe on the affective disorders in dementia praecox, I ventured at the Indianapolis State Hospital to try, on some selected cases on my wards, the psychoanalytic technique Freud was then using. Among them were two women who had been diagnosed dementia praecox by Dr. Max Bahr, then clinical psychiatrist at the hospital. These diagnoses would today I am sure be accepted as correct.

The psychotherapy began with the intentional cultivation of a positive *sympathetic rapport*, later called *transference*, with each patient in order to get her to confide in me the secrets of her troubles with herself. I was able to induce each one to tell me what she knew about herself. Each patient had worked herself into an automatically repetitious convergence of mind on preoccupations with past social ridicule, frustrations, and inferiorities covering shame, guilt and struggle with unspeakable autoerotic cravings, producing an attitude of indifference to present and future social relations. In each instance the repetitious pressure of the erotic cycle was regarded with obsessive dread, anxiety, and inferiority, followed by pleasurable infatuations and indulgence, ending in remorse, shame, and anxiety, often to the degree of hopeless despair and impulses to suicide. Each one had special kinds of sexual infatuation, and thought and fought with them in highly individualized ways although with similar stupefying preoccupations, restlessness, sleeplessness, and incapacity to work, learn, or eat normally. As usual, the treatment soon came to an impasse beyond which the patient could not make progress and talked in confused, repetitious circles with superficial distractions and painful discouragement at not being able to think of anything else.

I then decided to adopt, contra to Freud, the innovation of persuasively, aggressively, insistently working on each patient with direct and leading questions in order to break through the self-repressive fear of me and of themselves and what they might remember

and say and do impulsively. In each instance, within a few hours, decisive autoerotic fantasies, memories, and emotions were released and rapidly increased to a passionate flood with its autonomic tides converged upon me. Their reactions to my sympathetic, controlled interest varied from narcissistic disappointment, anger, and self doubt and negative reversions to coming back for more analytic help.

Case A was a young wife with compulsive jealousy, autoerotic inferiorities, paranoid thinking, socially specifically conditioned hysterical jerking spells that involved all of her body, and conditioned vomiting, visual constriction, and hemianesthesia. She recovered in a psychologically interesting series of well-differentiated steps as she recalled the accumulative repressed memories and emotional reactions to a series of painfully humiliating experiences with her foster-mother, mother-in-law, and husband.

Case B, a once fairly efficient young woman stenographer, had an extremely severe, symbolically and physically self-cleansing compulsive mysophobia with suicidal desperation which had continued for a year without relaxation. Her preoccupations had completely incapacitated her for doing any kind of work. She recovered after recalling her repressions and assimilating them through talking out in fragments the meaning to her of her autoerotic infatuations for genital, anal, and fecal fantasies with masturbation, centered upon her father. She had been progressively cultivating a semi-seclusive, shut-in, weakening social attitude, and became precipitated into a panic when she suddenly realized during an erotic episode that her secrets were suspected by her sister.

Both cases were fully reported to Dr. Adolph Meyer in 1913 and led to my becoming a member of his staff. Both cases were later published in my *Psychopathology* in 1920 with a large series of other cases of dementia praecox, including every type (9). Case A was also published in the Journal of *Abnormal Psychology* in 1917 (6). [For other publications on this psychopathology, see Kempf (4, 5, 7, 8, 10, 11).] Many of these cases had been treated with sufficient success at the Phipps Psychiatric Clinic through 1914 and Saint Elizabeths Hospital up to 1919 for them to be discharged as social recoveries *with insight* into how the pathological thinking had been progressively cultivated. The degree of insight and social adaptability distinguished them from the ordinary form of autogenous social recovery without insight.

The great importance of the quality of a person's insight as an indication of his sociability was developed for psychiatry by Adolph Meyer over forty years ago. It is as fundamental for psychiatry and general psychology as Freud's rediscovery of the ancient knowledge of hypnotic, good, and evil suggestion (see Frazer, 3) as repressed unconscious activity. By insight is meant the understanding of the emotional and other attitudinal interactions in oneself and other people. Recognition of the importance of developing insight or understanding for everyday life has been traced by Breasted (2) back through the ancient Greeks and Hebrews to the Egyptians as far as 3000 B.C., and seems to have developed with the beginning of the consistent culture of conscience and equilateral fraternalism to replace primitive unilateral opportunism.

The two Indianapolis cases of schizophrenia were, it now seems from the history of recorded cases, the first to have been successfully treated in America or Europe by the Freudian psychoanalytic method. Some of the Phipps and Saint Elizabeths patients reacted with decisive changes toward recovery with only one or two hours of active analytic-suggestive psychotherapy. Since 1920 this series of more or less successfully treated cases has been extended in private practice under improved methods of analysis of the *ego-attitude* towards its physiological cravings under the culture of its familial and other social requirements.

