of the physiological dictum: *omne animal post coitum triste*. The time-intervals would tally: The man is improved by every course of treatment and every absence from home—that is, by every period of relief from intercourse. Of course he is, as he says, faithful to his wife. His use of a condom is evidence of weak potency; being something analogous to masturbation, it acts as a continuous causative factor of his melancholia.

21

Reichenau, 29. 8. 94.

My dear Fliess,

. . . On this Monday[1] I have collected only a few cases:

No. 3.

Dr. Z., physician. Age 34. Has suffered for many years from irritability of the eyes: phospheum [flashes], dazzle, scotomas, etc. These have increased enormously, to the point of preventing his working, during the last 4 months (since the time of his marriage). Background: masturbation since the age of 14, apparently continued up to the last few years. Marriage not consummated; greatly reduced potency; incidentally, divorce proceedings started.

Typical case of hypochondria relating to a particular organ in a masturbator at a period of sexual excitation. It is interesting to observe to what a superficial depth medical education penetrates.

No. 4.

Herr D. Nephew of Frau A. who died a hysteric. A highly neurotic family. Age 28. Has suffered for some weeks from lassitude, pressure on the head, shaky knees, reduced potency, premature ejaculation, the beginnings of perversion: very young girls attract him more than mature ones.

Alleges that his potency has been capricious from the first; admits masturbation but not for an unduly long time; has a long

[1] Obviously the day on which Freud went into Vienna for his consultation hour during the summer holiday.

period of abstinence behind him at present. Earlier, anxiety states in the evening.

Has he made a full confession? . . .

A monograph by Moebius has appeared, called *Neurologische Beiträge*.[1] It is a collection of previously published little essays, very well done; they are important on the subject of hysteria. His is the best mind among the neurologists; fortunately he is not on the track of sexuality.

Actually I realize I have nothing to say at the moment. When I get back to Vienna my editor[2] will certainly be after me for articles. Might I not offer him a critical article on M's "Migraine"?[3] You would have to let me have some of your observations. Will you not get your essay on the stomach-menstrual business[4] off your chest as soon as you feel better? That is the kind of thing the profession is waiting for.

Sigm.

Draft G

[Undated. ? 7. 1. 1895.[5]]

MELANCHOLIA

I

The facts before us seem to be as follows:

A. There are striking connections between melancholia and

[1] Moebius (1894).

[2] Dr. Paschkis, editor of the *Wiener Klinische Rundschau*. Freud was one of his regular contributors.

[3] The reference is presumably to a paper of Meynert's.

[4] This article, frequently mentioned in the correspondence, was submitted to the *Wiener Klinische Rundschau* by Freud on Fliess' behalf and appeared in 1895. See Introduction, p. 6.

[5] This draft, according to the postmark on the envelope that apparently belongs to it, seems to have been written on 7. 1. 1895, after a meeting with Fliess at Christmas. In it Freud follows the practice of the older German psychiatrists and uses the term "melancholia" to describe all states even of mild parathymia and depression. Freud naturally soon found this attempt to derive "melancholia" from a reaction to sexual excitation insufficient. He pointed out in "Further Remarks on the Neuro-Psychoses of Defence" (1896 b) that "'periodic melancholia' in particular appears to be reducible with unexpected frequency to obsessional affects and obsessional ideas" and hence could be explained by the nature of obsessional-neurotic conflict. A little later he recognized the whole attempt to have been

[sexual] anæsthesia. This is proved (1) by the discovery that so many melancholics have a long history of anæsthesia; (2) by the experience that everything that provokes anæsthesia also encourages the development of melancholia; and (3) by the existence of a type of woman, very demanding psychically, whose desire changes over very easily into melancholia, and who are anæsthetic.

B. Melancholia can arise as an intensification of neurasthenia as a result of masturbation.

mistaken. (See also Letter 102). All that survived clinical observation was what could later be translated into the language of the libido theory, especially the comparison between mourning and melancholia. It was used in Freud's conclusion to the "Discussion on Suicide" (1910 g) and in "Mourning and Melancholia" (1917 e), where he refers to Abraham's work on the subject. (Abraham, 1912).

