Lipot Szondi

Ego Analysis*:

XII. The Ego and Delusion:

The Delusion Formation Function of the Ego

Translated by

Arthur C. Johnston, PhD

[*Ich-Analyse
(In German)

By Verlag Hans Huber, Bern]

Table of Contents:

Third Part

THE INTEGRATION OF THIS LIFE AND THE WORLD BEYOND

Beyond Reality
The Ego and Delusion, Dream and Belief

Chapter XXIV. *The Ego as Bridge Builder between this Life and the World Beyond*

1. The Concept of Reality 366
2. Reality in the Light of Pure Transcendental Phenomenology 370

Chapter XXV. *The Ego and Delusion. The Delusion Formation Function of the Ego*

I. Delusion and the Participation Drive..... 375
II. Thoughts on the Nature and Forms of Delusion..... 379
III. The Forms of the Delusion Formations..... 386
Elementary Delusion Forms..... 388
I. The Projection Delusion..... 398
II. The Inflation Delusion..... 412
III. The Introjection Delusion…….. 417
IV. The Negation and Destruction Delusion..... 421
Other Psychiatric Results of Experimental Ego Analysis..... 428
I. The Role of Integration and Disintegration of the Ego in Delusion Formations..... 428
II. Stupor and Ego Function..... 431
III. Confusion and Ego Function 431
IV. Quarreling Delusion and Ego Function 432
V. Erotomania and Ego Function 432
VI. Hallucinations and Ego Functions..... 433
Summary:
The Participation Theory of Delusion Formations……. 438
The Participative-Projective World..... 450
The "*p*" Dimension..... 450

THIRD PART

THE INTEGRATION OF THIS LIFE AND THE WORLD BEYOND

BEYOND REALITY
THE EGO AND DELUSION, DREAM, AND BELIEF

Chapter XXIV

THE EGO AS BRIDGE BUILDER BETWEEN THIS LIFE AND THE WORLD BEYOND

There is now an opposition that the ego is able to bridge with difficulty. This is the transcendence from this life to the other world, thus transcending from the present into the future and out of life into death. A human is rooted in the past, lives in the present and always prepares for the future. He or she is thus also a *conscious-of-the-future being.* Therein consists his or her peculiarity among all beings. This eternal preparing oneself for the future is called striking a bridge between this life and the world beyond. The bypass of the two existence forms is the *futuristic function* of the ego. The ego as the *pontifex oppositorum* [bridge between opposites] thus also that court that always is traveling between this life and the other world. The ego abandoned the literal world and climbs into the world of otherworldliness. The healthy ego is never only in this life. Continually it makes a step in the direction toward the other world. Exactly the same as the conscious and the unconscious are two landscapes of the soul, which *both* depend on the ego, we must state: *This life and the other world depends on the ego.* Thus life and the other world reality are for the ego a complementary opposition, which it is able to rise above. The ego moves itself always between these two opposite poles of being and must bridge the contrast between this worldliness and other worldliness by its *completing* at the same time present and future activity. The simultaneous being in the present and beyond reality is a special attribute of the human being that is made possible *only by the transcending ego*. Without the ego there is for being neither a conscious present nor still another conscious other world.

The *present* is for the individual the earthly natural reality in space and time. Space and time are placed in consciousness by the "present" ego.

The displacement of the spatiality and temporality in a world is called the *future* and the *other world* of reality, which is no longer terrestrial and not on this side. It is the mental reality of the other world. Therefore an ego analysis would be incomplete if it would ignore this future function of the ego.

In the last part of this book we must explain thus first of all the problem of reality and scan secondly the ways in which the ego is able to touch the

otherworldliness of mental reality: *delusion, dream and belief.*

1. The Concept of Reality

Our knowledge about reality is very unsatisfactory. Even more so is the philosophical, epistemological, and metaphysical literature. The path, which we have to go, would be certainly a mistake if we started here to describe all that was written about the concept formation, essence, origin and criteria of reality, historically or also only critically wanted to impart. We look for the relationship between the ego and reality. Because on that basis we asked the question: *Why do humans move crazily beyond the boundaries of reality?* Our objective is to examine only that knowledge about reality that allows us to analyze the relationship of the ego to reality. This objective forces us to limit to the minimum the representation of the concept formation of reality as also the relationship of the teachings on reality to the psychology of consciousness. Our actual work begins first with the question: What has the unconscious and the ego to do with the buildup and dismantling of reality?

The word "*reality"* [*Wirklichkeit*] means "the epitome of what has or has not become effective, come into being [*Dasein*], come into existence and as being efficacious or an effect that is palpable or visible." [1]

Its twin word *"reality"* [*Realität*] is called: thingness, thus "the presence in the outside world or in the mind and in the idea." [2] One therefore differentiates between an *objective, empirical* reality and a *subjective ideal* reality. The word "reality" [*Wirklichkeit*] comes linguistically from "effect" [*wirken = to act*], the other one, "reality" [*Realität*], however, from "*res,*" from "*thing*"[*Ding*]. The first expresses therefore somewhat dynamic, the second somewhat static.

Medical psychology and psychiatry of the past decades *left* the basic question of our knowledge about reality completely to the philosophers. Both disciplines went around the question about essences, origin, characteristics, criteria and transformations of "reality [*Wirklichen*]" simply in such a way that they with Janet only spoke of a "*fonction du réel*" and of a "sense of reality" [*Wirklichkeitssinn*].

With this medical view all the knowledge becomes about reality [*Wirkliche*], which originates from philosophical, epistemological, and metaphysical sources and neglects the tendency favoured by psychologists of the "natural attitude of the philosophically naïve."

Under this medical-psychology aspect of the sense of reality [*Wirklichkeitssinnes*] the word "reality" [*Wirklichkeit*] does not only mean nature, the outside world, that is all what as thing [*Ding*] and object that the ego actually [*wirklich*] faces. "That means in a still higher degree" -- writes Kronfeld -- "everything that affects [*wirkt*] the ego and compels it to attitudes, reactions, and adaptations, beyond all determinants, from out of which comes those forces derived from the ego and its body restrictions." … "It is a direct, primary fact that the ego and reality enter into opposition to each other." [3]

What does the term "sense of reality" [*Wirklichkeitssinn*] mean for the psychologist?

The word *"sense"* means originally "way" and for Latin the word *ratio* [*reason*] then only later was substituted for "sensus." Into this meaning of the word "sense" means at first the organs with whose assistance humans and animal can receive stimuli, thus organs by which feelings are released and then the "organs" of the knowledge, thus the susceptibility for mental works and ethical values. In addition, "sense" is as much as "significance" and "purpose," for example the sense of a word, a work, an action. Sense of reality [*Wirklichkeitssinn*] should therefore in the medical psychology be evaluated in the sense in which the psychic organ, with whose assistance we can feel, recognize, and evaluate very specifically "reality." In its function the sense of reality does not mean a unit function, but "a particular total attitude that the ego takes with all its functions toward reality." (Kronfeld). Thus from the affirmation and acknowledgment respectively the denial of reality, we can conclude on the capability of the sense of reality and furthermore on the biological, vital adaptation and respectively on the "natural psychic tension" of the person (*tension psychique,* Janet).

The sense of reality points to a substantial constitutional variation possibility from person to person, and this circumstance served as basis for several typologies (Kretschmer, Jung).

With Freud the sense of reality seems as a metapsychology principle, as the so-called *"reality principle"* in opposition to the pleasure principle that prevails in the realm of the drives. In the metapsychology of Freud the discharge of the mental processes is adjusted automatically by the pleasure principle. If there is an inhibition of instinctual discharge and that results in an unpleasurable tension in the soul, then the pleasure principle strives to decrease this tension either by production of pleasures by means of the drive satisfaction or by reduction of the displeasure. One of the most important sources of the displeasure represents precisely the reality principle, which replaces the pleasure principle of the infant in the course of its development under the effect of the instincts of self-preservation

of the ego in the soul (Freud).

The reality principle forces the person to limit the drive life and the Id in favor of the outside world. Due to this drive restriction with individuals can appear ego changes and reaction formations, with other escape, avoidance, and closing oneself off from reality, even renovation and new formations of reality. Thus neuroses and psychoses occur according to Freud. A lack of the sense of reality and respectively an easing of the psychic tension with neuroses, psychopathy, and psychoses thus has the result of a regression of the mental life to earlier developmental stages.

The definition of reality in medicine took naturally this biological direction. Under this aspect a "sense" or a leading principle was thus accepted for the detection, recognition, and valuation of the outside world, and the relationship of the ego to reality was investigated with the help of this supporting "sense," respectively "principle."

Jung stresses the soul against the monarchy of reality [*Wirklichkeit*]. In place of nature reality he stresses "mental reality." "Everything that we can know" -- according to Jung -- "consists of psychic material. Psyche is the most real essence because it is the only thing directly immediate. This reality can be called psychology, namely the reality of the psyche." [4] Direct experience of reality can be only psychological. Therefore spirit and magic effects [*Wirkung*] are material events for primitive humans. All our sensory perceptions, which force upon us the things of the outside world, are psychic pictures. Our consciousness contains simply these "mental pictures" of the external objects. The soul -- Jung states -- falsified even the external reality in the extent that we need artificial aids in order to determine what the things outside of us are. Therefore Jung believes that the idea of mental reality represents the most substantial achievement of modern psychology. Jung adds however somewhat melancholic: "If it (the mental reality) as such would be recognized?" [5]

So much or respectively so little about the concept formation of reality in medicine.

*

Philosophy, as is well known, separates an objective, empirical reality [*Realität*] from a subjective or ideal reality [*Wirklichkeit*].

The empirical reality [*Realität*], i.e. the *external reality* [*Außenwirklichkeit*], is the epitome of what humans recognize as being objective on the basis of outside and internal perception. The perceived something is critically examined on its

subjective and objective side, from the perceptions are then drawn conclusions and recognizing or questioning the objective being of this something. "What is related with the material conditions of experience (sensations) is reality," states Kant.

The only character of reality [*Wirklichkeit*] is according to Kant is perception.

The ideal, subjective *interior reality* is the epitome of what influences work directly and is experienced without reference to our sensory perception. Reality [*Wirklichkeit*] is called in Fichte's idealism as much as perceptibility and emotionalism.

Under the aspect of metaphysic reality [*Wirklichkeit*] is the epitome of true being and essence. Reality [*Wirklichkeit*] should therefore embody the contrast to the insignificant, to the only-empirical, to the appearing, and to the accidental. In the metaphysical-ontological meaning "reality" [*Wirklichkeit*] therefore means: Necessity that contrasts to the not-real and/or still not real. [6] It may be noted in that way the possibility of a preliminary stage of reality.

In his reality teachings H. Driesch defines the concept of the reality as follows:

> The simple word *wirklich* stands for us… for what in Latin *absolutum* indicates: The real has indeed 'detached,' namely is detached from the ego-centered being; it should be considered certainly detached from the self-centeredness not only as if it would be detached from it; it has the sign, the 'sound' of the real [*wirklich*]. [7]

Driesch differentiates between a doctrine of a direct, earthly reality from a higher non-earthly reality [*Wirklichkeit*]. Thus: a reality doctrine of the world and a doctrine of a reality that is not of the world.

The teachings on nature and the teachings on the soul in the form of experiences give us signs of the world as reality. According to Driesch there is however a second and higher level of metaphysics, in which no more is asked for the relationship of the contents of experience to a world or a reality, but first *"according to the conditional nature of this world to another."* This question ties now directly to the fact of death. Driesch asks: Does the world of reality [*Realität*] with its contrast of the ego and the world and of subject and object still make sense after death? How can it still yield after death a something and an ego?

Is this world alone the reality [*Wirklichkeit*]? Or is there another reality

[*Wirklichkeit*] ‘beside’, ‘before’, and ‘behind’ it where the words should mean completely indefinite forms of relationship to another being? [8]

Here we must remain for a moment and deliberate. The word reality [*Wirklichkeit*] means once somewhat materially limited and a material object. Is reality [*Wirklichkeit*] that which is connected to the *material* conditions of the experience said Kant.

Other times -- for example with Driesch -- the same word *wirklich* means the same as the *Absolutum* [*absolute*].

Thus both material-limited as well as from matter and from the ego, which is detached from the absolute, the unrestricted, and the highest but in religion and theology is called God, is meant the “real” [*wirklich*].

Where are the boundaries of the reality [*Wirklichkeit*] therefore? Can one speak in general still of “beyond” reality? Precisely is the acceptance that there can be something beyond reality, the not “unreal?”

From the plethora of concept formations in philosophy and metaphysic we have noted the reality teachings of H. Driesch. As we will see later, the insights of “another being” world of reality that is developed beside, behind or before the outside world precisely stand in a narrow relationship to the displacement of the boundaries of reality with the mentally ill.

2. Reality in the Light of Pure Transcendental Phenomenology

The real [*Wirklich*] is what is connected with the *material* conditions of experience stated Kant. In the experiences of the will and not in thinking arises the reality of the object say Dilthey. Drive, pressure and resistance give the solidarity to the object in reality. Both the ego and the object lie within consciousness (Dilthey).

Only the acceptance and the attention of other humans from moral obligation and ethical conscience and only the restriction of the personal freedom can lead according to Fichte to the acceptance of reality. Only if humans adopt the existence [*Dasein*] of others by social and altruistic feelings can the reality of the outside world be developed correctly (Riehl). Thus these philosophers think on the one hand about reality. The other group thinks however differently. The real is that which already detached itself from the ego; the unlimited, the absolute, is real believed Driesch. There is however in philosophy still another kind of thinking about reality that perhaps is still more suitable than Driesch’s: the peculiarity of the

lunatic mode of thought to "rehabilitate" or to throw light on the nature of this relationship with reality. This is Edmund Husserl's teachings: The "pure phenomenology and phenomenological philosophy." What we learn from these teachings of philosophy in relation of the ego to reality serve here only a goal and the act by which the crazy person moves the boundaries of reality. We stress here that by this comparison no criticism is given of the great services of philosophy, which we admire and highly esteem; we seek a simple way of thinking with whose help can be made understandable to us the strange relationship of the lunatic to reality. We hear now Husserl:

> Reality [*Wirklichkeit*], the word already says, finds the ego as an awake ego in never ending coherent experience as existing [*daseiende*] and accepting it as it is given to me also as existence [*daseiende*]. All doubting and distortion of conditions of the natural world do not change anything in the *general thesis* of the natural attitude. 'The' world as reality is always there, as I suppose, this or that is from here or there different from under the titles 'delusion' and 'hallucination' and so on and in terms of the general thesis: is always the existing [*daseiende*] world. [9]

Rather than remaining now in this attitude, Husserl tried to change it radically. He did this with from Descartes, who delivered the so-called "doubt test," which Husserl used however *only as a methodical* expedient. Husserl states: "Everything and everyone that we are still so firmly persuaded about and no matter how adequate ensured be the evidence, we can try to doubt it." [10] This belongs in the realm of complete freedom of thinking. With this doubt test Husserl approaches it quite oddly. He does not doubt a "being" or an "essence" of the world, but he tries to set it also as such "out of action," "to turn off" this being, and "to put" it in parentheses. Just as in this thinking of the doubt test is "like the putting in brackets with the bracket and like a switching off is further always there outside of the connection of the circuit." Only Husserl as has already been mentioned makes no use of this doubt test of the natural general thesis of being and essence.

He says: "In the doubt test, which follows "the switching off" of a thesis…, executes "the switching off" in a modification of the antithesis, namely with the 'heading' of not being that forms thus the position of the doubt test." The exclusion is thus a particular modification of negation. While however Descartes in his doubt test implements the negation universally and perfectly, Husserl is content that the thesis of being and essence becomes placed only "outside of action" and is only "bracketed." The natural thesis: "That is!" or "It behaves in such a way" does not become therefore denied in Husserl's doubt test but is transformed into the modification of a "bracketed thesis" and "bracketed judgment." He calls this

manner of the doubt test *"ἐποχή."* The word means as much as a "stopping, retaining, restraining." For the skeptics, the word was used as the holding back of the determination or the definitive affirmation and negation. Husserl comprehends the word in the sense of this thinking act of *"ἐποχή"* as follows:

> We put the essence of the natural attitude belonging to the general thesis outside of action -- everything and anything that are encompassed in ontological terms -- and we set it in one stroke in brackets: Thus to put in brackets this entire natural world, which is constantly for us there, present and will always stay there as conscious reality [*Wirklichkeit*] even when also favored by us it will remain bracketed.
>
> If I do this in such a way in my full freedom, then I do not *negate* this 'world,' *nor doubt its existence* as if I were a skeptic; but I practice a 'phenomenological' *ἐποχή* [this process of bracketing] in the actual sense, that is: there is a resistance in me to take as being the predetermined world, as I do constantly in my entire natural-practical life, more directly but even so as I do in the positive sciences: As one in an existing world and in last analysis not as a universal fundamental being for a recognition of progressing in experience and thinking. No experience of the real [*Realem*] do I henceforth carry about naively. [11]

With this particular modification of the negation or of the doubt test by "putting in brackets" or "switching off" of the natural ground of being Husserl closes "ipso facto the execution of each judgment and every predictive attitude to being and experience and all the being modalities of spatial-temporal existence of the real [*Realen*].

