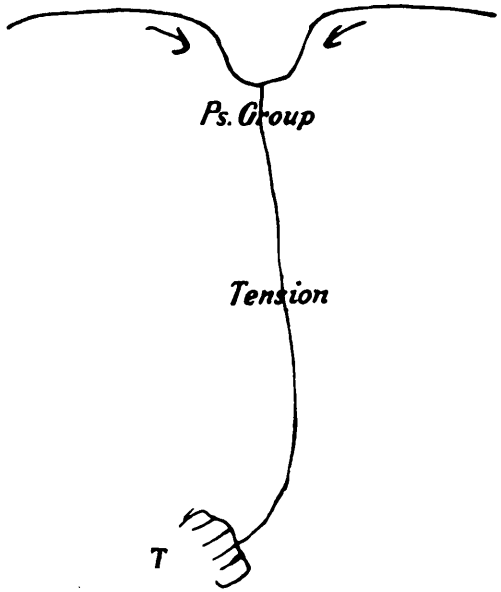

Fig. 2

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]

The counterpart to this is afforded by mania, where an overflow of excitation is communicated 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 melancholia the hole is in the psyche. Neurasthenic impoverishment 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.

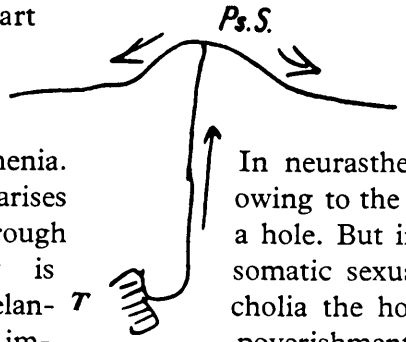

Fig. 3

[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].

and intelligent. He lived with them for a year and was on the most companionable and sociable terms with them. After this he went away, but returned after six months. This time he stopped only a comparatively short time and then disappeared for good and all. The sisters used often to lament his absence and could speak nothing but good of him. Nevertheless, the younger sister told the elder one of an occasion when he made an attempt at getting her into trouble. She had been doing out his room while he was still lying in bed. He had called her up to the bed, and, when she had unsuspectingly obeyed, put his penis in her hand. There had been no sequel to this scene, and soon afterwards the stranger had gone off.

In the course of the next few years the sister who had had this experience fell ill. She began to complain, and eventually developed unmistakable delusions of observation and persecution to the following effect. She thought the women neighbours were pitying her because she had been jilted and because she was still hoping for the man to come back; they were always making hints to her of this kind and kept on saying all kinds of things to her about the man, and so on. All this, she said, was of course untrue. Since then the patient has only fallen into this state for a few weeks at a time. Her insight then temporarily returns and she explains that it is all due to getting excited; though even in the intervals she suffers from a neurosis which can easily be interpreted as a sexual one. And she soon falls into a fresh bout of paranoia.

The elder sister was astonished to notice that whenever the conversation turned to the scene of seduction, the patient at once denied all knowledge of it. Breuer heard of the case and she was sent to me. I tried to correct the tendency to paranoia by trying to bring her memory back to the scene, but without success.[1] I talked to her twice and got her to tell me all about the lodger in a state of "concentration hypnosis". In reply to my searching enquiries as to whether nothing "embarrassing" had happened, I was met by the most decided negative and—I saw her no more. She sent me a message to say that it upset her too much. Defence! That was obvious. She *wished* not to be reminded of it and consequently deliberately repressed it.

[1] [The transitional technique, half way between hypnosis and free association, described in the last chapter of *Studies on Hysteria*.]

There could be no doubt whatever about the defence; but it might just as well have produced a hysterical symptom or an obsession. What was the peculiar nature of the paranoic defence?

She was sparing herself something; something was repressed. And we can guess what that was. She had probably in fact been excited by what she had seen and by recollecting it. So what she was sparing herself was the self-reproach of being "a bad woman". And the same reproach was what reached her ears from outside. Thus *the subject-matter remained unaffected;* what was changed was something in the *placing* of the whole thing. To start with it had been an internal reproach; now it was an imputation coming from outside. The judgment about her had been transposed outwards: people were saying what she would otherwise have said to herself. Something was gained by this. She would have had to accept the judgment from inside; but she could reject the one from outside. *In this way the judgment, the reproach, was kept away from her ego.*

The purpose of the paranoia, therefore, was to fend off an idea that was intolerable to her ego by projecting its subject-matter into the external world.

Two questions arise: (1) How is a transposition of this kind brought about? (2) Does all this apply equally to other cases of paranoia?

(1) The transposition is brought about very simply. It is a question of the abuse[1] of a psychical mechanism which is very commonly employed in normal life: the mechanism of transposition or projection. Whenever an internal change occurs, we can choose whether we shall attribute it to an internal or external cause. If something deters us from accepting an internal origin, we naturally seize upon an external one. In the second place, we are accustomed to our internal states being betrayed to other people (by the expression of emotion). This explains normal delusions of observation and normal projection. For they are normal so long as in the process we remain conscious of our own internal change. If we forget it, and if we are left only with the leg of the syllogism that leads outwards, then we have paranoia, with its exaggeration of what people know about us and of what people have done to us—what people know about us, what we have no

[1] [*Missbrauch* in the MS. The 1950 German edition reads, incorrectly, *Ausbruch* ("breaking out").]

knowledge of whatever, what we cannot admit. *This, then, is a misuse of the mechanism of projection for purposes of defence.*

Something quite analogous takes place with obsessions. The mechanism of *substitution*, once again, is a normal one. If an old maid keeps a dog or an old bachelor collects snuff-boxes, the former is finding a substitute for a companion in marriage and the latter for his need for—a multitude of conquests. Every collector is a substitute for Don Juan Tenorio—so too the mountain-climber, the sportsman, and so on. These things are erotic equivalents. Women are familiar with them as well. Gynæcological treatment falls into this category. There are two kinds of women patients: one kind who are as loyal to their physician as to their husband, and the other who change their physicians as though they were lovers. This normally operating mechanism of substitution is misused in obsessions—once again for purposes of defence.