The theoretic assumptions from which Freud proceeds in this draft are known from the first of his two papers on the anxiety neurosis (1895b), which appeared a little later but was written earlier. In this he states: "In the sexually mature male organism somatic sexual excitation is produced—probably continuously—and acts periodically as a psychical stimulus. In order to define this idea more clearly, let us interpolate that this somatic sexual excitation takes the form of pressure on the walls of the *vesiculae seminales* which are lined with nerve-endings; this visceral excitation will then actually develop continuously, but only when it reaches a certain height will it be sufficient to overcome the resistance in the paths of conduction to the cerebral cortex and express itself as a psychical stimulus. Thereupon,the group of sexual ideas present in the mind becomes charged with energy and a psychical state of libidinal tension comes into existence, bringing with it an impulse to relieve this tension. The necessary psychical relief can only be effected by what I shall describe as a *specific* or *appropriate action*. For the male sexual instinct this appropriate action consists in a complicated spinal reflex act leading to the relief of the tension at these nerve-endings and in all the preparatory psychical processes necessary to induce this reflex. Nothing but the appropriate action would be effective; for, once it has reached the required level, the somatic sexual excitation is continuously transmuted into psychical excitation; the action which will free the nerve endings from the burdensome pressure and so abolish the whole of the somatic excitation present, thus allowing the subcortical tracts to re-establish their resistance, must absolutely be carried into operation. . . . In women also we must postulate a somatic sexual excitation, and a condition in which this excitation becomes a psychical stimulus, evoking libido and the impulse to a specific action to which voluptuous pleasure is attached. Where women are concerned, however, we cannot state what is the process analogous to the relief of tension in the *vesiculae seminales*."

Draft G carries these considerations further and the schematic picture of sexuality (p. 104) illustrates them. The attempt to explain on a purely physiological basis the difference between the male and female sexual function is also carried a little further, presumably under the influence of Fliess, who may well, here as elsewhere, have pressed for a physiological explanation.

C. Melancholia appears in a typical combination with severe anxiety.

D. The typical and extreme case of melancholia appears to be the periodic or cyclical hereditary form.

II

Before we can do anything with this material we must have some fixed points of departure. These seem to be provided by the following considerations:

a. The affect corresponding to melancholia is mourning or grief—that is, longing for something that is lost. Thus in melancholia there is probably a question of a loss—a loss in the subject's instinctual life.

b. The nutritional neurosis parallel to melancholia is anorexia. The well-known *anorexia nervosa* of girls seems to me (on careful observation) to be a melancholia occurring where sexuality is undeveloped. The patient asserts that she has not eaten simply because she has no appetite and for no other reason. Loss of appetite—in sexual terms, loss of libido.

So it would not be far wrong to start from the idea that *melancholia consists in mourning over loss of libido.*

It now remains to be seen whether this formula explains the occurrence and peculiarities of cases of melancholia. I shall go on to discuss this on the basis of the schematic picture of sexuality. [Fig. 1].

III[1]

I will now discuss, on the basis of the schematic picture of sexuality which I have often used [see Fig 1] the conditions under which the excitation of the psychical sexual group[2] (Ps.S) becomes reduced in

[1] Several of the ideas in this section are developed far more clearly in the section of *Three Essays on the Theory of Sexuality* (1905 d) headed "The Problem of Sexual Excitation". Greater light was thrown on the ideas with which Freud is here concerned with the introduction of the concept of libido as the "psychical energy of the sexual instinct".

[2] [*I.e.*, the group of ideas with which the physical sexual tension enters into contact after reaching a certain magnitude, and which then work over the tension and deal with it psychically (see p. 91.) Here as elsewhere in these MSS. (see footnote on p. 355) Freud makes use of numerous abbreviations. These are not always uniform, and their expansion by the editor has not been easy. Thus in this passage Freud himself explains that "Ps. S." stands for "psychical sexual group"; but a few lines lower down he uses the initials "Ps. G." for what appears to be the same term.]

magnitude. There are two possible cases: (1) when the production of somatic sexual excitation (S.S.) diminishes or ceases, and (2) when the sexual tension is diverted from the psychical sexual group (Ps.S.).

