In his short study, 'Cold, Disease and Death', Ernest Jones, linking up his own ideas with some trains of thought in my "Stages in the Development of the Sense of Reality", and related views of Trotter, Stärcke, Alexander and Rank, traces the tendency of so many people to feel or like illnesses in part to early infantile traumatic impressions, particularly to painful experiences which the child must undergo on removal from the warm maternal environment and which, according to the laws of the 'repetition compulsion', he must later always experience anew. The conclusions drawn by Jones were based chiefly on physiopathological, but partly also on analytic considerations. In the following brief communication I shall put forward a similar train of ideas, ranging, however, over a rather wider field.

Since the epoch-making work of Freud on the irreducible instinctual foundations of everything organic (in Beyond the Pleasure Principle) we have become accustomed to look upon all the phenomena of life, including those of mental life, as in the last resort a mixture of the forms of expression of the two fundamental instincts: the life and death instinct. On one single occasion Freud also mentioned the derivation of a pathological manifestation from the almost complete defusion of these two main instincts; he surmised that the symptoms of epilepsy express the frenzy of a tendency to self-destruction that is almost free from the inhibitions of the wish to live. Psycho-analytic investigations of my own have since in my opinion corroborated

1 German and English versions appeared simultaneously in Dr. E. Jones's 50th Birthday Numbers of the Int. J. of Ps. (1929), 15, 149 and of the Int. J. of Ps. (1929), 10, 125.
3 First Contributions to Psycho-Analysis, p. 161.

the plausibility of this interpretation. I know of cases in which epileptic attack followed upon painful experiences which made the patient feel that life was hardly any longer worth living. (Naturally I do not mean this as a pronouncement upon the nature of the attack.)

As physician in charge of a war hospital it was one of my duties to decide upon the fitness of many epileptics for service. After excluding the not infrequent cases of simulation and hysterical attacks, there remained a series of cases with typical epileptic manifestations, in which I was able to examine more closely the expressions of the death instinct. After the tonic rigidity and clonic spasms had run their course, there usually followed (with continuing deep coma and pupillary rigidity) complete relaxation of the musculature and an extremely laboured and inadequate stertorous breathing, evidently caused through relaxation of the muscles of the tongue and larynx. At this stage stopping up the respiratory passages which were still open was very often effective in cutting short the seizure. In other cases this attempt had to be broken off on account of threatening danger of asphyxiation. It was natural to conjecture behind this diversity in the depth of coma a difference in completeness of diffusion of the death-instinct. Unfortunately, however, external circumstances prevented any deep analytic working through of these cases.

I obtained a somewhat deeper insight into the genesis of unconscious self-destructive trends during analysis of nervous circulatory and respiratory disturbances, especially of bronchial asthma, but also of cases of complete loss of appetite and emaciation, not explicable anatomically. All these symptoms fitted on occasion perfectly into the total psychic trend of these patients, who had to struggle a great deal against suicidal tendencies. I also had to interpret the retrospective analysis in two of my cases of infantile glottal spasms as attempts at suicide by self-strangulation. Now in the analysis of these latter cases I came to form the surmise which I wish to communicate here, in the hope that a wider circle of observers (I am thinking particularly of pediatricians) will bring forward further material in its support. Both patients came into the world as unwelcome
guests of the family, so to speak. One was the tenth child of a mother who was manifestly much overburdened, the other the offspring of a father who was mortally ill and in fact died soon after. All the indications show that these children had observed the conscious and unconscious signs of aversion or impatience on the part of the mother, and that their desire to live had been weakened by these. In later life relatively slight occasions were then sufficient motivation for a desire to die, even if this was resisted by a strong effort of will. Moral and philosophic pessimism, scepticism, and mistrust became conspicuous character traits in these patients. One could also note ill-disguised longing for (passive) tenderness, repugnance for work, incapacity for prolonged effort, and thus a certain degree of emotional infantilism, naturally not without attempts at over-compensation, resulting in a rigid character. A case of alcoholism in a still youthful woman revealed itself as a particularly severe case of aversion to life, existing from infancy. She naturally reacted to difficulties in the analytic situation on several occasions with suicidal impulses, mastered only with effort. She can remember, and members of her family also confirm, that as the third girl in a family without boys she was very ungraciously received. She naturally felt herself innocent, and by precocious brooding she sought to explain the hatred and impatience of her mother. She kept for life a leaning towards cosmological speculation, with a strain of pessimism. Her broodings about the origin of all living things were only, as it were, the continuance of the question which had remained unanswered, why she had been brought into the world at all if those who did so were not willing to receive her with love. As in other cases, so in this, the Oedipus conflict naturally proved an ordeal to which the patient was not equal, any more than she was to the difficulties of adaptation to married life, which happened in her case to be unusually great. She remained 'rigid', just as all the 'unwelcome children' of the male sex observed by me suffer from more or less severe disturbances of potency. The tendency to colds postulated by Jones in similar cases was often present; in one special case there was even a quite peculiar, intense cooling down at night, with subnormal temperatures, difficult to explain organically.