By this manner of thinking he wants to eliminate all sciences related to this natural world and absolutely to make no use of its validations; literally he states:

> Not one of them (in the sciences) and with its associated propositions and complete evidence do I make my own; none are accepted by me, and none give me a foundation -- mind you as long as it is understood that as it is in these sciences it gives one truth about the realities of this world. I may only assume that after I have given it the bracketing as a consequence that I have already submitted any natural experience subjected it to the modification of putting in brackets each natural experience, on which as existence

> [*Dasein*] demonstrates is rejected by all scientific explanation in the long run. That means: Only in the consciousness of the modifying judgment bracketing not just like the proposition in science, a proposition whose validity of the claim and its validity that I recognize and use. [12]

Through the act of the phenomenological *"ἐπογή"* [the process of bracketing] Husserl tries now to limit the universal sphere of the experiencing being and the possible judgments, and after elimination of the universal basis of natural experience, he wants to open "the absolute being region," the region of the "absolute or transcendental subjectivity." This region of the absolute or transcendental subjectivity is to bear in itself according to Husserl "in a special and in a peculiar way the real universe and respectively all possible real worlds and all worlds of each extended meaning," namely "in itself through real and possible intentional constitution." [13] According to the "pure" phenomenology Husserl thus loses the "immanent being sphere" by the execution of the phenomenological "setting ouf of play of its validity of the objective world," the sense of a reality as "humans" respectively "animal," and also the meaning of human consciousness life. It however did not peter out but is preserved through putting in brackets the sense of an absolute being sphere, which is "in itself what it is, without question about its being or not being the world and its humans with preservation of the attitude in this regard…." "Thus remains the pure sphere of consciousness with that inseparable from it (including "the pure ego") as *'phenomenological residuum'* as a principle particular existence region, which can become as the field of a consciousness science of an accordingly new -- new in principle – meaning: the phenomenology." [14] This "pure" consciousness Husserl calls "transcendental consciousness," the thinking operation, which leads to this, the "transcendental "*ἐπογή,*" "shutting out" and "putting in brackets" and thus steps of the *"phenomenological reductions."* Husserl calls his particular theory: "transcendental phenomenology."

*

We will summarize the thought steps of the phenomenological reductions, respectively *ἐπογή,* in this manner:

1. The person -- as ego -- has the freedom to doubt "everything and everyone -- even as we were so firmly convinced -- yes even when insured of its adequate evidence."

2. One may switch off thus the *real basis* of the natural experience of being and existence, put it in brackets, and instead open an *absolute being region,* an

absolute, transcendental subjectivity region.

3. One has the freedom, “natural” consciousness, the “natural, awake ego” to not use and instead of this to set up a “pure, transcendental” consciousness, a “pure transcendental” ego.

4. One may not simply switch off all sciences, which refer to the natural world, and make no use of its validations. The truths, which these sciences give about the reality to the world, remain in the brackets further truths; however, they must be put out of use. All these acts of thinking do not mean the absolute negation of these natural truths about the reality of the world, but only the addition of the use of reduction of the being validation of the objective world.

*

It is surely not exaggerated when the psychiatrist asks the question: How is it nevertheless possible after this elimination of the natural truths of the world mentally to remain further healthy? In other words: Where does the healthy freedom of the philosophical thinking operations end and where does illness begin in the delusion thinking of the lunatic? This question leads us into the first area of the otherworldliness, into the world of the delusion formations.

Chapter XXV
THE EGO AND DELUSION
THE DELUSION FORMATION FUNCTION OF THE EGO

I. Delusion and the Participation Drive

In the first book of the fate analysis [*Schicksalsanalyse*] we have reported on a music teacher, who was a paranoid-homosexual enthusiast and exhibited in her diseased thinking of traits over 32 years that agree remarkable with the thinking of the pure, transcendental phenomenology. She once attended a theosophical lecture, whereby -- and as she said -- "The psychological mysteries that catholicism could not solve for her suddenly found their explanation." Under the effect of a theosophy professor were created "new" objects for her enthusiasm: Thus the "absolute universe," the "absolute sea," the "holy woman," the "metaphysical silence," the "metaphysical peace," etc. She loved and cultivated the transitional state between wakefulness and sleep, so she personalized this state and worshipped it as the "holy woman." This "holy woman" lived with her mother in a small wooden house. She was cradled by this holy woman when sleeping, "heard her voice in the evening" that was somber, infinitely gentle, and soothing. For a while she loved this "holy woman" as absolute "silence" and "loneliness," as if she were a living being. But this absolute ideal woman was likewise rejected in the end as were the concrete, physical mother and all other real women whom she had on this side of the ever beloved natural reality. When this "holy silence" one evening did not come to her, she turned full revenge against it. She decided to abandon the city and go into a distant forest, where she is not deterred from her "sleep."

*

We have added -- already in 1944 -- the following: The case of this paranoid-schizophrenic girl shows that the schizophrenic deprives the "physical" object of her desires to strip from the physicality the "skin limitation" as it were and to expand the boundaries of the object into the cosmic and the absolute. Thus she can convert a real, concrete object into an abstract "cosmic silence" and into a "metaphysical peace." In this way the original concrete, physical object of her desires becomes an abstract, metaphysical, absolute or any occult idea that must

be regarded as delusional. [15]

We can divide and understand however the mental process that made an abstract "holy woman" from the concrete mother, from the concrete silence of the forest in the evening into an "abstract silence" and a "metaphysical peace" with the thinking tools of the pure, transcendental phenomenology.

This paranoid-schizophrenic girl was in fact in love with the concrete mother, in her body. She does not let this physical object of reality come into play however; she simply switched off the physical mother as concrete nature reality, put her in brackets -- to speak in Husserl's terms -- made no more use of her, and after elimination of the natural experience of the mother, she opened the *absolute* being region to a "holy woman," who as the absolute "silence" and the "metaphysical peace," visited her and cradled her to sleep.

As in transcendental phenomenology, this paranoid schizophrenic also never negated the reality of her mother but had only set her out of use, and in place of the "natural" mother had put her "in brackets," and had placed "an absolute mother" and "the holy woman" in her transcendental consciousness. The thinking process is the same with her as with the philosophers.

We do not stand alone with this interpretation of the delusion process. In Freud we can read the following proposition:

> If we think in the abstract, are we in danger of neglecting the relations of the words with the unconscious special ideas and it cannot be denied that our philosophizing then attains an unwanted similarity in expression and contents with the mode of operation of the schizophrenics. On the other hand one can try the characteristic way of thinking of the schizophrenics who treat concrete things as if they were abstract. [16]

The mentioned ill girl made use of the same freedom as transcendental phenomenology. She set the natural general thesis "That is mother" or "Mother is like that" outside of action and made no use of her, and in place of the concrete mother she set up a transcendental "absolute idea of the mother," that of the "holy woman," the "absolute silence," and the "metaphysical peace."

If one does give however the freedom to the philosophers of this "way of thinking on the switching off and bracketing" of nature reality, why would they then deny this freedom to the insane?

One can find the decisive difference in the way of thinking of the

philosopher and the delusional patient as follows:

1. The delusional patient thinks with *falsified* conceptions, with a pathologically transformed reality and consciousness that is not accessible to a correction of his or her distorted ideas by arguments. The conceptions of the philosopher are however not falsified; they should at least not be falsified judgments. If they are this nevertheless, then its philosophy is simply a "false" philosophy, whose falsity can be corrected with arguments.

2. Delusion is a special case of spiritual being, which is without "elimination" certainly impossible. But: *Only the making absolute by bracketing,* i. e., the *complete loss of the bracketed is called delusional.* Only then the spiritual to reality stands no longer positively enhancing but a negating, substituting relationship. The philosopher however knows the methodical nature of putting in brackets; with him the putting in brackets never loses the natural being or existence. He *consciously* is aware of this method because he makes no use of the bracketing in his thinking.

Thus a complete loss of the bracketed is out of the question for him.

3. Freud states: "Psychosis is the result of a conflict between the ego and its outside world. Neurosis and psychosis are both only expression of the rebellion of the drive life (the Id) against the outside world. They are the result the displeasure or the inability to adapt itself to the real reality, *ἀνάγχη.*" [7] While however the neurotic does not deny the reality, he remains yet obedient to it and wants to know from it, yet rips loose the delusional ego from reality. With the psychosis the reality loss is given from the beginning according to Freud. The psychotic *denies* reality and develops for himself a new delusional world. The reality loss is complete. The elimination of the natural world with the psychotics is not thus the result of a conscious, deliberate thinking act as with the transcendental phenomenologist. The way of thinking is with both nevertheless the same: That is either absolute or transcendental and that is a transcendental subjectivity exceeding the limits of reality. Both set the natural "being" and "essence" outside of action.

We are the opinion that the difference between the philosophers of the absolute and transcendental subjectivity and the mad is only in the *"how."* In the *"why"* both bear the same fate. A philosopher deliberately and consciously puts in brackets the natural being. A psychotic does the same unconsciously. The decisive question is however:

Why did they both switch out the natural world? Why do they put both the natural being in brackets? Why do they both flee into an absolute, transcendental

region of subjectivity? Fate psychologists [*Schicksalspsychologen*] provide the answer:

Because both their all-human and primordial drive to being one and to being the same with the world are not able to be satisfied. Therein the philosopher with the mad must be on an equal footing.

In the section of the "Elementary Ego Functions" we expressed the opinion that the original tendency of the still unconscious "instinctive" ego is the *participation drive*. The native participation drive as the original, still instinctive ego function drives people to be *one and the same,* and to be *related* to the objects of the environment. The human ego does not bear however being alone. The being alone is however an attribute of the human being in this life. The ego wards off and changes the fate of this world's being alone through the participation drive by being one and the same and being related to the other. We discussed in detail, how this drive forms the entire personal, familial and collective life of the primitive nature peoples to have part in the other one and in the world according to Lévy Bruhl. We spoke also about the child with Piaget of an a-dual phase of the soul, in which the child tries to satisfy the participative ego striving in form of a *dual union* with the mother. In the first volume we referred also to the desire in a mother-child dual union that is to live in a participation is an all-human, eternal, unquenchable demand of the human ego essence from birth to death.

The participative *p*-ego, that is striving for being one and the same and being related with the other and with the things of the world, is never extinguished in humans. The tragedy of humans everywhere in the world -- in particular however in the West -- consists now precisely that humans on this level of his or her culture and civilization is incapable to satisfy their original drive for participation. And because humans in their growing culture and civilization can become one and the same less and less both with the other as well as with the nature world and, therefore, for this reason they bracket this world of reality, therefore they do not want to know about this natural world, therefore they deny and negate the natural reality, and therefore they must abandon in any way this life and go on the search after an other world that makes possible the participation for them.

All humans have the common fate never to be able to satisfy in reality the drive to be one and the same in the real world. The way the individual reacts to the impossibility of the real participation in the natural world of this life is very diverse.

The *first one* looks for himself or herself an *addictive object,* with which he or she substitutes the misappropriated participative dual union. We say yes: The

addiction is a permanent prosthesis for the misappropriated mother and for the real dual union. [17] (See on this the destruction delusion.)

The *second* represses a piece of reality about which he does not want to know. He avoids by fleeing this piece of reality and substitutes for the damage of the partial reality loss by *neurotic* symptoms (Freud).

The *third* denied *ab ovo* [from the beginning] reality completely and develops the world *again* so that it is able to satisfy his original demand of the participation completely. He becomes mad.

The *fourth* denied natural being and essence and develops consciously an absolute, transcendental new subjectivity world. One calls him a philosopher.

The fifth also does not deny the terrestrial world, he opens however his ego to the highest power court and forms a participation, a dual union with God and the Holy Spirit. Thus he becomes a believer.

The mystic participation of the primitives with the totem animal and the totem plant, with all things of the world and with all things that have "mana," the real dual union of the child with the mother, the sick relationship of the addicted with his or her addictive object, symptom and complex-formation of the neurotic, the delusional world of the mentally ill, the absolute, transcendental subjectivity world of the philosophers, religious-spiritual connection with God with the believers -- all these various fate possibilities are ways in which the ego seeks to change the tragic fate of being alone and seeks to abandon this unbearable life.

All these forms of fate originate from the same source of the soul: From the eternal desire for not being alone, after being one, the same and being related with the other and with the world and from the longing to be guided by the other and be safe with the other. And because this unquenchable eternal striving after participation in this real life can never be satisfied, humans must go somehow *beyond reality* in order finally there to experience the being one.

II. Thoughts on the Nature and Forms of Delusion

"Delusional ideas are pathologically distorted ideas that are not accessible to correction through arguments." [18] Thus has E. Kraepelin determined the nature of delusion formations. Why however are these distorted ideas corrected by arguments inaccessible through reason? The emergence of the delusion world as replacement for the misappropriated participation -- in the fate analytic [*schicksals-analytischem*] sense -- gives us just the answer to the above question: *Because pure*

reason is never able to quench the instinctual thirst after participation. The drive of the ego after being one with the other in a dual union can be satisfied only by the devotion to another, never however by logical arguments.

"Delusional ideas are incorrect ideas, those not from a coincidental inadequacy of logic but have become shaped from an internal *need* ('need for delusion')." … *"The delusional ideas do not have thus their physiological analogue in an error but in faith,* and accordingly the main delusion is also regularly egocentric and of essential importance for the personality of the patient himself, while however the patient does not directly use other forms of explanation and secondary delusion." [19]

To this definition of the delusion according to E. Bleuler, we must add now only a recognition by Fate Psychology [*Schicksalspsychologie*] that this "need for delusion" originates from the drive source of the drive after participation.

This need for delusion is, in our opinion, a substitute form for the need to be one and the same. The insane person lives exactly the same with the delusion object in a unity and in a dual union like the addicted with the addictive object, like the philosopher with the transcendent, absolute idea world, or like the believers with God and the Holy Spirit.

*

According to K. Jaspers the delusion is a primary phenomenon. The field of the delusion is defined by *the absence of consciousness of being and existence* that manifests itself as estrangement from the perceptual world. Delusion is called

> "a *conversion in comprehensive* (given secondarily in reality judgments) *reality consciousness* on these experiences and in the practical world, which it develops resistances and meanings where, however, the deceptive hallucinatory living presence plays only an incidental, not sufficiently established role beside the changes of basic experiences that makes it most difficult for us to understand." … "The delusion communicates itself in *judgments*. Only where one thinks and one judges can a delusion arise. To that extent one calls delusional ideas pathologically falsified judgments." [20]

Those express characteristics of the delusion Jaspers summarizes as follows:

1. *Subjective certainty*, the extraordinary conviction.

2. *Uninfluenceable* by experience.

3. *Impossibility* of the contents.

During *internal* exploration of the delusion nature, Jaspers differentiates between the original *experiences* and the petrified *judgments* that are based on the experiences. Depending upon the *origin* he divided them into two classes: 1. the class of the *"genuine delusional ideas"* and 2. those of the *"delusional ideas."*

Genuine delusional ideas are according to him only those that reject "as sources on the basis of primary pathological experiences or demand as a precondition an explanation of their transformation of their personality." [21]

By *"delusional ideas"* Jaspers wants to understand those that psychologically lead back to emotions, drives, desires and fears. One does not need thus their explanation of a transformation of the personality. They arise either from the continuing inclination of the personality or from a temporary state of mind.

Into the group of the delusional ideas Jaspers lines them up with the melancholic sense of guilt, improvishment, nihilistic ideas, manic delusional ideas, the temporary deceptions by false perceptions and in particular the overvalued ideas.[22]

This would be now the leading basic ideas that were developed about the essence of the delusion in classic psychopathology. About the further development of the question about the essence of delusion, G. Schmidt [23] in 1940 and C. Haffter [24] (Basel) in 1944 in his paper give a detailed picture. Here we follow the paper of Haffter that groups the relevant work in three directions. These are: 1. the *analytic-dynamic,* 2. the *phenomenological-function-analytic,* 3. the *philosophical-anthropological* (existence-analytic) working direction. We highlight from this summary paper only the views on delusion formations.

1. In the *analytic-dynamic* works the authors attempt to discuss the *meaning of the symptom choice in the delusion formations* by fine consideration of the presented life history and actual constellation. The leitmotiv of all of these works was to uncover the conditioning factors in the choice of the delusion contents with the help of an *analytic-guiding psychology*. The works of G. Schmidt, Kurt Schneider [25] and 0. Kant [26] are here of a fundamental nature.

0. Kant differentiates a causal and a final factor with respect to the delusion formations. The causal factor is "to enable" the delusion formations into a certain direction, which is the final "guide." The delusion to be a useful structure whose

goal is to save the person from the threatened self-esteem experience and to fulfill the unrealizable drive demands.

The Waldauer school by J. Klaesi [27] stated that the delusion should undo the damage of the experienced vital and moral insufficiency feelings. This interpretation goes completely in the direction of S. Freud, who emphasized the reparation in the delusion formations as the second stage. The delusion formations are thus a *psychic* reaction to a "something" that was seized variously by the authors. The one believes that the delusion is the mental reaction to the *disturbances of the thinking and activity* (0. Kant).

Another one leads back the delusion reaction to the changed libido positions, but that would be caused organically (P. Schilder). [28] A third (Citron) assumes that the *schizoid constitution* brings with it an impoverishment of the drive life and this constitution then leads to the schizophrenic delusion formation.[29] A fourth author (Schultz-Hencke) [30] attributes the delusion-forming powers -- exactly the same as with "inhibited persons" -- without any organic process of childhood experiences and "escape mechanisms." The Freudian original interpretation breaks through the façade of a new nomenclature. This author makes even the attempt to replace the two hereditary factors of schizophrenia accepted by geneticists (Luxemburger) by the mental factors of "over-softness" and "hyper-motor skills."