(2) And now, does this view apply equally to other cases of paranoia? I should say to *all* of them. But I will take a roll-call.

The litigious paranoic cannot bear the idea that he has committed an injustice or that he ought to part with his property. Consequently he thinks that the judgment is not legally valid, that he is not in the wrong, etc. (The case is too clear and perhaps not quite unambiguous; maybe it could be explained more simply.)

The "*grande nation*" cannot face the idea that it can be defeated in war. *Ergo*, it was *not* defeated; the victory does not count. It provides an example of mass paranoia and invents the delusion of betrayal.[1]

The alcoholic will never admit to himself that he has become impotent through drink. However much alcohol he can tolerate, he cannot tolerate this knowledge. So the woman is responsible—and there follow delusions of jealousy, etc.

The hypochondriac will struggle for a long time before he has found the key to his feeling that he is seriously ill. He will not admit to himself that it arises from his sexual life; but it gives him the greatest satisfaction to believe that his sufferings are not endogenous (as Moebius says) but exogenous. So he is being poisoned.

The official who has been passed over for promotion needs to believe that persecutors are plotting against him and that he is being

[1] [The reference is, of course, to the Franco-Prussian War of 1870.]

spied upon in his room. Otherwise he would have to admit his own shipwreck.

But what develops here need not always be delusions of persecution. Megalomania may be even more successful in keeping the distressing idea away from his ego. Here, for instance, is a cook whose looks have faded and who should accustom herself to the thought that she has lost her chance of happiness in love. This is the right moment for the emergence of the gentleman across the way, who is clearly anxious to marry her and has given her to understand as much in a remarkably bashful but none the less unmistakable fashion.

In every case the delusional idea is clung to with the same energy with which some other intolerable, distressing idea is fended off from the ego. Thus these people love their delusion *as they love themselves*. Herein lies the secret.

Next, let us compare this form of defence and those we already know: (1) hysteria; (2) obsessions; (3) hallucinatory confusion; and (4) paranoia. We have to consider the affect, the content of the idea and the hallucinations. [See Fig. 4].

(1) *Hysteria*. The intolerable idea is not admitted into association with the ego. The content is retained in a segregated condition; it is absent from consciousness; its affect is displaced into something somatic by means of conversion. . . .

(2) *Obsessions*. Here again the intolerable idea is not allowed into association [with the ego]. The affect is retained; a substitute is found for the content.

(3) *Hallucinatory confusion*. The whole of the intolerable idea—both its affect and its content—are kept away from the ego. This is only possible at the price of a partial detachment from the external world. Recourse is had to hallucinations, which are friendly to the ego and give support to the defence.

(4) *Paranoia*. In direct opposition to (3), the content and the affect of the intolerable idea are retained; but they are projected into the external world.—The hallucinations which occur in some forms are hostile to the ego, but nevertheless support the defence.

In *hysterical psychoses*, on the contrary, it is precisely the ideas fended off that gain the mastery. The type of these is the attack and the *état secondaire*. The hallucinations are hostile to the ego.

SUMMARY

	Affect	Content of idea	Hallucinations	Outcome
Hysteria	got rid of by conversion —	absent from consciousness —	—	Unstable defence with satisfactory gain
Obsessions	retained +	absent from consciousness — substitute found	—	Permanent defence without gain
Hallucinatory Confusion	absent —	— absent	friendly to ego friendly to defence	Permanent defence brilliant gain
Paranoia	retained +	+ retained projected out	hostile to ego friendly to defence	Permanent defence without gain
Hysterical Psychoses	obtain mastery +	over consciousness +	hostile to ego hostile to defence	Failure of defence

Fig. 4

The *delusional idea* is either a copy of the fended-off idea or its contrary (*e.g.*, in megalomania). Paranoia and hallucinatory confusion are the two psychoses of obstinacy and defiance. The "reference to the self" in paranoia is analogous to the hallucinations in confusional states, which seek to assert the exact opposite of the fact that is being fended-off. Thus the reference to the self always tries to prove the correctness of the projection.

22

Vienna, 4. 3. 95.

My dear Wilhelm,

. . . There is nothing new on the scientific side. I am working hard on the paper on the therapy of hysteria.[1] Hence the delay. . . . I have nothing to send you this time. At best a little parallel to D.'s dream psychosis, which you and I went through. Rudi Kaufmann, Breuer's very intelligent nephew, and a doctor too, is a late riser. He has himself woken by a charwoman in the morning, but he is very reluctant to get out of bed. One morning, as he did not answer, she knocked a second time and called him by name, "Herr Rudi!" He thereupon had the hallucination of a chart-board on a hospital bed (*cf.* the "Rudolf Hospital"!) with the name "Rudolf Kaufmann" on it, and said to himself: "Well, Rudolf Kaufmann's at the hospital in any case, so there's no need for me to go," and went off to sleep again.[2] . . .

Perhaps the short paper on migraine will come into your hands. It contains only two leading ideas.[3] . . .

Best wishes from us all for a speedy recovery.

Your

Sigm.

[1] Published as the last chapter of *Studies on Hysteria* under the heading "On the psychotherapy of hysteria."
[2] Quoted in *The Interpretation of Dreams* (*trans.* 1953), p. 125.
[3] This apparently refers to the next draft.