Schematic Picture of Sexuality

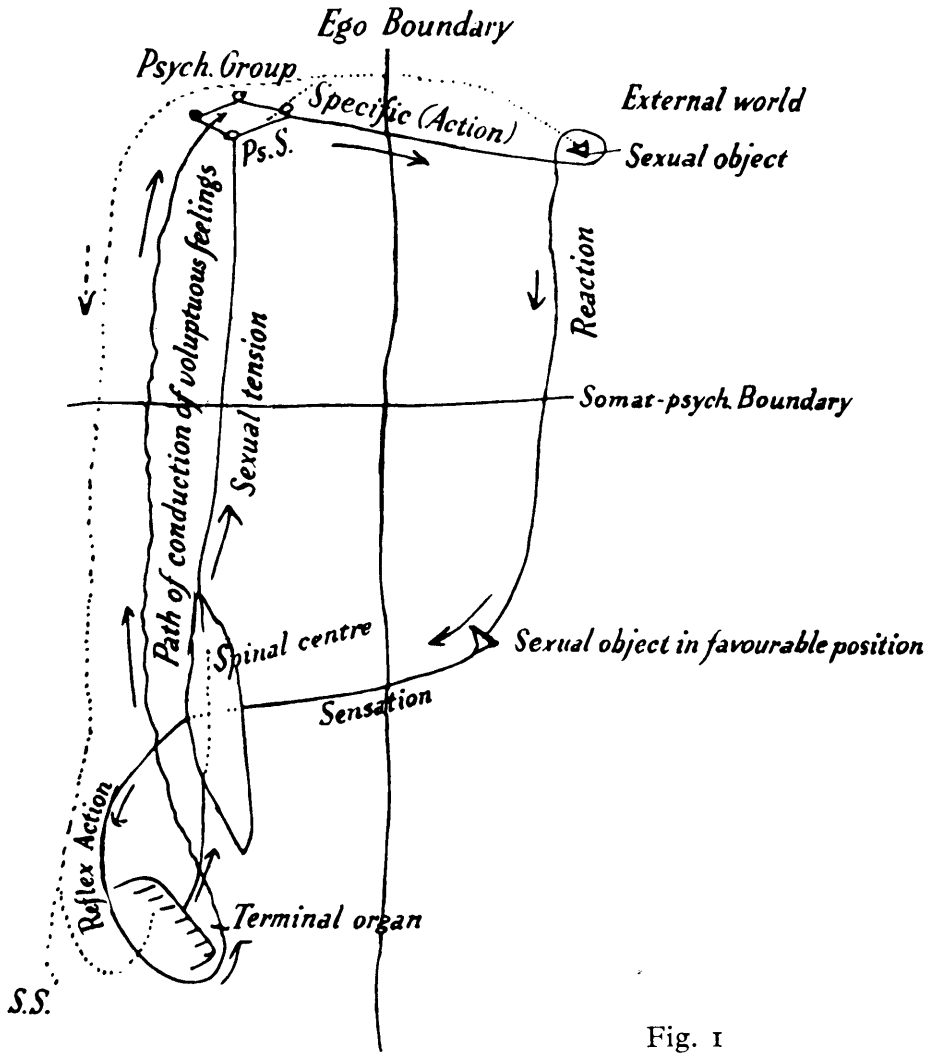

Fig. 1

[In the original all the arrows are in red, except the dotted one on the extreme left.]

The first case, in which the production of somatic sexual excitation (S.S.) ceases, probably characterizes common severe melancholia proper, which recurs periodically, or cyclical melancholia, in which periods of increase and cessation of production alternate. Now, our theory of excessive masturbation assumes that it leads to excessive discharge from the terminal organ (T.) and so produces a low level of stimulus in that terminal organ. We may therefore conclude that excessive masturbation goes on to affect the production of somatic sexual excitation (S.S.) and to bring about a lasting diminution of it, and that it consequently leads to a weakening of the psychical sexual group. Here we should have neurasthenic melancholia.

The second case, in which sexual tension is diverted from the psychical sexual group while the production of somatic sexual excitation (S.S.) remains undiminished, presupposes that the somatic sexual excitation (S.S.) is employed elsewhere—at the boundary [between the somatic and the psychical, see Fig. 1]. This however, is the determinant of anxiety; and this case accordingly coincides with that of anxious melancholia, a mixed form combining anxiety neurosis and melancholia.

In this discussion, then, I have accounted for the three forms of melancholia which have in fact to be distinguished.

IV

How does it come about that anæsthesia plays this part in melancholia?

According to the schematic picture, we have the following classes of anæsthesia.