As an inspiring example for the question of the *delusion choice* figures the investigations of Klaesi on the delusion forms of the different ages. He shows how the passive-acquiescing person by the influence delusion [delusion of control] makes the last attempt to remain in contact with the environment. This interpretation is consistent completely with that of S. Freud, who has determined that the final goal of the delusion-forming projections is making the repression return back the libido to their abandoned persons. In the works of Sachs and Bärtschi in the sense of Klaesi the delusion choice is likewise investigated by a discrete analysis of the personal life history. Maternal-inclined mentally ill women never select their children as persecutors. On the other hand transvestite women project their own disease conditions on their own beloved children. The Freudian assertion that nevertheless libido connection between the lovers created by the delusion formations though made in an unrealistically form, however, attains further confirmation by the investigations from the "Waldau" school. On Wyrsch we will report similar results and interpretations of the choice of the hallucination objects with the hallucinations.

2. *The phenomenological function analytic movement* is characterized according to Haffter by psychopathological symptoms -- included the delusion --

that are represented in functional associations. The symptom association teachings of C. Schneider [31] were represented in detail in the first volume of this book. [32] The individual successions of the symptom associations are thus 1. the symptom association of the "thought withdrawal," 2. the "volatility," 3. that of the "babbling," according to C. Schneider should not only represent the particular type of defect in the thinking processes, but be the roots, the radicals, and be of a comprehensive nature by addressing the processes of thinking, will, and feeling in the common roots of the past.

In the light of this symptom associations teachings, the paranoid, the catatonic and the hebephrenic are the completely decided "divisions" of the three symptom associations, whereby with the paranoid the association of the babbling, with the hebephrenic the volatility, with the catatonia all three associations representing the carriers of the changes and thus also the bearers of the delusion formations. Based on this theory it is however impossible to find for the different forms of the delusion formations a specific core since for example the delusion formations with cosmic experiences, estrangement, thought deprivation, thought insertion, etc. figure both with the paranoid as well as with the hebephrenic as the same division of the symptom associations of the thought deprivation. -- This is a further proof for the correctness of our interpretation that the "roots" do not represent really specific roots on the basis of which one would be able to separate the mental processes at the origin and in the appearance from each other from Carl Schneider. [33]

To the "function-analytic" works Haffter adds the experiments of K. Zucker given in the essay "Functional Analysis in Schizophrenia." [34] He tried by means of experiments to produce the direct relationship among thought disturbance, delusion, and hallucinations of schizophrenics. With these experiments the patient with his eyes closed is presented singular things, which the test operator indicates to him -- as in the association experiment -- faithfully reports on the process and on the experiences in the presentation procedure. Zucker notes: The discontinuities of the idea, a movement off, proliferation, transformation, and modification of the presented item. These occur when the patient is shown the presented object. Also delusional important feelings occur.

("The presented apple lies on a Roman coffin, it is a rotten apple.") Haffter writes: "The functional succession, which Zucker finds, begins thus when thought rips off, goes over strange experiences, made-up experiences, optical and acoustic hallucinations, important experiences, confusion, be it enigmatic up to incoherence and respectively talk at cross purposes." [35] Zucker attributes these phenomena 1. to the degree of the modification of the psychic contents and 2. to the possibility of introspection. The symptom of the thought deprivation enters,

"if the gap after demolition of the idea is felt simply as 'empty'." However the feeling appears "strange" and "made-up" as if the gaps are filled out by foreign ideas.

If then the breaks between the content experiences blur but introspection still continues, then the phenomenon of the "important experience" adjusts itself in the experiment. Here the entrance and the execution of the modification of idea contents are not any longer noticed but only the contents of the modification. The patient experiences what one calls "drivel" thinking (C. Schneider). With the term tools of the Gestalt psychology Zucker differentiates in the experience procedure 1. a primary material tendency that causes the removal of the figure from the background; 2. a secondary, *anticipatory tendency,* which during the process of perception the identification act with which the introspection carries out in the internal experience act.

In the experiments the number of the ideas is disturbed for the time being according to the material tendency (the figure-formation). In severe cases then there is also the secondary identifying respectively controlling tendency. From the thought breaking down (thought withdrawal) up to experiencing strangeness and the made-up, only the primary material tendency should be disturbed. An idea is then perceived as "strange" or felt to be "made-up" when it is seen as unexpected, thus anticipating the goal that is not anticipated,. Now Zucker states that hallucinations are function-analytically identical to strange experiences. Zucker sees the difference between the "made-up," thus strange thoughts and the hallucinations, only in the material structure. According to him there are smooth transitions from made-up thoughts to hallucinations. On the basis of the idea experiments, Zucker received from his patients the answer: "*Hallucinations and conceptions were qualitatively identical."*

Our experimental ego analysis, on which we will report, affirms this acceptance of Zucker -- however only in the limited area of the so-called *projection delusion.* These results seem to agree also with interpretation of P. Schroder, who wants to regard the schizophrenic hallucinations in connection with the alienation features in thinking and acting.

Similarly as Zucker, P. Matussek [36] recently tries with Gestalt psychology to begin to analyze the delusion perception in its structure. He states that with schizophrenics -- most often even before the manifestation of grossly striking delusional perception contents -- can be recognized in an increased priority of essential characteristics in certain perception objects. Thus he tries to understand the "perception character of the experienced delusion meanings and the overtones of other characteristics of the perceptual world on the basis of the essential

characteristics and the higher weight of the experienced significance" even where the delusion content can not yet be recognized. Apart from this abnormal emergence of essential characteristics, Matussek also determines a parallel continuous relaxation, respectively the elimination of the natural perception connection. Therefore the schizophrenic should remain longer with the details of the perception field than with the normal attitude. Certain parts of the perception field "are framed," and this strengthens still the strength of the abnormal magnification. The new pathological connection of the opinion forms are based on the *nonrepresentative* characteristics of the environment and not on the basis of the object. The statement of the author is important that no symbol consciousness but an identification of two different objects with the same essential characteristics is the basis for the delusion phenomenon of the "symbol connection." *The importance of abnormal experiencing in primary delusion is based on the perception that is in the compulsory knowledge.* The author admits that his investigations still give no explanation for the incomprehensible perception contents. We believe that so many of these phenomena are interpreted more easily by using a multidimensional experimental ego analysis than in terms of Gestalt psychology.

*

3. The third working direction, which C. Haffter calls the *"philosophical-anthropological,"* is the field of work of the psychiatric existential analysts (Gebsattel, L. Binswanger, E. Minkowski, M. Boss, H. Kunz, A. Stork.).

The existential analysts see the fundamental process of schizophrenia -- including the delusion formations and delusion tendency -- in a particular basic attitude and a fundamental structure of being in the world. They try to see in the psychotic existence "variations of transcendence." The phenomena, which they analyze, are mainly *linguistic* phenomena of the psychotics, in which -- in their view -- existence contents are the clearest to behold. [37] Binswanger comes to the conclusion that the vital emptying or depletion process constitutes the basic process in schizophrenia and that this process among horrible experiences "of standing before nothingness, the world destruction or internal dying."

The statement of H. Kunz has the same meaning: "The primary delusion of the schizophrenics is the only explicative possibility of experiencing one's own existence and experience transformation. In these explications and experience possibility however at the same time the existence change as such is hidden." [38] The existential analysts want to see also in the hallucinations the results of an existence transformation.

C. Haffter admits in his paper that in certain schizophrenic experiences -- thus in the *depersonalization, derealization* and furthermore in the *changes of the space and time experiencing* and in "Déjä vu" -- the linguistic self-descriptions the patient indeed refers to the "transcendental core" of the personality. The changes of "temporality" and "space" in the sense of Heidegger both with the schizophrenics as well as with the depressives are decisive for most existential analysts (V. E. v. Gebsattel, E. Minkowski, Betzendahl, Fischer, L. Binswanger, etc.), since precisely time and space constitute existence. The thought disturbances as also the delusion formations of the schizophrenics are likewise attributed to existence transformation (H. Kunz). The primary delusion is according to this author an inadequate self-explication of a fundamentally different way of the existence, i.e. represents the schizophrenic existence.

All these efforts are based on the conviction that on the basis of being is happening more than that which is accessible in experiencing (H. Kunz). Jaspers warns to interpret and to grasp the process and appearance of schizophrenia simply as "existence transformation." J. Wyrsch believes that the existence transformation is with the schizophrenia nevertheless a result of the process. "In the schizophrenic world view are imprinted prevailing mood and act disturbance and the symptoms, in the narrow sense of the word, indicate these changes for a long time need to be stated." [39]

We already expressed the opinion in the first volume of the *Triebpathologie* [*Drive Pathology*] that the *existence forms in meaning of Schicksalspsychologie* [*Fate Psychology*] *are given genetically, but are personally chosen and imprinted by the ego.* That means thus: *Existence forms are precisely the results of Ego Fates that even choose the existence forms.* [40] Experimental ego analysis of the different delusion existences has for us in this interpretation -- as we will later show -- been strengthened.

III. The Forms of the Delusion Formations in School Psychiatry

The present school psychiatry essentially maintained the old clinical form organization of E. Kraepelin. [41] This differentiates:

I. *Inferiority and greatness delusion ideas,* that is depressive and expansive delusion formations.

Among the depressive inferiority ideas lead the delusions of sin, the

impoverishment delusion, the nihilistic delusion in which the patient harbors the idea: "Everything is wrecked and destroyed, the world does not exist any more," and the like. The French call this depressive delusion form *"délire de négation,"* thus the denial delusion. E. and M. Bleuler differentiate this strongly from the *negativistic* phenomena of catatonia. (See later the chapter about the relationship between ego function and delusion formation.)

The grandiose ideas refer in particular to origin, possession, abilities, position, etc.

II. Persecution delusion ideas in particular with the paranoids but also in manic-depressive insanity are often accompanied by hallucinations. But one must never follow Kraepelin and make the hallucinations responsible for the delusion formations. [42]

III. Jealousy delusion, most frequently with alcoholics, cocainists, senile mentally disturbed, the sexually incapable.

IV. Transformation ideas respectively enchantments delusion by magic, magnetic, electrical, hypnotic influences; be the dead, conversion into animal forms (werewolves), into other personae, into lifeless things, etc.

V. Hypochondriac delusional ideas whereby the physical impairment is based on imaginary incurable illnesses.

The Forms of Delusion Formations in Fate Psychology [*Schicksalspsychologie*]

The old school psychiatry was content therefore with the purely descriptively forms of the delusion formations and accordingly to set up the *delusion contents*. For Fate Psychology a delusion formation is constantly a pathological ego function. It is a pathological ego function that distributes the omnipotence wrongly and through this unrealistically distribution of power to create a possibility for the satisfaction of its unquenchable participation drive. We say indeed: *Delusion is a particular unrealistically participation manner that takes place beyond reality by a pathological distribution of power.*

The need for delusion always wells up from the pathological increased participation drive. Despite the common source of need, nevertheless different

delusion forms occur because the ego by different elementary and complex functions seeks to distribute the omnipotence. That thus means: *The different delusion forms are caused by the different kinds of ego functions with which the ego seeks to satisfy the participation drive.* And still more: We can prove that the choice of the delusion objects and delusion contents in the first place depends on the particular kind of the ego function of the patients. *If the ego function changes, then the delusion form also changes.*

On the basis of the kind of ego functions we differentiate the following delusion formation forms:

Division of the Delusion Forms on the Basis of the Different Ego Functions

A. Elementary Delusion Formations

Elementary delusion formations that occur by a single, particular elementary "Uni"-function of the ego. These are: I. the *projective* (*p* —)*,* II. *the inflative* (*p* +), III. the *introjective* (*k* +) *and* IV. *the negativistic respectively destructive* (*k* —) *delusion form.*

B. Compound Complex Delusion Formations

These are formed either by a successive chain reaction of elementary ego functions or however by simultaneous cooperation of several elementary ego functions. These are:

I. *Inflative and projective delusion form* (*Sch* = 0 ±);

II. *Introprojection delusion form* (*Sch* = + —);

III. *Projection held back with compulsion delusion form* (*Sch* = ± —);

IV. *Negativistic, destructive projection delusion forms* (*Sch* = —!! —, —! —);

V. *Inhibited, negative inflation delusion* (*Sch* = —!! +, —! +);

VI. *Alienation delusion form (depersonalization delusion)* (*Sch* = —!! ±, —! ±, — ±);

VII. *True compulsive form* (*Sch* = ± 0);

VIII. *Integrative delusion form* (*Sch* = ± ±);

IX. *Disintegrative delusion form* (*Sch* = 0 0).

We designate thus the delusion forms constantly according to the particular ego functions with whose assistance the ego satisfies its participation drive and seeks thus to distribute the omnipotence. The division of the delusion forms in fate psychiatry is of a dynamic-functional nature. Our ego analysis extends the efforts of psychoanalysis that stressed that behind all delusion formations and hallucinations was only one ego function: *projection*. J. Harnik completed the delusion mechanisms with *introprojection* with melancholia. [43] We had naturally to perform the function of depth psychological interpretations of the delusion formations based on our advanced ego analysis. The inadequacy of the previous knowledge about the relations between that delusion and the ego showed up in particular in two circumstances.

The *first* circumstance is that the earlier research in this area was never able to check systematically the *four* elementary functions and the complex chain reactions of the ego to discover *their dependence on a global ego*. This circumstance explains why in psychiatry so far a continuous reference system between ego function and delusion formations was missing completely.

The second circumstance is that psychiatry had so far enacted no accurate, experimental method with whose assistance the regularities in the connection of certain ego functions with certain delusion forms would have been discovered.

However fate psychiatry [*Schicksalspsychiatrie*] has at its disposal in the choice test an experimental method of ego analysis with whose assistance the relations between delusion forms and ego functions can be determined in an accurate way. The results we report back here are all *empirical* and not speculative. The degree of the investigation material, which we collected in the past 16 years from different institutes of different countries, vouches for the soundness of the claimed connections.

Table 20 gives an overview of the number, origin and form of the psychosis cases that an experimental ego analysis with the drive profiles puts at our disposal. From the 2671 cases of mental patients we have, naturally we can only use those cases to elucidate the relations between delusion form and ego function with the particular delusion form that could be recognized unmistakably and those based on the patient histories and with those that were available to us with one or more test series not only just a test profile. This circumstance explains

why we have studied the relationship in question only in 180 cases and why most of them were selected from the collection of E. Stumper [44] (Ettelbrück, Luxembourg).

Table 20. Overview of Number, Clinical Forms and Origin of the Mentally Ill Tested with the Szondi Test

Clinical form	*Number of cases*	*Collection of*	*From the welfare and mental hospital*
1. Catatonic Schizophrenia	66	Susan Déri	Budapest Hüvösvölgy (Director: Zsakó)
2. Paranoid Schizophrenia	77	Susan Déri	ditto
3. Mania	70	Flora Illyés	ditto
4. Melancholia	33	Kozmutza	
5. Progressive paralysis	100	Déri and Kozmuta	ditto
6. *a*) Genuine Epilepsy	50	L. Szondi	ditto
b) Psychosis epilepsy	42	L. Szondi	ditto
c) Epilepsy	100	H. P. David	Western Psychiatry institute and Clinics, Univ. of Pittsburgh
d) Epilepsy	20	M. Bichsel	Schw. Epilep. Institute (Dr. Braun)
7. Miscellaneous types of psychosis and mixed psychosis	200	E. Stumper	Ettelbrück, Luxembourg (Director: E. Stumper)
ditto	1602	F. Soto Yarritu	Pamplona, Espaňa (You: F. Soto Yarritu)
ditto	12	L. Szondi	Univ. - Hospital T5ubingen (You: Professor E. Kretschmer)
ditto	60	L. Szondi	Prangins with Nyon (Switzerland) (Dir.: 0. Forel)
ditto	73	U. Boßhard	Rosegg, Solothurn (Switzerland)
ditto	140	Rüegg Märton and G. Eltz	Hohenegg, Meilen (Switzerland) (Dir.: A. von Orelli)
ditto	26	U. Moser	Burghölzli, Zurich (Dir.: Professor Manfred Bleuler)
Altogether	2671		

Delusion Forms in the Light of Experimental Ego Analysis

With our investigations we proceeded in the following manner:

First we determined the particular manner of the delusion form based on the patient history in each individual case. Many patients developed several forms of delusion in the course of their illness. We had therefore to leave the same patients in the different clinical groups of delusions several times. That is why the sum of the frequency values of the patients exceeds the absolute number of 180 and the percentage of 100. We had to do this in order to be able to avoid the reproach that we would have arbitrarily picked a form from patients with several delusion forms. We designated the delusion forms doubly. Once we did so clinically according to the contents of the delusional ideas, thus for example the delusion ideas of persecution, relationship, greatness, omnipotence, sinfulness, despair, jealousy, killing, and destruction delusion and delusional self-destruction ideas (alcoholism, suicidal ideas). We call the destruction delusion: *Thanatomania* and do speak of *allothanatomania* if the object of the deadly destruction is another person and of *autothanatomania* if the destruction delusion is directed against one's own person as, for example, with delusional suicide ideas, narcomania and dipsomania.

A further clinical group is that of the *sexual maniac,* with whom the delusional ideas are accompanied with bisexual, exhibitionistic, fetishistic coprophilia, necrophilia, and masochistic and sadistic ideas.

The frequency of these clinical delusion forms can be read from Tables 21 and 22.

Beside the *clinical* contents of the indicated designation of the forms with each group we also stated the *ego psychology* designation; thus: Projection, inflation, introjection delusion, etc. To this second designation of the clinical delusion forms precisely authorize for us the results of the investigations that uncovered the relations between the clinical delusion forms and the experimental ego analysis.

The Frequency of the Ego Psychological Delusion Forms

Due to the frequency values (Table 22) we can with our 180 delusional patients set up the ranking of the clinical delusion forms as follows:

1. *Projection delusion:* persecution, relationship, observation, impairment delusion: 32.2% (58: 180).