From 1915 to 1925 I had to accept many intolerant criticisms from leading Freudian psychoanalysts for daring to modify Freud's passive technique and his theory of the dynamic processes involved in the neuroses and psychoses. Freud, as late as the

end of World War I, had continued to assume the existence of a "censor" in the mind in order to explain the evidence of uncompromising conflicts and self-repressions. Although he had made the important scientific discovery that repressed, unconsciously emotivated thoughts continue to act in part as determinants of conscious thinking and behavior, he was unable to work out a theory of the psychophysiological processes that was satisfactory to himself, as the series of later experimental changes in his theory showed. When he divided the personality into the *id*, *ego*, and *superego* he had only renamed the ancient Hebraic triangular concept of *body, mind*, and *spirit*. His differentiation of all reactions into *life* and *death* and *love* and *hate* instincts was unsatisfactory. It neglected the endless pressure of development of body, ego-attitude and mind attended by fear of failure, as basic emotivations in all struggles for survival, maturation and reproduction.

Numerous controversial discussions had made evident the need for working out a consistent explanation of human and other animal behavior that specifically interrelated physiopsychological and psychophysiological circular sequences of reaction. These must include the integrative actions of the two neuromuscular systems, conditioning of reflexes, endocrine and autonomic emotivation, bisexual differentiation, and the social culture of the ego-attitude. Since 1912 I have devoted most of my studies in this direction, as some of you know.

Freud had continued, as late as 1923, in seeing the repressed factors as the chief cause of the neuroses although it had been shown in my *Autonomic Functions and the Personality* (1918) and *Psychopathology* (1920) that, while the character of the physical and mental symptoms is determined by the repressed functions maintaining themselves repetitiously in conditioned, pathological, postural autonomic and somatic, neuromuscular, circular reflex tensions, the intensity of the conflict is caused principally by the intolerant, self-controlling, repressive work of the ego-attitude. Anxiety is then not a so-called "free floating" nervousness, but the variable compulsion to act in oppositely conditioned ways at the same time, producing indecision under autonomic-affective pressure with conflicting reciprocal inhibition in autonomic and somatic organs. The fearful distress and weakness of the resulting tremors in these organs is relieved by obsessive, compulsive tensions driving to wishful thinking that distorts the values of the ego and its social environment.

Because resistance in orthodox psychoanalytic circles to innovations in treating the psychoses and in explaining their physiopsychology and psychophysiology continued with purblind obstinacy and deprived thousands of young men and women of the possibility of relief I was advised by some leading psychologists and psychiatrists to talk with Freud personally about our respective theories, methods, and results. G. Stanley Hall arranged the interview, which extended over two days in the Austrian Tirol.

Freud had been for a number of years developing the technique of sitting behind the patient, who would be required to lie on a couch and give way to expressing free associations of thought regardless of their nature or emotivation. While this procedure, although seriously time-consuming, was often highly successful with intelligent people who could hold themselves interested in the causes of their symptoms, he generally failed to get free, releasing associations from schizophrenics who, because of intense narcism, would not endure the recall of painful injuries to it.

My method was to sit face to face and eye to eye with the patient across a small empty table in order to hold the patient's attention on his analysis. I was able to demonstrate to Freud from several case histories how, with considerable foreknowledge of the personal and family history and the psychobiological pressure of growth and bisexual differentiation with or against the ego's attitude, one can make direct and leading questions with the certainty that releasing specific repressions helps to reintegrate the personality and reduce the resistance to recurrent emotivations and thoughts. Freud finally concluded that a more

directed and active technique was justified in the psychoses and encouraged me to continue my work. I think he was also influenced in this direction by Ferenczi, who was then developing more aggressive psychoanalytic methods. By 1930 Brill, who was Freud's authorized representative in America and who had previously been one of the severest critics of the psychoanalytic treatment of the psychoses, published several papers demonstrating the successful use of more aggressive psychoanalytic methods with nonhospitalized schizophrenics. Contributions on the successful treatment of schizophrenia have now been made by many psychiatrists, which cannot be listed here. Today, shorter, more aggressive and improved methods are being developed by many psychosomaticists as well as psychoanalysts after thirty years of obsessive rejections. It is a pleasure to see that Alexander and French (1) have also become converts to trying more practical and individualized methods.

Every human, like the lower primates and other mammals, is a plastic, bisexual mechanism in which every cell, organ, and the organism as a whole and all of its behavior are bisexually differentiated in more or less male and female ratios by chromosomal, gonadal, and socially conditioning factors. Therefore, social and other environmental successes and failures have more or less masculinizing or feminizing reactive effects upon the social-sexual attitude. Every person's ontogeny recapitulates its phylogeny and begins with hermaphroditic, self-loving, polyorificial (oral, anal, and genital) autoeroticism. It passes through phases of autoerotic development up to late adolescence, attended with more or less homosexual infatuation and experimentation, and eventually matures by conversion of affection towards heterosexualism and reproduction.

Naturally the chromosomal, gonadal, and social determinants may work more or less in alliance or opposition with one another. The physician, therefore, should work them out as far as possible in each case. The family history often indicates hereditary, chromosomal, sexual pathology, whereas the development of secondary bisexual characters reveals the ratio of male and female gonadal determination. The personality shows the effects of family and other social appeals, approvals and rewards, and disapprovals, threats and punishments, upon the bisexual differentiation of its attitude through childhood and adolescence and even in adulthood. When all three factors are bisexually abnormal the achievement of heterosexuality and mental integrity under social condemnation is obviously impossible. Pathological gonadal ratios can often be corrected by administering fitting ratios of endocrines. Pathological social conditioning in chromasomal and gonadal normals can very often be readjusted to potent heterosexualism if the social pressure has not been too seductive or intolerant too early in childhood and the person has not become too infatuated with perverted pleasures. Persons having as much as a high-school education seem to be able to learn how to make emotional readjustments to normal and gain insight more readily than persons of lower mental levels.