Anæsthesia always consists in the omission of the voluptuous feelings (V) which ought to find their way into the psychical sexual group after the reflex action which discharges the terminal organ. The amount of voluptuous feeling corresponds to the quantity of discharge.

a. The terminal organ is insufficiently charged and in consequence the discharge when copulation takes place is slight and V very small. Here we have the case of frigidity.

b. The path from sensation to the reflex action is damaged, so that that action is not sufficiently strong. In that case the discharge

and the voluptuous feeling will also be slight. Here we have the case of masturbatory anæsthesia, anæsthesia with *coitus interruptus*, etc.

c. Everything at the lower levels is in order. But the voluptuous feeling is not admitted to the psychical sexual group owing to being linked in another direction (with disgust—defence). Here we have hysterical anæsthesia, which is entirely analogous to hysterical anorexia (disgust).

How far, now, does anaesthesia encourage melancholia?

In case (*a*), that of frigidity, the anæsthesia is not the *cause* of the melancholia but an indication of a predisposition to it. This tallies with Fact A (1) mentioned at the beginning of this paper [pp. 101-102]. In other cases the anæsthesia *is* the cause of the melancholia, since the psychical sexual group is strengthened by the introduction of voluptuous feelings and weakened by their omission. (There is a reference here to the general theory of the "binding" of excitation in the memory.[1]) Fact A (2) [pp. 101-102] is thus taken into account.

Accordingly, it is possible to be anæsthetic without being melancholic; for melancholia is related to the absence of somatic sexual excitation (S.S.), while anæsthesia is related to the absence of voluptuous feelings. Anæsthesia is, however, an indication of or preparation for melancholia; since the psychical sexual group is as much weakened by the absence of voluptuous feelings as by the absence of somatic sexual tension.

V

The question deserves to be raised of why anæsthesia is so predominantly a characteristic of *women*. This arises from the passive part played by women. An anæsthetic man will soon cease to undertake sexual intercourse, but women have no choice. They become anæsthetic more easily for two reasons:

(1) Their whole upbringing aims at not arousing somatic sexual excitation (S.S.) but at translating into psychical stimuli any excitations which might otherwise have that effect—at directing the dotted path from the sexual object (in Fig. 1) entirely into the psychical sexual group. This [is necessary] because, if there were a

[1] Some account of this will be found in the "Project" below (p. 425).

vigorous somatic sexual excitation (S.S.), the psychical sexual group would soon from time to time acquire such strength that (as happens in men) it would bring the sexual object into a favourable position by means of a specific reaction. But women are required to omit the arc of the specific reaction and instead to adopt permanent specific actions calculated to entice men to perform the specific action. Their sexual tension is consequently kept low and its access to the psychical sexual group is so far as possible cut off, while the indispensable strength of the psychical sexual group is supplied in another way. If, then, the psychical sexual group gets into a condition of desire, it easily becomes transformed into melancholia, supposing the terminal organ is at a low level.[1] The psychical sexual group is capable in itself of little resistance. Here we have the immature, juvenile type of libido, and the demanding, anæsthetic women mentioned above [Fact A (3), p. 102] merely carry this type into later life.

(2) Women very frequently approach the sexual act (or get married) without any love—that is, with only slight somatic sexual excitation (S.S.) and tension of the terminal organ. In that case they are frigid and remain so.

A low level of tension in the terminal organ seems to constitute the main disposition to melancholia. Where this is present, any neurosis easily takes on a melancholic stamp. Thus, whereas potent individuals easily acquire anxiety neuroses, impotent ones incline to melancholia.

VI

And now, how can the effects of melancholia be explained? They can best be thus described: *psychical inhibition accompanied by instinctual impoverishment, and pain that this should be so.*

We can imagine that, if the psychical sexual group suffers very great loss in the amount of its excitation, this may lead to a kind of *indrawing in the psyche*, which produces an effect of suction upon the adjoining amounts of excitation. [See Fig. 2]. The neurones associated (with the group) are obliged to give up their excitation, and this *produces pain*. The uncoupling of associations is always painful. There sets in an impoverishment of excitation—of

[1] That is to say, if the tension in the terminal organ is at a low level.