2. *Self-destruction delusion*, *autothanatomania* with delusional alcoholism with psychotics: 24.4% (44: 180).

3. *Self-destruction delusion with delusional suicidal and self-mutilation* ideas: 23.8% (43: 180).

4. *Negation delusion*: Despair and jealousy delusion, hypochondriac delusional ideas with catatonic-negativistic behavior: 22.7% (41: 180).

5. *Allothanatomania*: Killing and destruction delusion: 22.2% (40: 180).

6. *Erotomania*: Inflative and introjective sexual delusional ideas, altogether: 12.7% (23: 180). Among them a pure *bisexual* inflation: 10.5% (19: 180); *introjective* erotomania (exhibitionism, fetishism, masochism with delusional ideas): 2.2% (4: 180).

7. *Introprojection delusion*: delusion of sin or magic omnipotence delusion: 8.2% (15: 180).

8. *Introjection delusion*: cosmic omnipotence delusion: 2.2% (4: 180). Here we get mention that *delusional ideas with hallucinations* occurred in our material in 22.2% (40: 180).

*

These figures refer exclusively to our material. Reexaminations will have to determine whether one may apply these frequency figures generally to the delusion-forming psychoses. We warn therefore the reader not to make absolute these figures and want them only to indicate the available patient material.

Table 21. Frequency of the Decisive Ego Functions with the Delusion Formations

Outstanding Ego Functions ↓	*Experimental Ego Analysis*	*No. of Cases*	*of 180*	*Rank Position*	*of 100*	*Leading, Particular Delusion Form*
A. Elementary Ego Functions						
I. Total projection	0 —!! 0 —! 0 —	1-37	37	2	20.5%	*Persecution,* relationship, Impairment, observation delusions and hallucinations.
II. Total inflation	0 +!! 0 +! 0 +	38-53	16	5	8.9%	*Megalomania,* erotomania, religious delusion.
III. Total introjection	+!! 0 +! 0 + 0	54-57	4	10	2.2%	*Cosmic omnipotence delusion,* exhibitionism, fetishism, sadomasochism.
IV. Total negation and/or destruction	—!! 0 —! 0 — 0	58-70	13	6	7.2%	*Negativistic self-valuation, hypochondriacal despair, destruction delusion* (alcoholism, suicide).
B. Complex Ego Functions						
I. lnflative projection or projective inflation	0 ±	71	1	13	0.5%	Heboid, erratic *megalomania with persecution delusion.*
II. Introjective projection	+ —!!! + —! ! + — +! ! — + ! —	72-89	18	4	10%	*Delusion of guilt, of sin,* omnipotence ideas, paranoid depression, body hallucinations, masochism
III. Projection held back with compulsion	± —! ± —	90-92	3	11	1.6%	*Compulsion delusion,* being degraded delusion, being offended delusion
IV. Negated, destructive Projection	—!!! — —!! — —!! —! —! —! — —!	93-118	26	3	14.4%	*Negativistic Stupor.* circular projection and destruction delusion, hypochondriac body hallucinations, thantomania, alcoholism
V. Negated, inhibited inflation	—!! + — ! +	119-128	10	7	5.5%	*Destruction delusion,* quarreling psychosis, psychosis in jail.
VI. Destructive alienation, negated inflative projection	—!! ± —! ± — ±	129-166	38	1	21.1%	*Jealousy delusion.* Hypochondriac delusion. Thantomania, alcoholism, narcomanie, suicide. Organic psychoses.
VII. Introjective negation	± 0	167-168	2	12	1.1%	*Compulsion delusion,* conversion delusion, hypochondria
VIII. Integration	± ±	169-173	5	9	2.8%	*Phobic delusional ideas,* disaster delusion.
IX. Disintegration	0 0	174-180	7	8	3.9%	*Confusion,* fugues, stupor (hysteria-epilepsia).
		Total	180		99.7%	

Experimental Ego Analysis and Delusion Forms

It was more difficult to group the 180 cases *on the basis of experimental ego analysis*. Here we had to select between two possible ways. The *first* way would be that we add the frequency of each individual ego function within each clinical group of delusion forms based on all ten profiles. The *second* way is that we determine the *leading and decisive ego function* in each case based on the ten ego reactions and determine only its frequency within each of the clinical groups of delusions. *As the decisive and leading ego function can be considered either which occurred most frequently in the ten series or which exhibited the greatest quantity tensions.* Both criteria refer thus to the *strength* and to the intensity of the ego function, thus the grouping is based on the relatively strongest ego function. After long consideration we selected the *second* way, thus that based on the *strength* of the leading and decisive ego function is decided case by case. By this procedure we could avoid that a banal ego form (as for example *Sch* = — —-), which surely has no relationship with the delusion formations and by its frequency leads to a false conclusion. The results of this second compilation are reported in Table 21.

The *ranking* of the leading and decisive ego functions can be specified on the basis of this table as follows:

1. *Destructive estrangement, alienation, derealisation, depersonalization* (*Sch* = —! ±, —!! ±, — ±): 21.1% (38: 180). Clinically in these ego functions groups belong in particular: Jealousy, despair, and destruction delusion, allothanatomania and autothanatomania, such as delusional drinking addiction, delusional suicide ideas, hypochondriac delusional ideas and definite organic psychoses (as with progressive paralysis).

2. *Total projection* (*Sch* = 0 —!, 0 —! ! , 0 —): 20.5% (37: 180). Clinically to this ego group belong delusion forms of persecution, relations, influence, observation, impairment, very frequently with hallucinations.

3. *Destructive projection* (*Sch* = —!!! —, —!! —! , —! —!!): 14.4% (26: 180). The clinical manifestation is here quite often: circular (manic-depressive) projection delusion, hypochondriac body hallucinations (“organ psychosis” according to H. Meng), autothanatomania and allothanatomania (drunkenness with delusion formations), negativistic stupor or substupor.

4. *Introjective projection* (*Sch* = + —!!!, + —!! , + —! , +! —, + —): 10% (18: 180). Here clinically the sense of guilt dominates, more rarely: Omnipotence delusion, paranoid depression, body hallucinations, delusional sexual power or powerlessness ideas like exhibitionism, fetishism, masochism.

5. *Total inflation* (*Sch* = 0 +!!, 0 +! , 0 +): 8.9% (16: 180). Clinical appearance: greatness mania (megalomania), bisexual erotomania, rarely religion delusion.

6. *Total negation respectively destruction* (*Sch* = —!! 0, —! 0, — 0): 7.2% (13: 180). This ego function dominates with the hypochondriac negativistic delusion forms, with destruction delusion (delusional suicide ideas, psychotic drinking addiction).

7. *Inhibited (negated) inflation* (*Sch* = —!! +, —! +): 5.5% (10: 180). Here we found prison psychosis, quarreling and destruction delusion psychosis.

8. *Disintegration* (*Sch* = 0 0): 3.9% (7: 180). Clinical pictures: hysteria epileptic delusion forms, fugues and confusion.

9. *Integration* (*Sch* = ± ±): 2.8% (5: 180). This ego function appears clinically rarely with delusional patients and if so in the form of disaster delusion or phobic delusional ideas.

10. *Total introjection* (*Sch* = +!! 0, +! 0, + 0): 2.2% (4: 180), in the form of cosmic omnipotence delusion or sexual power delusion, thus with exhibitionistic, fetishistic, masochistic delusional ideas.

11. *Projection held back with compulsion* (*Sch* = ± —!, ± —): 1.6% (3: 180), which manifests itself clinically as compulsion delusion or as offense, injury delusion of less severe form.

12. *Introjective negation* (*Sch* = ± 0): 1.1% (2: 180) appeared clinically as compulsion delusion transformation delusion with hypochondriac delusional ideas.

13. *Inflative projection respectively projective inflation* (*Sch* = 0 ±): 0.5% (1: 180). This ego function dominated only once with a heboid volatile mania with megalomania and persecution ideas.

Table 22. Frequency of the Ego Psychology Delusion Forms with 180 Interned Psychotics

Ego Psychology Delusion Forms ↓	*of 180*	*of 100*	*Rank Position*	*Experimentally Determined Leading Ego Functions*	
A. Projection delusion Persecution, relationship, observation, impairment delusion	58	32.2	1	*Projection:* Inflation: Disintegration: Negation destruction: Integration:	**84.3%** 5.1% 5.1% 3.4% 1.7%
B. Inflation delusion 1. Greatness mania, megalomania 2. Bisexual erotomania	19	10.5	6	*Inflation* Projection: Disintegration:	**63.1%** 31.5% 5.2%
C *I. Introjection delusion* Cosmic omnipotence delusion	4	2.2	9	*Introjection:*	4: 4
C II. Introprojection delusion Sense of guilt delusion, Magic omnipotence delusion	15	8.2	8	*Introprojection:* Self-destruction: Total projection: Total introjection: Estrangement with destruktion: Integration: Disintegration:	7:15 3:15 1:15 1: 15 1:15 1:15 1:15
D I. Negation delusion Despair delusion, hypochondriac delusion, jealousy delusion with negative, catatonic behavior	41	22.7	4	*Negation destruction:* Projection: Total introjection: Compulsion: Integration:	**78%** 14.6% 2.4% 2.4% 2.4%
D II. Destruction delusion 1. Killing destruction delusion (allothanato-mania)	40	22.2	5	*Destruction:* Projection: Inflation: Integration: Disintegration:	**62.5%** 20.0% 12.5% 2.5% 2.5%
2. Compulsive self-destruction ideas: suicide, self-mutilation. (autothanatomania)	43	23.8	3	*Destruction:* Projection: Inflation: Integration: Disintegration:	**53.4%** 30.1% 11.6% 2.3% 2.3%
3. *Self-destruction delusion* Delusional drunkenness	44	24.4	2	*Destruction:* Projection: Disintegration: Inflation: Integration:	**68.1%** 18.0% 6.8% 4.5% 2.2%
Different Manifestations					
I. Hallucinations beside delusional ideas	40	22.2	6	*Projection:* Inflation: Negation:	**87.5%** 7. 5% 5.0%
II. Erotomania: delusion formations with bisexual, exhibitionistic, fetishistic, coprophlia and necrophila ideas	23	12.7	7	Projection: Destruction Inflation: Ego loss: Introjection:	34.7% 25.9% 17.3% 13.0% 8.7%

From this compilation one can make the following observations about the relationship between delusion and the ego.

I. *The destructive form of estrangement* (*alienation*), *derealization and depersonalization* (*Sch* = —!! ±, —! ±) *and the total projection* (*Sch* = 0 —!) are those ego functions that we find *together* with 41.6% of *all* delusion patients.

II. The following ego functions *never* play a decisive role with delusion patients:

1. *Inflation held back with compulsion.* (*Sch* = ± +), thus the ego working compulsively and obsessed by work.

2. *Feminine have ego* (*Sch* = + ±), which thus is able to accept (*k*+) the abandonment (*p*±) and each object -- as compensation for the mother -- to take into possession.

3. *Introjective Inflation ego* (*Sch* = + + without any quantity of tension), which from being power is able to make real having power. This ego has thus the ability by an introjective deflation to defend itself against the danger of obsession (*Sch* = 0 +!) *through an occupation.* (We meet this ego quite often with psychologists.)

III. *The following ego functions very rarely are prominent with delusion patients:*

1. *Inflative projection* (*Sch* = 0 ±): 0.5%;

2. *Introjective negation, compulsion* (*Sch* = ± 0): 1.1%;

3. *Projection held back with compulsion* (*Sch* = ± —!): 1.6%.

The ego functions stated under points II and III *can* appear occasional also with delusion patients but play *no* decisive role in the delusion formations. We must indeed assume that precisely these ego functions represent a *self-healing* tendency of the ego against the threatening delusion formations. That also means: While the destructive estrangement and the total respectively introjective projection leads with the greatest probability to the delusion formations, perhaps the compulsion function works against inflation (*Sch* = ± +), the acceptance of the abandonment (*Sch* = + ±), the introjective professional deflation of obsession (*Sch* = + +), furthermore pure feminine Moll [soft] ego (*Sch* = 0 ±), the more pure masculine, compulsive pedantic Dur [hard] ego (*Sch* = ± 0) and under certain circumstances the projection held back with compulsion *inhibiting* the delusion

formations. Schematically we represent these experimental facts in Table 23.

The knowledge about these connections among the different ego functions and delusion formations seems to us to be both for psychiatric prognosis as well as for depth psychological therapy with delusion patients to be of particular importance.

Table 23. Ego Functions that Promote and Respectively Inhibit the Delusion Formations

The delusion formations become

most promoted through:		*most strongly inhibited through:*	
	Sch =		*Sch* =
1. Destructive estrangement, alienation, derealisation, depersonalization	—!! ± —! ± — ±	1. Inflation compulsively held back, that is through the compulsory labor	± +
2. Total projection	0 —!! 0 —!	2. Acceptance of the abandonment	+ ±
2.Destructive projection	—!!!— —!! —! —! —!	3. Introinflation, thus an incorporation of being power in an occupation	+ +
4. Introjective projection	+ —!!! + —!! +! —!	4. Pure Moll ego	0 ±
5. Total inflation	0 +!!	5. The pure compulsive respectively Dur ego	± 0
6. Total negation	—!! 0 —! 0	6. The compulsive held-back projection	± -

I. The Projection Delusion

1. *Generalizations*

a) *Definition:* The general determination of the delusion in Fate Psychology is: *Delusion is the product of an ego function that is characterized by a pathological distribution of power and an unrealistic manner of participation.* Accordingly to this determination we must test each individual delusion form on the basis of two criteria:

First of all: Wherein lies the special feature of the distribution of power?

Secondly: By which sick processes does the delusion patient produce by the participation with the world and the being the same with the objects -- beyond reality, thus in unrealistically form?

On the basis of these two criteria we determine the projection delusion as follows: *Projection delusion* is that form of the delusion formations with which the person

1. transfers out an important part of his own power into another person and thus expands the omnipotence of a stranger over his own ill self.

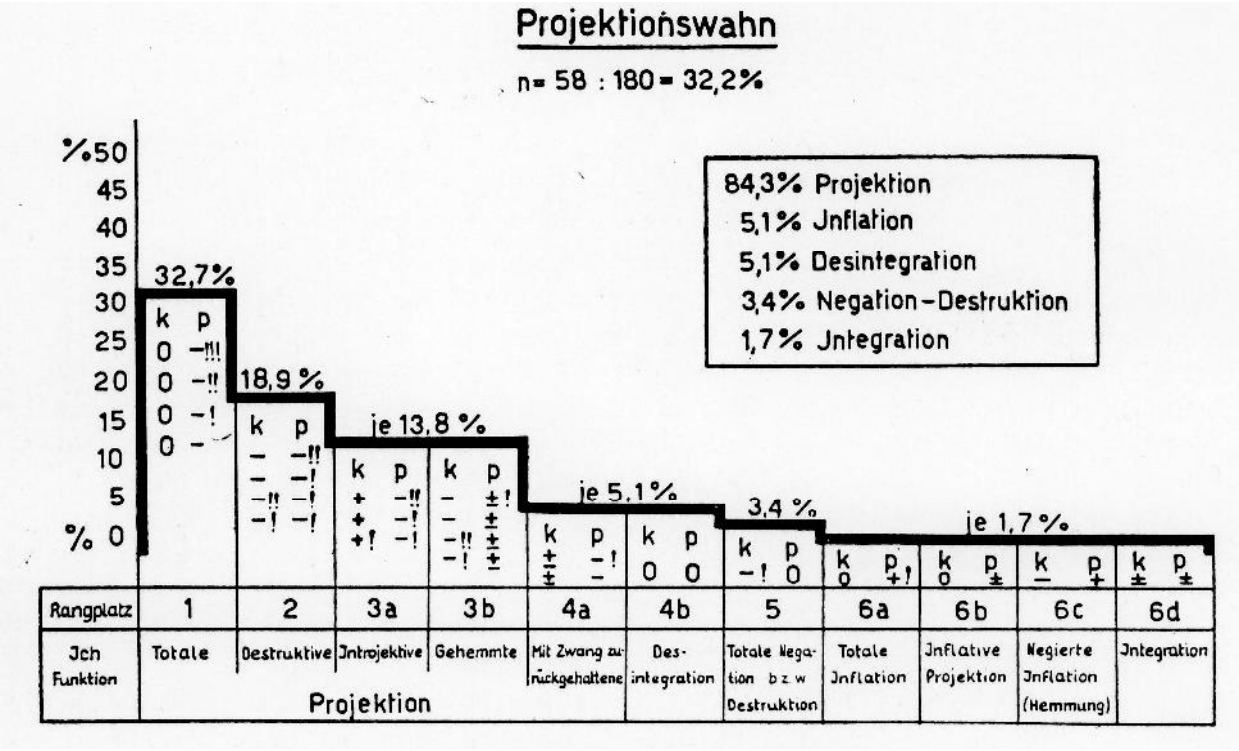
2. Through this pathological distribution of power arises an *unreal* mystic hate participation between the patient and his persecutor. In place of the desired being one and the same with the other in love and tenderness one thus enters a *participative hate relationship* between the omnipotent and the powerless, between the persecutor and the persecuted. The persecutor thus becomes omnipotent precisely by the pathological transfer of power and the delusion carrier on the other hand becomes powerless. That means: He faces the omnipotent enemy *without* power. The participative relationship nevertheless is created. Persecutors and persecuted are again united in an all-powerful and a powerlessness relationship. Freud states: With projection the *detachment of libido* from repression is cancelled and the *"libido"* is led back to the abandoned person. If one sets up the power, the *potestas**, thus the *p*-energy of the unconscious, instead of the libido, then we can further maintain the Freudian determination. *The projection delusion does not however concern any longer libido but is about a power connection in which the power of the partner* (*the environment*) *becomes expanded by the force of the pathological projection.* With the projection delusion the need of the ego diastole is therefore satisfied in favor of the environment and for the injury of one's own person. [**Potestas* is a Latin word meaning power or faculty. It is an important concept in Roman law. The idea of *potestas* originally referred to the power, through coercion, of a Roman magistrate to promulgate edicts, give action to litigants, etc. This power, in Roman political and legal theory, is considered analogous in kind though lesser in degree to military power. From *Wikipedia*]

b) Clinical projection delusion: All delusion forms that are labeled in the clinic under the delusion names of relationship, observation, influence, impairment, persecution belong to the group of projection delusions. It is remarkable that the quarreler does not belong to this group.

c) The experimental ego analysis of the projection delusion (Table 22): We found *clinically* the persecution delusion as symptom among the 180 delusion patients to be 58, that is 32.2%. With the majority of the patients dominated by

persecution, relationship, and impairment delusions and with also different delusion forms occurring next to the projection delusion. On the basis of the experimental ego analysis we determined the ego functions critical in the intensity (quantity tension).