Wherever we find a person who is in an emotionally driven psychopathological attitude we also find that one or more persons in his family or business from whom he cannot escape is egotistically obsessed to force or seduce that person into states of introverted, frustrated, affective confusion and mental indecision, even to the extent of destruction of his personal integrity. The interpersonal conflict tends to repeat itself to the egoistic pleasure of the dominant person and suffering of the defeated person. As a result the latter, more than the former, becomes progressively, endlessly preoccupied with mulling over what was said and done to him in order to make things come out right with egoistic satisfaction to himself. Such vicious circles of thinking and feeling tend to grow accumulatively and become increasingly autoerotic and regressive. They are the opposite of heterosexual and even homosexual exchanges in constructive directions.

More than thirty years of intensive investigation of these problems permits me to make the general statement that in man every case of emotional neurosis or psychosis is the result of more or less conflict and confusion

involving bisexual differentiation. In other animals also conflicting excitations producing indecision and anxiety involve sexual functioning pathologically. Dementing schizophrenia is essentially a regression to the cloacal level of hermaphrodism. I am quite sure that it would be easy to demonstrate these factors in any case and often within an hour of investigation.

The usual objection made to these statements is that since all men and women have been more or less autoerotic in youth and have not developed serious neuroses or psychoses, autoeroticism cannot be an important factor. My reply is that it is not so much the autoerotic fixation as the cultivation of the ego's attitude toward it that produces the destructive conflict. The objection to this view has been that most schizophrenics under commitment in hospitals are freely erotic and unrestrained. My reply is that this condition develops as the ego becomes disorganized and confused by the endless autoerotic pressure, and as the ego becomes reintegrated it resumes the old self-repressive, sensitive attitude without insight. In other words, an attitude of any normal ego that is fitted for doing accurately any responsible kind of work is at that time sexually repressive because the erotic attitude is not fit for doing such work. The normal person can change from a working to an erotic attitude or vice versa in adaptation to the immediate social situation, whereas the pathologically erotic person cannot do this as the result of many unsolved, pathological, interpersonal interferences during the development of his bisexual differentiation.

The psychotherapy of neuroses and psychoses is practically differentiated into two important steps, as experience has shown. The first step is best begun with the impressive sympathetic advantages of the first interview. Without taking a routine case history or making notes at the time, well-directed analytic-suggestive questioning is begun with the precise purpose of inducing the patient into adopting a less fearful, more relaxed attitude toward his sexual cravings, whatever they are and no matter how strong and repetitious they are, and talking about them freely. The patient has generally convinced himself that he is the only one of his kind as a result of the superior moral pretensions of his elders having been especially aimed at him. As he realizes that his attitude toward his sexual cravings and methods of trying to manage them, and not the cravings as such, have produced his illness, he improves decisively and his capacity for working and thinking becomes adequate for the needs of everyday life.

The second step is more involved and requires the inductive analytic conversion of the conditioned erotic and other emotional cravings to heterosexuality whenever possible. The former step is usually well started in an hour or two of confidential, sympathetic, understanding talk with the patient if the physician is not preoccupied with thinking in terms of neurology and toxicology. Psychological miracles often follow as the sexual fight becomes reduced. I am sure that literally thousands of autoerotic young men and women and children in our institutions and outside, who must otherwise remain incurable psychopaths, will be helped to readjust to a healthy personal integrity when psychiatrists adopt this method. The analytic readjustment to heterosexuality requires more time but generally it can be carried on outside of the hospital in private practice. It requires the recall and reliving of every decisive episode that tended to produce a repetitious emotional displacement until a normal readjustment follows without striving.

I have seen a number of patients that have been treated by insulin, metrazol, and electric shock and some who have been treated by frontal lobotomy or lobectomy who have improved sufficiently to be discharged as social recoveries. These cases have, however, little or no insight and retain, in milder form, their neurotic distortions. Hence most of them are doomed to eventual regression when they must live under the old conditions that formerly excited their repressions. On the other hand, patients who have acquired insight and released their repressed, conditioned emotivations and assimilated them by changing to more tolerant and practical and less conscientious but not conscienceless attitudes generally remain stable through most stresses. The effective results of electric or

chemical shock therapy or cerebral surgical shock therapy seem largely due to breaking up the intense fixation of attentive integration on fighting repressively against the conditioned emotivations involved in autoeroticism and homosexuality. Thereby the mind becomes able to resume interest in new everyday realities by producing a here-and-now, socially more carefree, happy-go-lucky, animal attitude. I think, however, that it is utterly unjustifiable to perform a surgical operation on the brain for this purpose without first sincerely attempting analytically to reeducate the patient on how to manage his sexual cravings without fighting against himself.

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