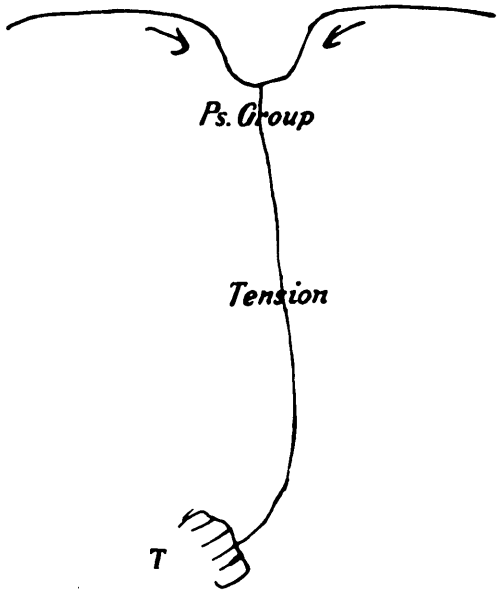

Fig. 2

reserve stock—in a way that resembles *internal bleeding*, and this shows itself in the other instincts and functions. This indrawing process has an inhibiting effect and operates like a wound, in a manner analogous o pan (*cit*f. the theory of physical pain).[1]

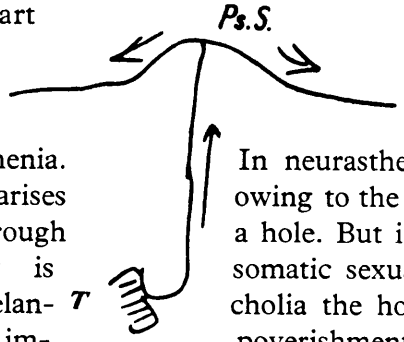

Fig. 3

The counterpart to this is afforded by mania, where an overflow of excitation is communi- cated to all the associated neurones. Here there is a similarity to neurasthenia. In neurasthenia a very similar impoverishment arises owing to the excitation running out, as it were, through a hole. But in that case what is pumped empty is somatic sexual excitation (S.S.) [Fig. 3]; in melan- cholia the hole is in the psyche. Neurasthenic im- poverishment can, however, extend to the psyche. And indeed the manifestations of these conditions are so similar that some cases can only be differentiated with difficulty.

[1] [This subject is touched on in the "Project" but was more fully described many years later in Chapter IV of *Beyond the Pleasure Principle* 1920 g).]

Draft H

(24. 1. 1895)

PARANOIA[1]

In psychiatry delusional ideas stand alongside obsessional ideas as purely intellectual disorders, and paranoia stands alongside obsessional insanity as an intellectual psychosis. If obsessions can be traced back to affective disturbances and their strength can be shown to be due to a conflict, the same view must be applicable to delusions, and they too must be the consequence of affective disturbances and their strength due to a psychological process. A contrary opinion to this is held by the psychiatrists, whereas laymen are in the habit of attributing madness to mental shocks; "a man who does not lose his reason over certain things can have none to lose".[2]

Now it is in fact the case that chronic paranoia in its classical form is *a pathological mode of defence*, like hysteria, obsessional neurosis and states of hallucinatory confusion. People become paranoic about things that they cannot tolerate—provided always that they have a particular psychical disposition.

In what does this disposition consist? In a tendency to something which exhibits the psychical characteristic of paranoia; and this we will consider in an example.

An unmarried woman, no longer very young (about 30), shared a home with her brother and [elder] sister. She belonged to the superior working-class; her brother was gradually working his way up into a small manufacturing business. Meanwhile they let off a room to an acquaintance, a much-travelled, rather mysterious man, very clever

[1] This paper was enclosed with a letter of 24. 1. 95 not reproduced here. Part of the material was subsequently used in "Further Remarks on the Neuro-Psychoses of Defence", (1896 b), the second section of which describes the analysis of a case of chronic paranoia which Freud classified in a footnote added in 1924 as dementia paranoides. The paper published in 1896 did not, however, go so far as the material published here. In particular, the detailed discussion of projection and its employment in normal and abnormal psychical processes is only to be found in Freud's later works. A complete, independent description of the mechanism of projection—a subject which is illuminated from many angles in the Schreber case history (1911 c) never appeared. The emphasis on the concept of defence in this paper and the comparison of the effectiveness as defensive mechanisms of the symptoms exhibited in different cases anticipates a good deal of what was to be stated thirty years later in *Inhibitions, Symptoms and Anxiety* (1926 d), when it was put on a new basis.

[2] A quotation from Lessing's play *Emilia Galotti* [IV, 7].