The results are plotted graphically in Figure 15.



[*Projektionswahn* =Projection Delusion; *Gehemete* = Inhibited; *Mit Zwang zurückgehaltene* = Held Back with Compulsion]

Fig. 15. Projection Delusion and Ego Functions

We emphasize the following results:

I. With persecution delusion (included the impairment and observation delusion) became in 84.3% as the critical ego function in any form of the *projection ego* (*p* = —!). This circumstance forced us to summarize the above-named clinical delusion forms ego-psychologically as “projection delusion.”

II. *The individual ego forms with projection delusion* show the following ranking in frequency:

1. *Total projection* (*Sch* = 0 —! ! ! , 0 —! ! , 0 —! , 0 —) keeps the leading role (32.7%) with persecution and similar delusion forms.

Here is turned on and reigns the unifunction of projection (*p* —!) without any braking or restraint of the projective delusional ideas. *The so-called projective paranoid* becomes quite often conditioned by total projection as a unifunction of the ego. The delusion formation with total projection is accompanied very frequently by hallucinations.

2. *Destructive projection* (*Sch* = — —!!, — —! , —!! —! , —! —!) figures as the second place with projection delusion. Here associated with the projection act (*p* = — ! ! ! , —! ! , — !) is still another another ego function, destruction (*k*= — !!, — ! , —), that partly refers to the complete disappointment in and depreciation of all values and partly signals also the danger of allo-destruction or auto-destruction (killing and suicidal drive).

We find clinically in these cases apart from the leading projection delusion: episodic catatonic form states with stupor and substupor (case No. 93, 94, 95) or hypomanic states (No. 96, 97, 98) or a *depressive* paranoid (No. 99) with apocalyptic ideas. Also destructive, hypochondriac organ delusion ideas with hallucinations (No. 100) can occur. *Through the concatenation of the projection delusion with the destruction delusion the prognosis becomes worse.* We are of the opinion that in these cases the mixed psychosis of the paranoid with the manic are conditioned on a hereditary-biological basis.

3*a) Introprojection* (*Sch* = + —!!, +! —!), that is the concatenation on projection with introjection, stands with 13.8% in the *third* position. Ego-psychologically we interpret this process in such a way that the person projects here the omnipotence not into a stranger but projects it in the form of guilt for everything onto one's own ego. The result of this ego act raises also sinfulness ideas and self-incrimination ideas beside the persecution ideas; however, there always nevertheless breaks in the primordial persecution delusion, in particular the relations delusion. These patients become clinically designated as paranoid depressives and as depressive paranoids (No. 72, 73, 74) or as pure melancholiacs (No. 75, 76, 77). The hallucinations, however with the leading projective delusional ideas, speak most often for the depressive paranoid. The suicide danger is great with these patients. Often they are labeled by the institute psychiatrists first as melancholiacs and years later as paranoid schizophrenics (case 81). We regard these cases however as projection delusional and also because in the ego the projection acts mostly quantitatively stronger than the introjection. (From this the ego picture: *Sch* =+ —!! , + —!).

3*b)* Equally as large (13.8%) as the frequency of the introprojection is that of *inhibited projection, the so-called projective estrangement* (*Sch* = — ±! , —±, — !! ±, —! ±). To this ego function we must bring to mind all that which we have

already determined about estrangement as a "defense mechanism." Ego-psychologically also here the projection (*p* —) leads, but it only becomes inhibited (*k* — *p* +). The estrangement from the world (alienation), the derealization, and fairly often the depersonalization are with these projective delusion patients the result of the loss of the positive *k*-function; that is the bridge to the world (*k* +) is broken off.

The persecution ideas that figure as the core of the delusion are accompanied by jealousy ideas (No. 141), by aggressions, ravings, allothanatomanic ideas (No. 140, 143, 145), and possibly by alcoholic delirium (No. 150). We found this form of the projection delusion also with some organ psychoses, as with paralysis progressiva (No. 164) and with E. Stumper's case of hyperacetonemia* (No. 163). Also substuporous conditions with a suicide risk were noted (No. 137). [*hyperacetonemia = a condition caused by elevated levels of acetone in the blood]

4*a) Projection held back with compulsion* (*Sch* = ± —!) as *a spontaneous healing act* of the projection delusion is rare: 5.1%. It stands with disintegration at the fourth position in frequency. In the three cases (No. 90, 91, 92) in which this ego function was decisive, impairment and offense delusion ideas led clinically. Conspicious in all three cases were also found *paroxysmal* symptoms such as poriomania* (No. 92), pyromania (No. 91) and asthma (No. 90). We always called the ego form *Sch* = ± — the "paroxysmal" ego. -- The act of violence and the compulsive thoughts constantly accompany the impairment of thoughts. Therefore one can speak here of "compulsive delusion." [*poriomania = a passion for wandering or journeying away from home]

4*b) Total disintegration* (*Sch* = 0 0) -- as the leading ego function -- was found with the projection delusion (5.1%) constantly together with *total projection* (*Sch* = 0 —). It appeared clinically as the accusation delusion (No. 177), as persecution delusion (No. 178) and as recrimination and accusation delusions (No. 174). With these disintegrated projection delusion patients we must assume that disintegration in the ego (*Sch* = 0 0) manifested itself mostly in confusion and stuporous conditions and constantly had followed after projection phases. Test recordings were given -- coincidentally -- repeatedly in a disintegration phase, but the projection phase (*Sch* = 0 —) could be also experimentally determined nevertheless in all these cases. This is an indication on how carefully one has to proceed in the establishment of the relations between the delusion and the ego function. The same refers to the following two ego functions:

5. *Total negation* (*Sch* = —! 0) led with two patients (3.4%), among other

symptoms also developed *persecution ideas*. One (No. 62) quite often developed persecution and guilty-of-sin ideas, had catatonic-like conditions, and was occasionally motor agitated. The other one had a *sensitive relations delusion,* gave episodic dementia in the ego form of total projection (*Sch* = 0 —) in the experiment test, but since with it the hypochondriac despair delusion was at the time of testing in the foreground, the test supplied the ego form of negation: *Sch* = —!! 0.

In both cases there are thus mixed delusion forms. We brought forth however these cases nevertheless because them are considered clinically as projection delusion patients. The phase in which these patients were tested was precisely not that of projection delusion ideas but that in which they developed negation delusion ideas. We wanted to refer here to this source of error. The above said is also valid for:

6*a) Total inflation* (*Sch* = 0 +!), which we found only in a case of projection delusion patients (1.7%) (No. 53). Here it concerns the case of E. Stumper, where an organic *Encephalopathia saturnina,* thus a poisoning, was accompanied with persecution ideas and the person in the experiment nevertheless produced the ego form of inflation (*Sch* = 0 +!, 0 +).

This inconsistent case in our opinion belongs into the group of those delusion formations with those where the delusion function is caused not by the foreground ego but by the background ego (Th. K. P. = ± —!). (See later the following argument about the role of the background egos in delusion formations.)

6*b) Inflative projection* (*Sch* = 0 ±) was the prominent ego function (7: 10) and likewise with a projection delusion patient (No. 71). This concerns a manic heboid, *paranoid-projective* (*p* —) who developed rambling, erratic inflative delusional ideas (*p* +). Its decisive ego function, the inflative projection, corresponds therefore completely to the clinical picture.

6*c) Negated inflation*, thus the inhibition (*Sch* = — +), is noted likewise *only with a case* of prison psychosis (E. Stumper) (1.7%). The patient developed accusation ideas: "One suspects him of homosexuality." This patient stated at the time when taking the test that he was the son of God (*p* +!). The fight against these inflative ideas came to light in the test in the ego forms *Sch* = — +!. He probably developed the projection delusion ideas at another time when he however was not tested.

6*d)* Also the *integration* (*Sch* = ± ±) came forward with disintegration with one case of persecution delusion (No. 172). The paranoid-schizophrenic

patient gave three times the total projection form *Sch* = 0 — and once the projection form held back with compulsion (*Sch* = ± —). We have inducted the case ego-psychologically nevertheless into the group of integration-disintegration since in the succession of the ego forms as shown the tendency of the integration is the most decisive: *Sch I:* ± ±, *Sch II:* + ±, *Sch III:* ± ±, *Sch IV: 0* ±, *Sch V: 0* +, *Sch VI:* 0 0. In this order of the *dismantling* of the ego functions we believe the prominent tendency has to be determined to be integration and disintegration.

III. The following ego functions in our material were *never* decisive in the projection delusion: 1. total introjection (*Sch* = + 0); 2. compulsion (*Sch* = ± 0); 3. introjective inflation (*Sch* = + +)*;* 4. introjective inflation also projection (*Sch* = + ±)*;* 5. inflation held back with compulsion (*Sch* = ± +).

2. *Specifics*

The Ego Psychology Classification of the Projection Delusion

Ego-analytically we must handle the projection delusion patients in two large groups of delusions.

A. The group of total projection (*Sch* = 0 —!).

B. The group of deprojection.

Here we differentiate between four sub-groups:

B 1. *Inflative deprojection* (*Sch* = 0 ±), where the the risk of total projection (*Sch* = 0 —!) is tempered by means of inflation. This deprojection action seems to occur extraordinarily rarely; we found it only once among 180 delusion formations.

B 2. *Introjective deprojection* (introprojection: *Sch* = + —!)*,* In which the projection danger is devalued by incorporation, by introjection. It appears clinical as a delusion of sinfulness.

B 3. *Compulsive deprojection* (*Sch* = ± —!), the projection held back with *compulsion*, is likewise a rare form of projection delusion. We found it three times among 180 delusion formations.

B 4. *Destructive deprojection* (*Sch* = —! —!), a relatively frequent complex delusion formation, is made by the deprojection when destruction ideas in an extremely dangerous form appear. Here the projection danger is

interlaced with the destruction delusion.

We now will show each group in sequence.

A. The Total Projection Delusion

Ego-analytically here the unifunction of total projection with quantity of tension dominates. The braking attitude of the *k*-ego is completely switched off. Among 180 delusion formations total projection figures as the decisive ego function in 20.5% (37: 180) and among the 58 projection delusion patients in 32.27%.

B. The Deprojection Delusion Formations

The commonality of this group of delusion formations consists in that the ego tries to ward off the danger of the projections by the involvement of other ego functions. This succeeds indeed with the ego up to a certain extent in the deprojection with inflation, introjection, and compulsion. However the danger increases for the self and the collective when the ego switches on the destructive negation.

B 1. Deprojection Through Inflation

As previously mentioned, we found inflative projection (*Sch* = 0 +) in only one case (No. 71), that of the manic-form heboid, whom we have generally already treated.

B 2. Deprojection by Introjection

The Introprojection Delusion. The Delusion of Being Sinful

a) *Definition: Introprojection delusion is that projective delusion form, with which the moved-out omnipotence* (*p* —) *in the form of all-guilt becomes incorporated into one's own ego* (*k* +). The distribution of power is here pathological for two reasons. First of all, because one's own ego carries the omnipotence. Secondly, because the ego converts the transferred-out omnipotence into an *all-guilt* of one's own person. The ego is guilty that the world is about to die, that humans die, that someone was poisoned, that someone committed suicide, etc. *This all-guilt is however basically only an omnipotence directed against one's own person in the form of guilt.* Because without omnipotence the ego would not be able to take the blame for all the evil occurring in the world. While with total

projection delusion (*Sch* = 0 —!) the omnipotence will be transferred out to a *stranger* from whom then his own person becomes persecuted and with *intro*projection delusion the person is tormented by his or her own ego with the transferred-out power that has been incorporated by means of introjection (*k* +). Thus ego-psychologically the *being sinful delusion* occurs.

The final aspect of the delusion of sin is the same need after having part in the other; only here the participation is pathological because it precisely manifests itself in *culpable having part* in the other. The partners in the participation are bound to one another by the guilt. If a melancholic woman accuses herself that her beloved man or their loved child got sick or died because she had sinned herself, then the participation with the man or the child in a pathological form becomes precisely created by this assumpting of guilt.

The diastolic nature of the projection emerges with that delusion of sin therein that the guilt of the loved partner becomes expanded -- absolutized -- very soon also on others, strangers similarly as with the persecution delusion. The delusion of sin is thus that form of the general projection delusion, with which one's own ego receives the projections. *Thus all guilt comes from the omnipotence.*

b) Clinically: The following delusion forms belong to the introprojection delusion group: *devil and hell delusions, poisoning delusion* (the person accuses himself of having poisoned family members or strangers); *cosmic, physical or magic omnipotence delusion,* with which the person develops the delusional idea that he would have basically directed other people in a magic way; quarrel delusion with self-accusations. The introprojection delusion of sin is accompanied quite often with delusional *masochism,* more rarely with exhibitionism, very rarely with allothanatomanic (homicidal) ideas. The clinical diagnosis is set mostly at melancholia or at paranoid schizophrenia and at schizomania or paranoid depression. Rare forms of the introprojection delusions are: morally-offended attitude (No. 86, 87). *Quite often we find with these patients suicidal thoughts* (No. 72, 74, 75, 84), *attempted suicides and hallucinations* (No. 72, 74), *in particular body hallucinations as organ psychosis* (H. Meng) (No. 76, 77, 89). So No. 89: “This head is contorted and must be operated on, the inguinal lymph nodes do not work and must be removed; he has bacteria in his head and wants surgery.” (a case of E. Stumper.) Also stuporous conditions are noted (No. 75, 89). Once we found the introjection delusion with the mythomania (*pseudologia phantastica*, No. 84).

c) Experimental ego analysis with delusion of sin:

1. The decisive ego function with delusion of sin is: *introjective projection, Sch* = + —!, + —. We can make this ego function experimentally apparent in

seven of fifteen delusions of sin cases (No. 31, 72, 73, 74, 75, 76, 77). In the cases where the delusion of sin is accompanied with another leading ego function at the time in the experiment, the delusion of sin was not in the foreground. The ego functions leading in these cases corresponded however to the *actual* foreground delusion form respectively the actual existing delusional manner of behavior completely. In addition, we enumerate these cases, since these patients developed before or episodically also the delusion of sin.

2. *Total negation* in 3 of 15 cases. In case No. 62 the delusion of sin was connected with *catatonic form rigidities;* in case No. 63 with hypochondriac *despair delusion* and organ hallucinations; in case No. 66 the delusion of sin had preceded a catatonic rigidity (*Sch* = — 0: 8 times).

3. *Total projection* led once among the 15 delusion of sin forms. Here it concerned a manic-depressive patient, who had been interned fifteen times (Ettelbrück) and in the melancholic phases developed delusion of sin ideas. The man supplied four times the form of the total projection (*Sch* = 0 —) and four times the disintegrated ego form (*Sch* = 0 0), four times the negative ego (*Sch* = — 0) and once the negated projection ego form (*Sch* = — —) in 13 test results. The man figures ego-functionally thus in *three* ego groups: total projection, disintegration and negation. *These different ego functions indicate however constantly the phase in which he was tested.* The disintegration phase became in the patient history noted as a "stuporous" phase and the negation phase as a "manic" phase. We must assume that the noted idea of sin originates with the patient from a phase in which he was never tested. Otherwise one would have had to find precisely the introjection phase.

4. *Disintegration* (*Sch* = 0 0) came with the same patient, as we stated, and occurred in the phase of stupor.

5. *Integration* (*Sch* = ± ±) was also found in a depressive case with ideas of sin; however, the tendency for integration (*Sch* = ± ±*;* ± —*;* — ±) appeared five times in ten profiles.

6. *Estrangement* (*Sch* = — ±) led once in the preceding case (No. 163).

7. *Total introjection* (*Sch* = + 0) was the leading ego function with one 30 year old epileptic, who despite the idea of sin leans to exhibitionism.

No. 54: "He carries out dramatic scenes, wants to kill himself, drops on his knees and asks for pardon." (E. Stumper.) He died in the *status epilepticus*. Despite pronounced ideas of sin expressed here, beside that the introjection projection is missing. Probably it was precisely not at the time of the ideas of sin but in the

phase tested where he was under exhibitionistic power ideas.

In the seven cases, however, in which the person developed exclusively at the time of testing ideas of sin, the prominent ego function was *introjective projection.* This circumstance induced us to the acceptance that with that delusion of sin the decisive ego function is introprojection. On this fact we have already indicated in 1947 in the *Experimentellen Triebdiagnostik* [*Experimental Drive Diagnostic*]. In Table No. VI (p. 264) in the frequency rank range of the introprojection (ego form A2) figures melancholia in first place and schizophrenia in second. From the clinic it is however well-known that with the melancholia the delusion of sin represents the leading delusion form.