It cannot of course be my task to go at all exhaustively into the symptomatology of this nosogenic type, here presented only in its etiological aspect; for this purpose, as already indicated, the experience of one person would not suffice. I only wish to point to the probability that children who are received in a harsh and unloving way die easily and willingly. Either they use one of the many proffered organic possibilities for a quick exit, or if they escape this fate, they retain a streak of pessimism and aversion to life.

This etiological assumption is based upon a theoretical view differing from the accepted one as to the operation of the life and death instincts at various ages. On account of the dazzling effect of the impressive unfolding of growth at the beginning of life, the view has tended to be that in infants only just brought into the world the life instincts were greatly preponderant. In general, there has been a disposition to represent the life and death instincts as a simple complementary series in which the life maximum was placed at the beginning of life, and the zero point at the most advanced age. This does not appear, however, to be quite accurate. It is true that the organs and other functions develop at the beginning of life within and without the uterus with astonishing profusion and speed—but only under the particularly favourable conditions of germinal and infantile protection provided by the environment. The child has to be induced, by means of an immense expenditure of love, tenderness, and care, to forgive his parents for having brought him into the world without any intention on his part; otherwise the destructive instincts begin to stir immediately. And this is not really surprising, since the infant is still much closer to individual non-being, and not divided from it by so much bitter experience as the adult. Slipping back into this non-being might therefore come much more easily to children. The 'life-force' which rears itself against the difficulties of life has not therefore any great innate strength; and it becomes established only when tactful treatment and upbringing gradually give rise to progressive immunization against physical and psychical injuries. Corresponding to the drop in the curve of mortality and disease in middle age, the life-instinct would only counterbalance the destructive tendencies at the age of maturity.
If we were to assign to cases with this etiology their place among the nosogenic types of neurosis which Freud formulated so early and yet so exhaustively, we must locate them somewhere about the point of transition from the purely endogenous to the exogenous, i.e. among the ‘frustration’ neuroses. Those who develop so precociously an aversion to life give the impression of a defective capacity for adaptation similar to those who, in Freud’s grouping, suffer from an inherited weakness in their capacity for life, but with the difference that in all our cases the innateness of the sickly tendency is deceptive and not genuine, owing to the early incidence of the trauma. There remains of course the task of ascertaining the finer differences in neurotic symptoms between children maltreated from the start and those who are at first received with enthusiasm, indeed with passionate love, but then ‘dropped’.

Now there naturally arises the question whether I have anything to say as to a special therapy for this nosogenic group. In accordance with my attempts, published elsewhere, at a certain ‘elasticity’ of analytic technique,¹ I found myself gradually compelled, in these cases of diminished desire for life, to relax my demands for active efforts on the part of these patients more and more as the treatment went on. Finally a situation became apparent which could only be described as one in which the patient had to be allowed for a time to have his way like a child, not unlike the ‘pre-treatment’ which Anna Freud considers necessary in the case of real children.

Through this indulgence the patient is permitted, properly speaking for the first time, to enjoy the irresponsibility of childhood, which is equivalent to the introduction of positive life impulses and motives for his subsequent existence. Only later can one proceed cautiously to those demands for privation which characterize our analyses generally. However, such an analysis must, of course, end like every other, with the clearing up of resistances which have inevitably been aroused, and with adaptation to a reality full of frustrations, but supplemented, one hopes, by the ability to enjoy good fortune where it is really granted.