Deprojection with Compulsion

Projection Held Back with Compulsion. The Compulsion Delusion (*Sch* = ± —!)

a) *Definition:* With this delusion form of the deprojection group it is a matter of the persecution and impairment delusion patient, who tries to tame the projection delusion with the compulsion mechanism before or after the outbreak of his psychosis. The compulsion, which here both clinically and with the test ($k \pm$) is established, consists in the attempt to heal the projection delusion. *The deprojection is in our opinion constantly a spontaneous self-healing process.* The distribution of power remains also here pathological since the magic power is transferred to compulsive acts. The person lives henceforth not with the persecutor but with the compulsive acts and compulsive ideas in an inseparable participation entity. Of the 180 delusion patients only three (No. 90, 91 and 92) belong to this group.

b) Clinically: The patients develop first typical impairment and persecution ideas with hallucinations. Then the projections step into the background, and in the foreground the patients develop delusional compulsive acts, which appear once in compulsive *poriomania,* other times in *pyromania* or in different compulsions. As an example we mention here the case (No. 93) of a 34 year old actress.

Case 50: Her illness began with a projection delusion: She felt constantly insulted, harmed in the theater, spied on by her colleagues; thus she had to give up her profession. *For awhile she lived with her mother in a pathological participation.* Suddenly she had to give up however this living together with her mother because she was tormented by the compulsive thought *that she must kill her mother.* She moved into a hotel so that the killing thought was not executed. Her compulsive ideas were announced previously in other ways. With sexual

intercourse with a man, she had to think constantly that her partner bore an animal face. Since this experience on the street, she had always to fight the compulsion to pick up and eat horse or dog faeces. A happy feeling overcame her often and on the street she hears the pounding of horse hooves (*participative identity with animals*). Also cleaning and washing compulsions seized her.

c) Experimental ego analysis: This patient supplied the ego form *Sch* = ± — five times in six profiles*;* once with quantity tension in projection: *Sch* = ± —!. Ego-psychologically it is thus proven that she tried to hold back the projection delusion (*p* = —! , —) with compulsion (*k* ±). Her compulsion delusion is a spontaneous healing act against the dangerous projection delusion.

Case 51: The second patient (No. 91), a 16 ½ year old high school student, produced the picture of the projection held back with compulsion (*Sch* = ± —) before the outbreak of his persecution delusions. He also had poriomanic and pyromanic compulsions, furthermore the compulsion to hold religious or anti-religious discussions in bed when he was alone. This boy before his illness (paranoid schizophrenia) was *connected with his father participatively.* He became ill when this love became impossible.

Case 52: The third patient of this group (No. 90) had been interned in the institute Ettelbrück. He supplied in the test alternating the projection ego held back with compulsion (*Sch* = ± —) together with introprojection (*Sch* = + —). According to the description of E. Stumper the first symptoms were: Taciturnity, connectivity, unmotivated laughter, hallucinations and -- as in our case 91 -- talking to oneself. He believes himself watched and suspects hidden influences. People talk about him. Everyone had talked about everything that he thinks. “I had ardently thought that my mother had talked about me. I thought, now she has me.” … “There I gave her a blow and thought, now I am rid of her. *I heard that the mother is becoming younger, it is however the phenomenon of love nevertheless.”* (*Sic*!)* *The participation with the mother in love and hate was expressed by the patient.* To the picture of the projection delusion with this patient belongs still the idea that “another speaks through his mouth” and that “one wants to cut off his testicles. ” The experimental ego analysis shows the enormous effort of this patient to overcome the projection delusion with the help of the compulsion. He supplies three times in ten test results the ego form *Sch* = ± —*,* thus just as often as that of introprojection. We judge these efforts as signs of the self-healing process. We find also here the *paroxysmal* in the form of asthmatic seizures. [**Sic*! = Thus!]

B 4. The Destructive Projection. Deprojection by Destruction (*Sch* = —! —!)

Of 180 delusion patients 26, that is 14.4%, belong to this group. Of the 58 projection patients 11, thus 18.9%.

a) *Definition:* With this delusion form one can differentiate historically two phases. First is a usual persecution respectively relations delusion. Second is the destruction delusion phase in which the patient seeks to destroy either himself or the first loved and then hated object. The pathological distribution of power consists here that the delusion patient for the time being transfers the omnipotence over his person to the participation partner, he however then gives himself the power to use it for destruction. While in the first projection phase a negative personal hate relationship was still possible, in the second phase any personal kind of participation is made impossible since the delusion patient destroys either himself or the partner.

The two phases, which we divided here, flow together quite often into *a* delusion picture. The patient still preserves relations or persecution ideas, at the same time however destroys himself by delusional drinking addiction and attempted suicide, or he kills the object, from whom he feels injured. As example for this is the case of E. Stumper.

Case 53: A 50 year old typographer attacked his sister with an axe first, then his mistress and her mother. He killed his own sister and the mistress and seriously injured her mother. After this bloodbath he wanted to poison himself with gas, came into detention however without severe poisoning, and was then interned. After he had at first behaved completely confused and knew nothing about his action, he asked nevertheless for the assistance of an attorney and indicated that *he was persecuted for a long time by the three women. They were conspiring against him, affected him by rays, and threatened to kill him with an axe.* He indicated that he had been harassed by mysterious lights and that he had been brought intentionally to a hearse. Each memory of the purchase of the axe and of the act is denied by him. Also in the institution he assumes that the meals are poisoned. E. Stumper tested the man in two ten series. In the first series he gave in the V. G. P. I the ego form of *Sch* = — —!, thus that of the negative with increased projection, and in the V. G. P. IV *Sch* = —! —, thus the picture of increased destruction with projection. We assume in this case that the concurrence of projection and of destruction delusion led here to the tragic act. The sister lived a life of vice (prostitution?), exactly as the mother of the perpetrator. Behind the projection delusion we must accept a hate-love to the sister and to the mother. This hate-

participation was transferred by the patient to his mistress and her mother. He said that he was "the victim of a plot of the three women." With the destruction act he wanted to put an end to his participation with these women. -- Another case (No. 103).

Case 54: A 68 year old baker in Los Angeles killed a six year old child, whom he had repetitively raped, because he was afraid of being persecuted by the police. This child murderer supplied the picture of destructive projection in the test: *Sch* = —! — (V. G. P. II). [45]

Arsonists who feel themselves persecuted can likewise supply the picture of destructive projection. (Case No. 105 of E. Stumper.) They are led by the paranoid ideas to the destruction act.

b) The clinical manifestations of destructive projection delusion are:

1. *Negativistic, stuporous conditions* with persecution ideas and hallucinations (Cases: No. 93, 94, 95).

2. *Circular (manic-depressive) patient with projection and negation delusion ideas* (No. 96, 97, 98, 99), which can be associated with persecution ideas.

3. *Hypochondriac self-destructive delusional ideas* with impairment and persecution delusion, also quite often with body hallucinations (No. 100, 101).

4. *Display delusion with persecution ideas* (so-called channel letterwriter) (No. 102).

5. *Allothanatomania* (homocidal killer) on the basis of persecution delusion (No. 103: Child murderer, No. 104: Family murderer, No. 105: Arsonist with attempted suicide, No. 106: Attempted murder [brother-in-law], No. 107: Attempted suicide and murder, No. 108: aggressive violent criminal, No. 109: a paranoid, who constantly talked about robberies).

6. *Sell-destruction:*

a) Drinking addiction and attempted suicide with paranoids (No. 111, 112, 113, 114).

b) Drinking addiction with epilepsy (No. 115, 116).

7. *Organic, paranoid psychoses* (case No. 117: Encephalitis, No. 118 progressive paralysis).

II. The Inflation Delusion

Greatness Delusion (*Megalomania*)*, Bisexual Erotomania, Quarreling Delusion, Religion Delusion*

1. Generalizations

a) *Definition:* By inflation delusion we understand that delusion form in which the delusion formations are characterized by *power doubling* of one's own ego. The pathological participation with the loved and hated object occurs beyond reality in such a manner that the delusion builder becomes at the same time *both*, thus the person who receives the love is the one who gives the love. We have already mentioned suckling and masturbation as the physiological, ontogenetic model of this beyond-reality, transrealen participation. The phylogenetic model for this ego condition is the two-sexual being. This prototype is reflected indeed in the bisexual form of erotomaniacs, who precisely experience the hermaphroditic original primordial delusion-formation: They are at the same time both, man and woman, and can not understand the contradiction of this being a double nature. These bisexual sexual maniacs are mostly excessive masturbators and play in fantasy the role of both sexes, quite often in an addicted form. Men who lead a strong heterosexual life are possessed continuously also by homosexual demands. Women want to seduce each man and each woman. Being both is no problem for them. Thus an erotomanic woman formed out of a towel a penis for herself, and in this hermaphroditic condition she masturbated excessively before a mirror. Apart from the excessive bisexual masturbation they are still quite often possessed by *greatness ideas*. A 16 year old school girl who had never written a literary line lives under the delusion that she is the greatest novelist of all time. A 21 year old mathematician, an excessive masturbator, believes himself to be the greatest mathematician of the world. A 30 year old high school teacher who lives continuously in a bisexual obsession asked me nearly each hour whether he will be indeed the greatest man in the world. *Erotomania and megalomania are twin features of the same inflation delusion formation.* The last to be mentioned is a megalomaniacal teacher who wore pants in which he could put his genital on display. At the nightly exhibition outings he wanted to attract both sexes.

The third manifestation of the inflation delusion is the *quarreling delusion.* We knew these three phases of *megalomania, bisexual erotomania and quarreling* legitimately has been observed in the depth psychological treatment of inflative delusion patients.

Often these three phenotypes alternated in phases, or they appeared nearly at the same time. Some patients develop first greatness delusion ideas, then erotomanic bisexual ideas, and only in the end become quarrelers. Often we had the impression that the *quarreling delusion represents a spontaneous healing with the quarreling defect in the character.*

b) *The clinical* form of inflation delusion therefore shows the following manifestations:

1. *Greatness delusion:* Megalomania (No. 38, 39, 40, 41, 42, 43, 44, 45); 2. *Religion delusion* (No. 38), quite often with sadomasochistic coloring; 3. *Erotomania in a bisexual direction* with excessive masturbation and with inclination to exhibitionism or voyeurism (No. 46, 47); 4. *Quarreling delusion* (No. 39, 40); 5. *Thanatomanic obsession: a*) *Inflation* with killing ideas, quite often with murder thoughts against parents or marriage partner (No. 48, 49). We have the *Sch p*+ class in the Linnaeus as the class of the "lost genius and parents' murderer."[46] *b*) or inflation with suicide and simultaneous with lust-for-life thinking." (No. 50, 51). *c*) Drinking addiction with inflative paranoid ideas (No. 52). 6. *Organic psychoses* after poisonings. Case No. 53 of E. Stumper: Encephalopathia saturnina* with hallucinations and with paranoid ideas. In case No. 46 the patient in prison developed the Ganser syndrome** with conversion-hysteria signs (E. Stumper). [**Encephalopathia saturnina* = lead poisoning encephalopathy (disorder or disease of the brain)] [***Ganser syndrome* is a rare dissociative disorder previously classified as a factitious disorder. It is characterized by nonsensical or wrong answers to questions or doing things incorrectly, other dissociative symptoms such as fugue, amnesia, or conversion disorder, often with visual pseudo-hallucinations and a decreased state of consciousness. It is also sometimes called nonsense syndrome, balderdash syndrome, syndrome of approximate answers, pseudo-dementia, hysterical pseudo-dementia or prison psychosis. This last name, prison psychosis, is sometimes used because the syndrome occurs most frequently in prison inmates, where it may represent an attempt to gain leniency from prison or court officials. From *Wikipedia*]

2. *Specifics*

Experimental Ego Analysis of Inflation Delusion

With the 180 delusion patients we found 19 times the inflation delusion, that is in 10.5%. Based on the experimental ego analysis one can divide the inflative

delusion patients -- similarly with the projective -- into two groups.

A. *The group with a "total inflation": Sch* = 0 +! ; 0 +! ! ; 0 +! ! ! Total inflation occurred in 16 cases (8.9%) of the total material (180 cases), and with the specific inflation delusion patients themselves in *42.1%* was the decisive ego function.

B. *The group with "deflation"* contains cases in which the person tries to ward off the danger of inflation by engagement of other ego functions. The most frequent forms of deflation are:

B 1. *Estrangement* (*Sch* = —! ±; — ±), one decreases, respectively reduces, the inflation (*p* +) partly by projection (*p* —) and partly by negation (*k* —). The inflation delusion patient gives the alienation reaction in 15.8% as the leading ego function (No. 138, 161, 164). Case 164 was a paralytic.

B 2. *Destructive inflation respectively negated inflation* (*inhibition*) (*Sch* = — +; —! +! ; —! +) the decisive ego function was only with one case (5.2%) of the megalomania delusion (No. 119). Here the danger of inflation becomes defended by denial or repelled by destruction.

C. We find however with inflation delusion formation also ego functions as decisive ego activities that are not of an inflative nature. In these cases was *noted* an inflation delusion form (for example megalomania) *in the patient history,* but the patient was tested at times in which *other* delusion forms stood in the foreground. We enumerate also these cases in order to be able to indicate this discrepancy between the clinical and experimental results.

C1. *Destructive projection* (*Sch* = — —! *;* —!! —! *;* —! —!) was the leading ego function in three cases (No. 96, 98, 115) (15.8%). In case No. 96 it concerns a "manic form paranoid," the influence and the injury delusional ideas developed with hallucinations, their contents interpreted by the psychiatrist partly negative and partly positive in a slightly megalomania sense (E. Stumper).

The megalomania was thus here not suggested as a continuous delusion form but only as episodic contents of the hallucinations.

Case No. 98 originates likewise from the institute Ettelbrück and is diagnosed as "manic-depressive" and made in the hypomanic phases of megalomania spending money. Here this is also not about what one understands by *"inflative* paranoid."

Case No. 115 was a 57 year old alcoholic that according to E. Stumper was

reported as epileptic form convulsions. *In the delirium he showed megalomaniac delusion ideas* without an actual delusion system.

C 2. *Total projection* (*Sch* = 0 —!) with episodic greatness ideas figures twice in our material (No. 5 and 10, 10.5%). No. 5, an 18 year old girl, was observed by me for a year. Her clinical diagnosis was made as "schizomania." The schizoid part showed itself with her in projective persecution ideas (she gave also the appropriate ego form of *Sch* = 0 —) and in her greatness ideas the bisexual erotomania. In this phase she gave also the form of inflative projection: *Sch* = 0 ±. Her psychosis was however strongly mixed with manic-depressive symptoms.

The case No. 10, a 23 year old student, whom I had observed, was tested quite often in a projective paranoid phase. The greatness ideas showed up with him only episodically and mostly before a persecution delusion episode. He believed that he could become a famous psychologist or an actor.

C 3. *Introprojection* (*Sch* = + —!) (No. 78) in the second series led (5.2%) with a patient of E. Stumper. The clinical diagnosis indicated: Paranoid schizophrenia. In his village he believed himself *to be worth more than all the others.* Later he felt watched and expressed ideas of poisoning. In this phase (first series) the man supplied three times the form of total projection (*Sch = 0* —), once however the inhibited inflation form (*Sch* = — +) and once the negated and projective inflation form (*Sch* = — ±), that is the estrangement. In the second series the same man produced the introprojection form (*Sch* = + — seven times in ten recordings). We must assume that he lingered at this time in a deep depression. The syndrome of melancholia: *d* +!!, *d* +!, *k* + and *s* —!, is five times present in this ten series.

C 4. *Disintegration* (*Sch* = 0 0) played also only once a decisive role (No. 178) among 19 megalomania delusion formations (5.2%). This case of E. Stumper concerns a 60 year old, already 30 years as a paranoid heboid, staying in the institution with a drinking addiction and *homosexual* inclinations. As initial symptom in the patient history was noted the *"inventor delusion."* Disintegration (*Sch* = 0 0) corresponded completely to his total deterioration with aging; he gave this the ego form five times in 13 recordings. The paranoid reveals by the three recording total projection (*Sch* = 0 —).

We can conclude the discussion of these "failures" in the experimental ego analysis with the following statements. (See Fig. 16.)

1. We found in total 63.1% inflation, 31.5% the projection and 5.2% disintegration as the decisive ego function with delusion patients, who among

others also developed megalomania ideas. Inflation was thus experimentally twice as frequently as the leading ego function with megalomania as projection.

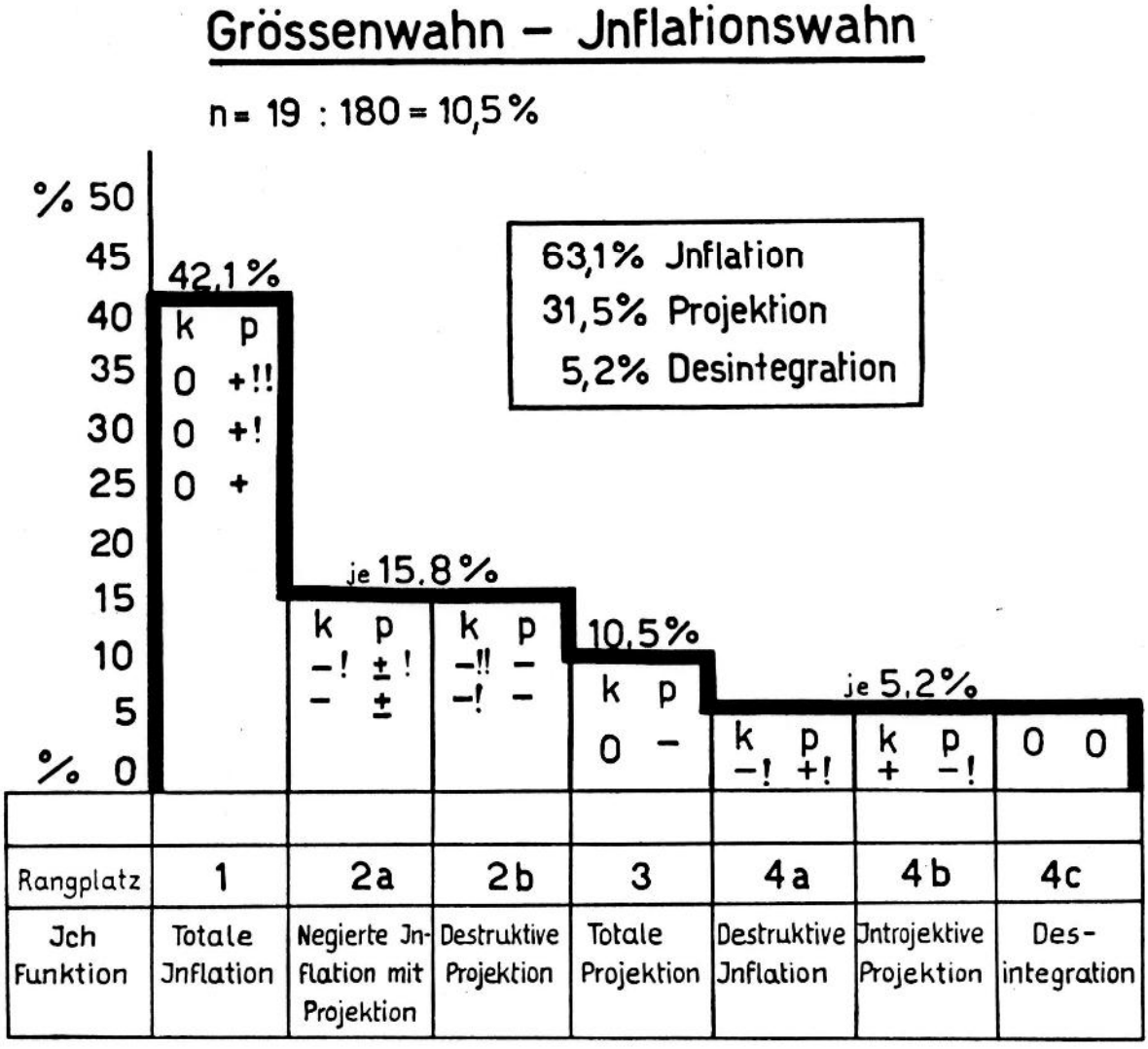


Figure 16: Inflation Delusion and Ego Functions

[*Größenwahn* = Megalomania or Delusions of Grandeur; *Inflationswahn* = Inflation Delusion; *Rangplatz* = Rank Order]

2. The so-called *"failures"* in the experiment were either projection-schizophrenic or manic-depressive patient or heboid mixed psychotics, who had *before* their projective or *before* their depressive phases had *temporary ideas of grandeur*, but who at the time of testing however developed different delusional ideas that corresponded completely to the actual ego forms. The analysis of these "failures" encourages thus the thesis that ideas of grandeur can be diagnosed in the experiment by the inflative ego functions (*Sch* = 0 +, 0 +! , 0 +! !).

III. The Introjection Delusion

Pre-schizophrenic, pre-catatonic or heboid omnipotence ideas or ideas of sin or delusional order ideas with movement stereotypes and verbigeration**.* [**movement stereotypes* = rhythmic movements of the body; ***verbigeration* = stereotyped and meaningless repetition of words and phrases]

Delusional perversion ideas with sexual power ideas with heboids: Fetishism, exhibitionism, masochism.

1. Generalizations

a) *Definition: Introjection delusion* is the delusion form of having power par excellence. While the pathological power transmission of the diastolic projection and inflation delusion forms constantly refers to the possibilities of being, that is on its *being omnipotence*, with the introjection delusion form it always concerns the possibility of having, thus the *having omnipotence.* That means persecution and the megalomania thinking expand pathology of the *being power* of one's persecutors and respectively one's own person. The introjection delusion carriers however want not only to be everything but to *have everything,* that is to *have* all that the other sex, his parents, his superiors, the state, and the whole world possess. *The false power transmission refers thus to the having. With introjection delusion therefore the having power that the other one possesses is incorporated into one's own ego.* These delusion patients do not develop relations, meanings, or persecution ideas, they do not hallucinate; however, they stretch the having power of the ego in false ways beyond the boundaries of reality. We say that they make out of the pathological being possibilities pathological having possibilities. *They are delusion patient of having and not of being.* The illness comes off thus through the *ego systolic* positive *k*-function and not through the ego diastole positive or negative *p*-function. Their premorbid personality is characterized by a pathological increased pride. He or she takes all that one has in knowledge, character traits, and property. These egocentric *have narcissists* are the result of the *k*+ function. A further characteristic is the movement stereotypes and the verbigeration. The requirements for omnipotence can refer also to *cosmic* powers. The *magic* power is experienced quite often *actively*; so for example with heboid exhibitionists, who incorporate a magic power to their sexual member. With the exhibiting they tend to keep a certain distance from the victim in order to be able just to read correctly on the face of the observing partner the power of the phallus. Also sadistic demands mix quite often with this phallic power. Some experience having power passively, thus in such a way that the partner has him or her completely in his or her power. Thus in particular with *masochistic* heboids or pre-schizophrenic catatonics. In

these cases also sinfulness ideas, thus, all guilt can occur. All guilt is constantly the *passive* form of the omnipotence.

A particular form of the introjection delusion ideas is *fetishism.* The fetish is always a symbolic replacement for the sex organ that the person does not have in reality. With the fetish the person is completed to a two-gender being. In this way also the pathological kind of participation of this delusion patient becomes understandable. If the child can fall asleep only with a piece of fur or only with a teddy bear, then he completed himself with this "fetish" into a double being of mother and child. He has his missing mother in the form of the piece of fur or the teddy bear or the cushion taken into possession. He holds firm even in sleep the fetish object in his hand. With the fetishers the same happens ego-psychologically. With the shoe or glove or the hair, he has taken in possession the sex organ of the other sex.

The magic charms that the magician has taken in his possession lend to him a magic power that only the God ancestors possess. By the having power agents or any religious device (Tjurunga) the magician produces the participation between the dead ancestors and his totem animal and his own person. He himself is now by the possession of the magic charm or the cult instrument the bearer of this magical power.

The same happens also with the delusion patient, who incorporates a cosmic power into his own ego and now believes he possesses a magic omnipotence over his fellow men. The delusion of sin -- as we already discussed with introprojection -- is likewise the result of a magic omnipotence introjection in which the person uses the omnipotence, which he has incorporated into his own ego, for the destruction of other persons or the whole world and thus from the omnipotence developed an all guilt. The patients have also with gambling (playing cards) a particular relationship: They nearly always win.

b) *The clinical aspects* of introjection delusion indicate the following manifestations: 1. *Cosmic and magic omnipotence ideas, telepathic delusional ideas;* 2. *Sinfulness ideas, all guilt ideas* (for example with melancholiacs); 3. *Sexual power ideas: fetishistic, masochistic, exhibitionistic delusional ideas;* 4. *Pedantic, compulsive order ideas* (*"compulsion delusion"*). The patients carry these delusional ideas quite often in a *forephase* of negativistic catatonia or as a defect symptom *after* a paranoid-depressive episode or in a melancholia condition. As with the inflation delusion ideas, thus we find also the introjection delusion ideas mostly *at the beginning* and *at the end* of a psychosis. This circumstance is connected to the fact that we have so rarely encountered the introjection form among the delusion patients. 5. *Defiance reaction,* protest against any authority: It

plays the role of knowing everything. 6. *Inclination to play-acting.* 7. *Pathological narcissism* also belongs to the illness picture.

The frequency of the introjection delusion form is small: 4:180 = 2.2% (Cases No. 54, 55, 56 and 57).

2. *Specifics*

Here we must be content with four cases to show the connection of the most important clinical symptoms in connection with the results of the experimental ego analysis.

a) *The Heboids*

Case 55 (as a delusion patient, University Clinic Tubingen, case No. 304). The 19 year old education assistance in an *anthroposophical** home offered the picture of a hebephrenic. Already the choice of the occupation place (anthroposophical home) could occur through the power of introjection. She showed a grotesque juvenile appearance, made banal jokes, was negativistic, critically snippy and flopped with her flat-affect *self-assertion* (*k* +) and often persisted in *movement stereotypes* and *verberations.* Premorbid she took a strong protest attitude toward her mother, separated from society, and looked for connection with anthroposophical circles. After electric and insulin shock treatment the hebephrenic condition faded away. [**anthroposophical* = Anthroposophical medicine is a complementary medical direction connecting medicine with Rudolf Steiner's Anthroposophy and is now practiced in 80 countries. Anthroposophical medicine is based on the teachings of Rudolf Steiner. From *Wikipedia*]

From the introjection crisis we single out the following phenomena: 1. She was always self-willed and represented in principle another world view than her mother. 2. Claimed she knew much more than her mother and others and *protested strongly against any authority.* In her patient history we read: “Perhaps I was in former times too good. Always danced to the tune of others. Now I do not do that any longer: The same racket is there. It is I however who pipes the tune and do not anyway go along any longer with my mother.” “Have given my mother a slap on the ear because she would otherwise still be more sassy to me.” One sees that this 19-year-old daughter incorporated the full power of the mother in her own ego. 3. She *“feels*” all that is happening to someone else: *Magical all knowledge.* 4. *Compulsions:* Order and cleanliness rituals. 5. Extremely orthodox attitude to the church. Wants to proselytize the mother with force.

In the experiment test this hebephrenic girl supplied seven times the ego form of total Introjection (*Sch* = + 0) and three times that of introprojection (*Sch* = + —).

Case 56 (as a delusion patient No. 55). This 20 year old student was presented by us already in the first volume as the person with a "sweating hand fetish." [47] Here the hand of the mother, that of a kitchen girl, and later certain more masculine persons had exercised magic power on him. Also smelling gloves, discarded skirts, and underpants excited him. Temporarily he still had the fantasy of being beaten (*masochism*) and likewise sexualized it.

This boy supplied six times in six profiles the introjection picture *Sch* = + 0; once with quantity tension (V. G. P. III). Since this first report we had the opportunity to examine the boy again two years later and carry through a short analysis with him. The patient made now a *heboid* impression. In particular we noticed his volatility, his bizarreness, the pathetic theatrical behavior, his inability to work, the hypochondriac ideas regarding the smallness of his sex organ, the projection readiness and the moodiness. He has become over the years addicted to playing card games and that had worsened but he still subsisted from the card playing. The hand fetish inclination remained unchanged.

b) *Delusion of Sin and Exhibitionism*

Case 57 (as delusion patient No. 34). A 30 year old epileptic (Ettelbrück) carries out dramatic scenes in the institution, wants to kill himself, throws himself on his knees and asks for pardon. His main sin indeed is practicing exhibitionism (E. Stumper). Here he shows thus the introjection delusion in the narcissistic power transmission to the sexual member and in his magic fascination of the environmental persons by means of his exhibition. Therein consists the *active* have power phase. Then however he turns around the omnipotence into a delusion of sin, thus into *all guilt* and stays in a passive, passionate, masochistic phase.

The man produced the introjection form *Sch* = + 0 four times in a ten series and once (V. G. P. X) with quantity tension (*Sch* = +! 0). The further ego forms point to epilepsy (*Sch* = ± —, — ±). He died in *status epilepticus* in the institution.

c) *Pedantic Awkward Superiority with Schizophrenics*

Case 58 (as delusion patient No. 56) is a 57 year old businessman, who abounded with an egocentric narcissistic character, bursting with self-satisfaction and pride for his achievements. This ego condition is reflected in his ten series in the introjection forms. V. G. P.III-IV: *Sch*= + 0, V. G. P. VII: *Sch* = +! 0, V. G. P.

VIII: *Sch* = +!! 0, V. G. P. IX: *Sch* = +!! 0, V. G. P. X: *Sch* = + 0. He gave thus 6:10 to introjection forms. Later he falls first into a depressive-paranoid state, then into a slight catatonic condition with anxious agitation, with negativism and self-destruction urges. From this phase we do not have test recordings, only V. G. P. II: Sch = ± ± that indicates a disaster delusion. Improved, he is very industrious, *pedantic, painfully meticulous,* from ironical superiority. From this phase stems the introjection Sch = +!! 0.

IV. The Negation and Destruction Delusion

1. *Negativistic self-depreciation delusion,* 2. *Hypochondriac despair delusion,* 3. *Allothanatomania and autothanatomania, delusional drinking addiction and suicide ideas.*

1. Generalizations

a) *Definition:* Regarding the power transmission and distribution of power the *depreciation of any having and being power is characteristic* of the negation delusion. While the introjection delusion patient affirms the have-addicted omnipotence, the negation delusion creator *denies* all values and objects that its counterpart affirms. *The negativism is the result of the depreciation of all values.* One could say: The introjection delusion is based on a pathological affirmation of have power and the negation delusion on a pathological denial of it. Quite often not only have power but also each being possibility is denied and canceled by these patients.

The relationship of the negation delusion patients to participation follows from the negative attitude to have power and being power. They deny for the time being having any part with the other; later their negation grows to destruction, and they want to destroy themselves or the partner or the two together.

b) *Clinical manifestations of the negation delusion.* 1. *Negativistic self-depreciation, unworthiness delusion with pre-catatonia, catatonia, hebephrenia.* 2. *Delusional hypochondria with despair delusion.* 3. *Autothanatomania: delusional drinking addiction, delusional suicide ideas.* 4. *Allothanatomania: Extermination ideas of family members, marriage partners, etc.*

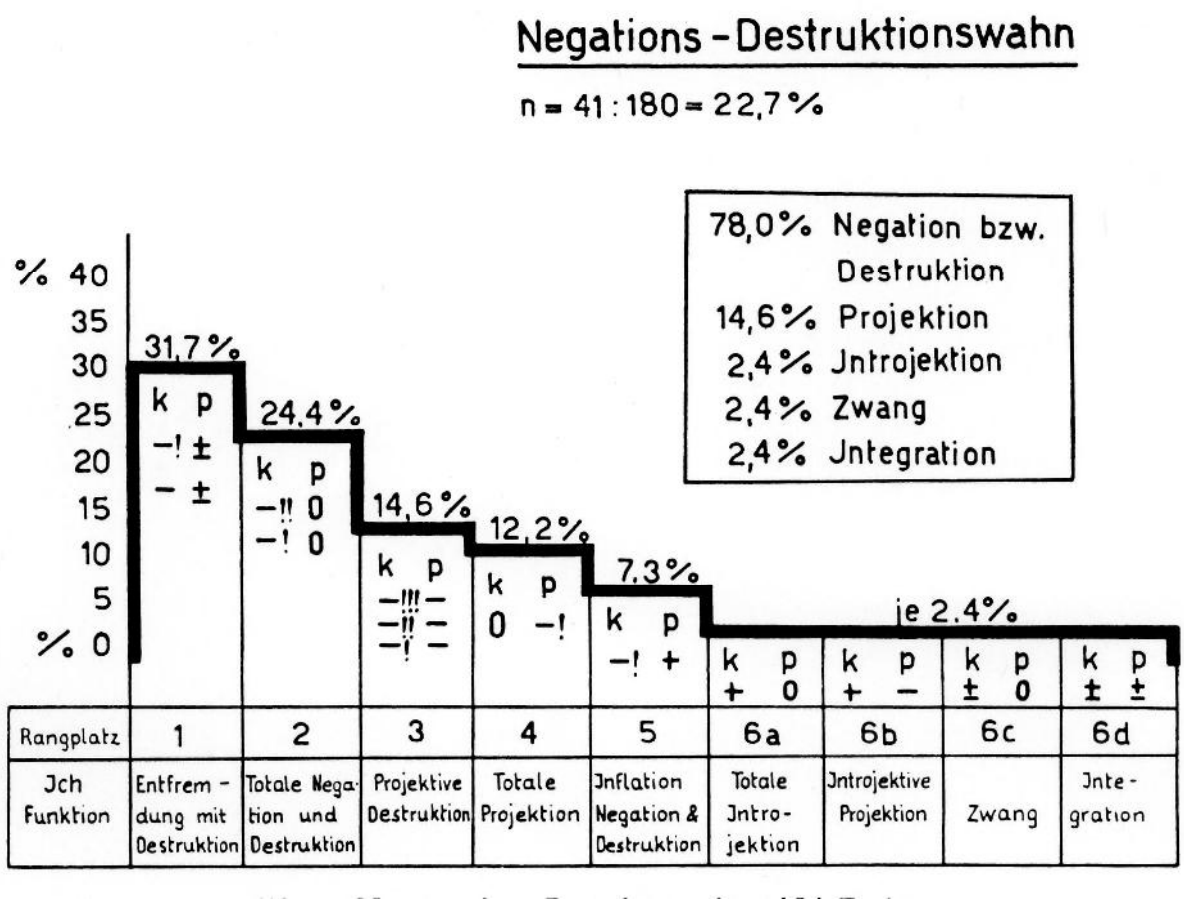


Fig. 17. Negation Delusion Respectively Destruction Delusion and Ego Functions [*Destruktionswabn* = Destruction Delusion]

2. *Specifics*

Experimental Ego Analysis (Fig. 17)

A. *Total pure negation and destruction: Sch* = —! 0*;* —!! 0*;* —!!! 0. In the preceding discussions we represented this classic form of the negation delusion. Of the negation delusion patients 24.4% belong into this group of classic total negation. Of 11 negativistic catatoniacs 5 supplied total negation ego as the decisive ego function. Of the 20 hypochondriac delusion patients total negation was likewise the leading ego function in five cases.

B. *Denegations* are negation respectively destruction delusion forms that join the destructive negation with still different ego functions such as inflative projection, simple projection, and inflation,. The clinical picture is quite often prognostically aggravated by these concatenations and only rarely weakened.

B1. *Destructive estrangement: Sch* = —! ±; —! ! ±, was most frequent with the destruction delusion patients: 31.7%. These delusion formations are ego-psychologically characterized as follows: The ego rebels against the abandonment (*p* ±) in destructive form (*k* —!). *Clinically* this destructive abandonment manifests itself:

a) in *jealousy delusion* (No. 129, 130, 131);

b) in *hypochondriac delusional ideas* (No. 132, 133, 134, 135, 136);

c) in *persecution ideas with destructions,* possibly with stuporous (No. 137) and hallucinatory conditions (No. 139);

d) more rarely in *hypomanic drive for prestige* with destructive ideas (No. 138);

e) in *allothanatomania* (fig. 18). Case No. 140 threatened the mother with a knife; Case No. 141 made an assassination attempt on his friend because of jealousy of the woman; No. 142, an epileptic, attacked the grandmother sexually, case 143 showed persecution ideas with accompanying aggressions; No. 144 threatened the woman with death; No. 145, a paroxysmal maniac who was a public danger by his act of violence (E. Stumper);

f) in *autothanatomania,* thus self-destruction delusion, is the most frequent clinical feature of the destructive alienation delusion. Thus:

α) *Narcomania* (No. 147, 148: with drinking addiction);

ß) *Drinking addiction* with various delusional ideas (No. 149, 150), thus with ideas of being offended; No. 151: destruction while intoxicated; No. 152: with delirium tremens; No. 153: with suicide ideas and fugues; No. 154, 155, 156, 157: with Korsakow syndrome*; No. 158: with stupor, hallucinations and attempted suicide; No. 159: with showing off, lack of inhibitions and attempted suicide; No. 160: with hypochondriac delusional ideas and repeated attempted suicides; No. 161: with megalomanic delusional ideas and suicide thoughts, No. 162: with criminality (burglar) and attempted suicide (E. Stumper). Figures 19-20.
[**Korsakow syndrome* = In the late 1990s, Florian Thalhofer began developing a software program to produce a documentary about alcohol consumption to accompany his Master's thesis. During his research, Thalhofer learned about an effect of extreme alcoholism known as "Korsakoff's Syndrome," characterized by short-term memory loss and a compulsion to tell stories. Thalhofer borrowed the name for his thesis and from the first Korsakow-film, "Korsakov Syndrome." From *Wikipedia*]

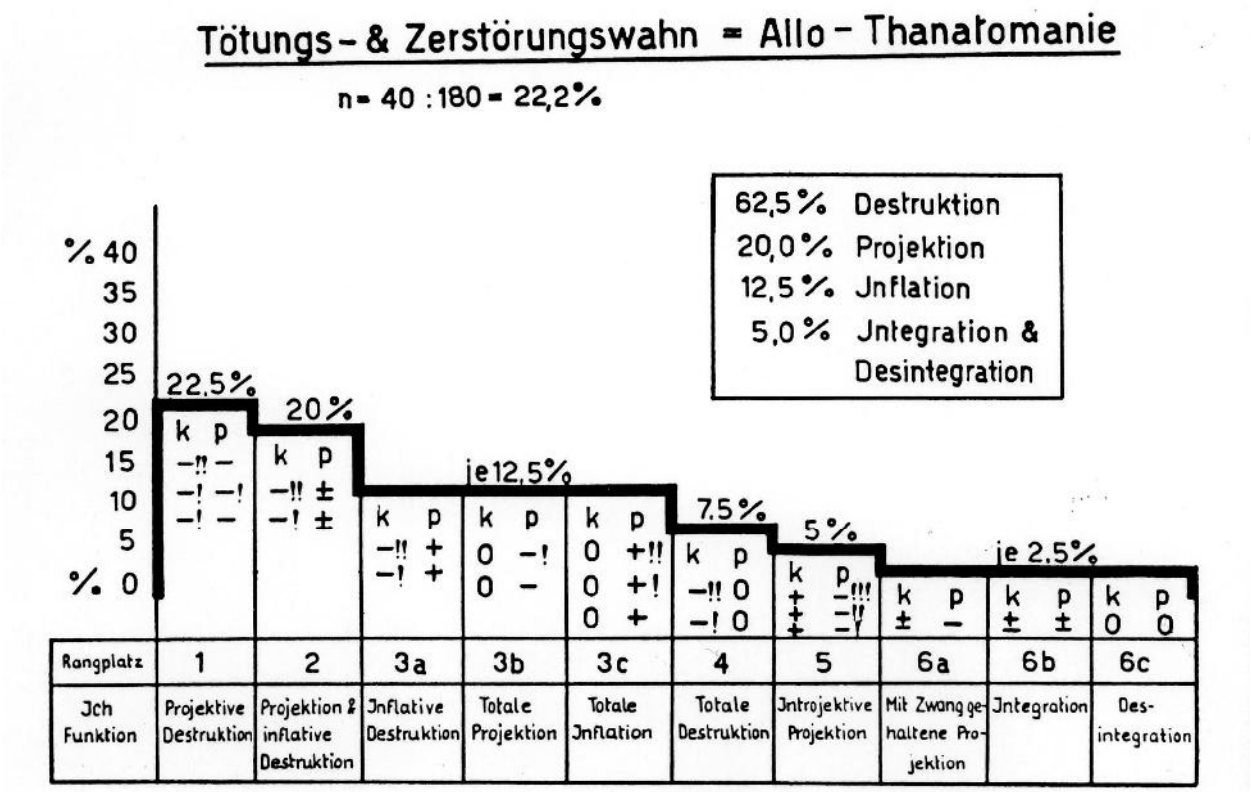


Fig. 18. Killing Delusion and Destruction Delusion, Allothanatomania and Ego Functions

[*Tötung*= Killing; *Zerstörungswahn* = Destruction Delusion; *Allothanatomanie* = Killing Others Mania]

g) Psycho-organic delusion formations can produce also destructive estrangement ego as the leading ego function. No. 163: hyperazetonemie with relationship and delusion of sin and confusion; No. 164: progressive paralysis with greatness and persecution ideas and with manic-depressive traits; No. 165: Jealousy delusion with a paralytic; No. 166: Schizophrenia defect that developed gradually (cases of E. Stumper).

B 2. *Destructive projection*: *Sch* = —!!! —; —!! —; —! —: was the leading ego function with 14.6% of all 41 destruction delusion patients. This delusion form was represented in detail clinically with the projection delusion forms. The cases No. 93 to 118 belong to this group of the destruction delusion. (For their clinical manifestation see under B 4 of Projection Delusion.)

B 3. *Destructive inflation*: *Sch* = —! +; —!! + is that destruction delusion form that either by a destructive negation defends itself against the pure inflation or

as the leading ego function is affected by the still more dangerous inflation. Among the destruction delusion patients this negation form only came to 7.3%.

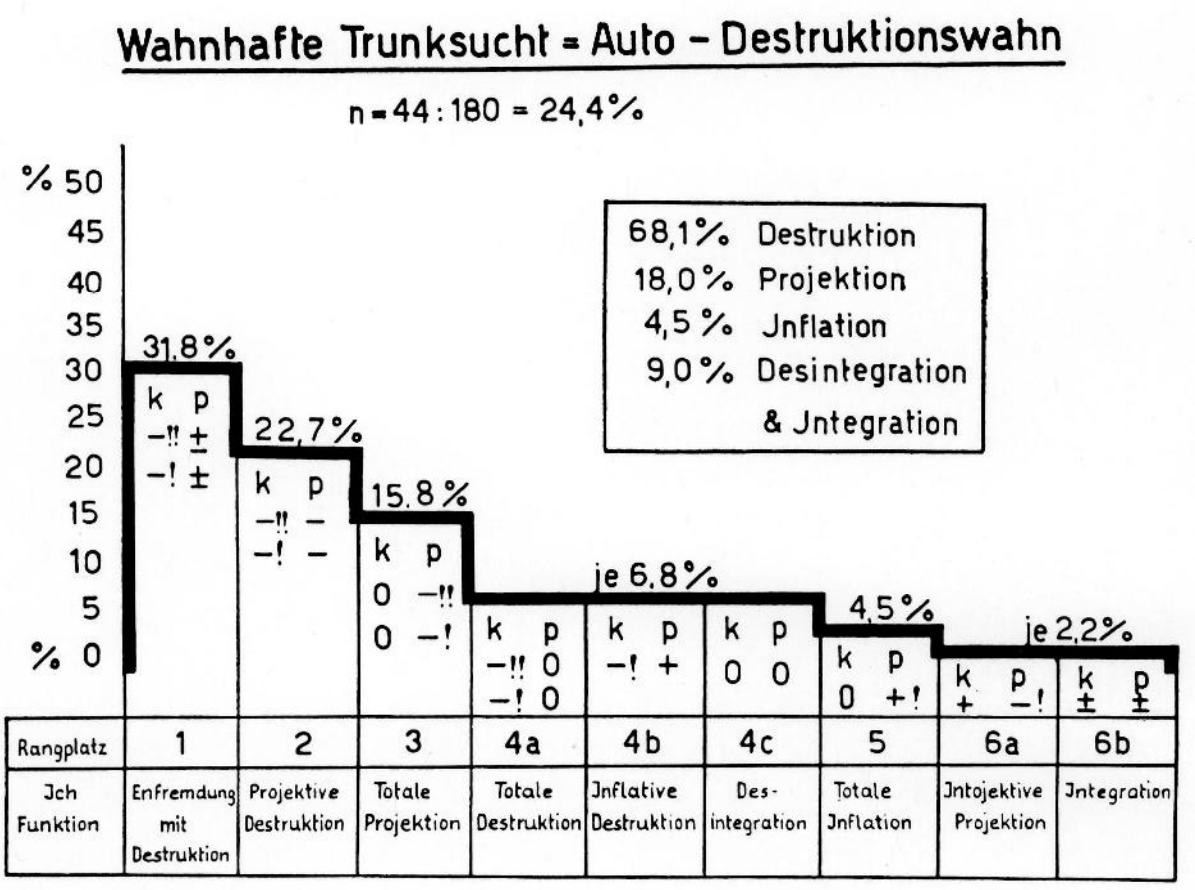


Fig. 19. Delusional Drinking Addiction, Self-Destruction Delusion, Autothanatomania and Ego Functions

[*Wahnhafte Trunksucht* = Delusional Drinking Addiction; *Auto-Destruktionswahn* = Self-Destruction Delusion]

The clinical manifestations were the following:

Transition of the inflative paranoid to the negativistic-destructive catatonic with quarreling:

Case 59 (as a delusion patient No. 119): A 54 year old man with *greatness delusion ideas* (from the institute Ettelbrück) had read many psychology and philosophical works (*p*+); "compulsion" was placed in the center of his philosophy and he maintained: "The compulsion is the parasite of meaning and consciousness." Compulsion has magic powers and wants to do its duty "until mankind appropriately recognizes *it*." Apart from these inflation ideas (*p*+), he

develops also destruction ideas in such a way that in his articles -- which however never appear – he seeks to make medicine and the law ridiculous. The man gave six times in ten recordings the ego form of negated inflation, about which the ego form was of a *destructive* nature (V. G. P. IX: *Sch* = —!! +).

No. 120: A hebephrenic with inflation and autistic-negativistic aggressions.

No. 121: Quarreling with hypochondria (*Sch* = —!! +).

No. 123: Robbery murderer in prison (*Sch* = —!! +).

No. 124: A paraphrenic* vagabond with hallucinations (*Sch* = —! +, — +!!).

No. 125: Epileptics with jealousy delusion, hallucinations and paroxysmal fits of rage.

No. 126: A drinking addict who threatens to kill a woman and a child (*Sch* = —! +, — + 9: 10).

No. 127: Delirium tremens with raving and contentiousness.

No. 128: Drinking addiction, with the destructive inflation in the experimental complementary drive profiles (E. K. P.) emerges in the form of *Sch* = —! + (3: 10) —! +.

[**paraphrenic* = Paraphrenia is characterized by the preoccupation with one or more semi-systematized delusions. These delusions are not encapsulated from the rest of the personality as in delusional disorder. The affect is notably well-preserved and appropriate, as is the ability to maintain rapport with others. There is no intellectual deterioration, no flat or grossly inappropriate affect. Disturbance of behavior is understandable in relation to the content of the delusions. The illness is associated with distress and agitation. Irrational behavior may appear as delusions become more vivid and judgment lessens. Patients may accuse others of persecution and complain to the authorities. From *Wikipedia*.]

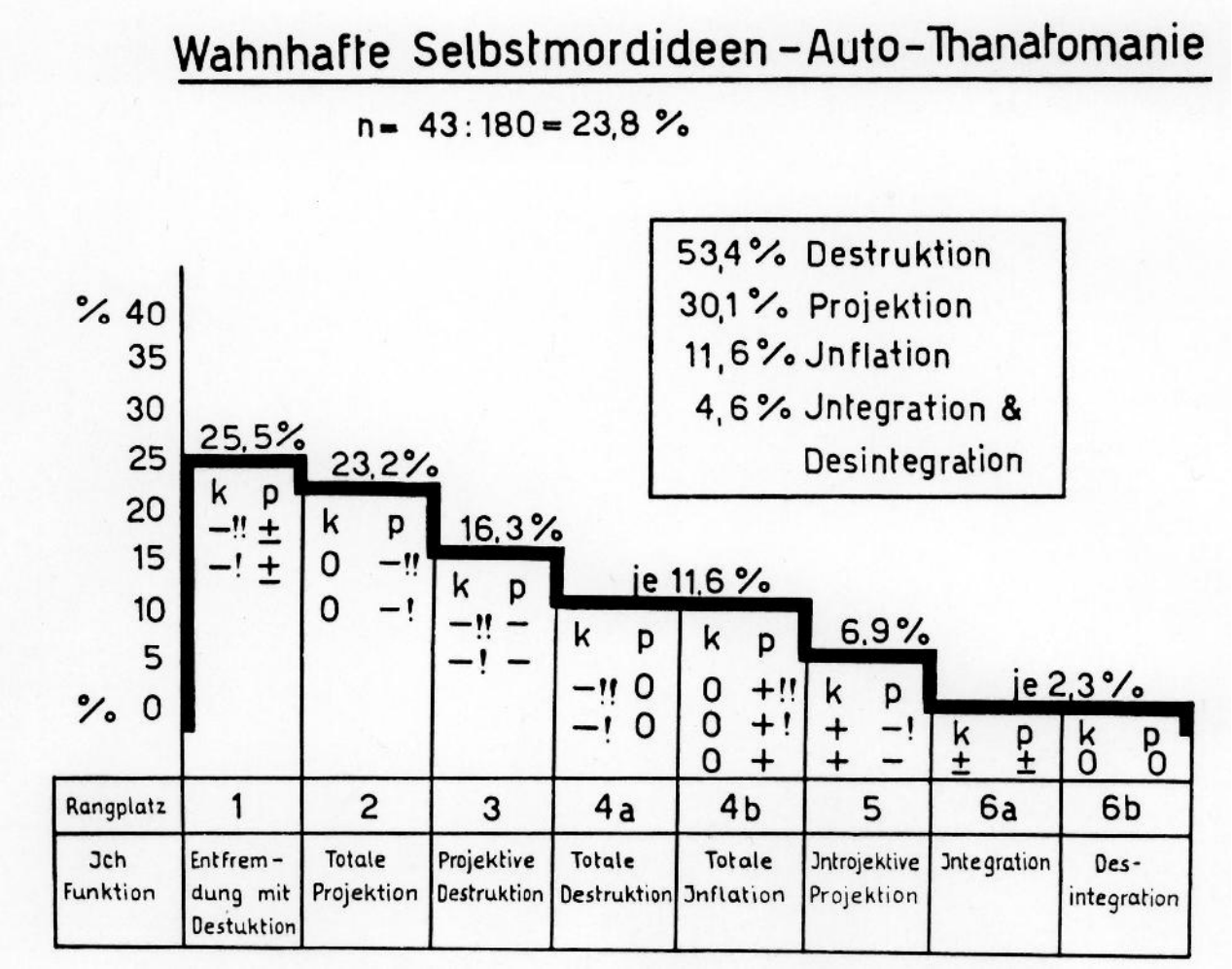


Fig. 20. Delusional Suicide Ideas, Autothanatomania and Ego Functions
[*Wahnhafte Selbstmordideen* = Delusional Suicide Ideas]

C. The *"failures"*: Negation respectively destruction delusion form was recorded with some patients with whom in the test was not the destruction form but another ego form played the leading role. Thus:

1. *Total projection*: *Sch* = 0 —! in 12.2% of the cases: No. 1 murder intentions, No. 4 self-mutilation, No. 12, 17, 24 attempted suicide.

2. The following ego functions led in only one case of 41 with destruction delusion (2.4%);

a) Total introjection (No. 54): negativistic destruction;

b) Introprojection (No. 89): hypochondriac despair delusion;

c) Compulsion (No. 168): hypochondriac despair delusion;

d) total integration (No. 169): Hypochondriac despair delusion with aggressive destruction.

Fig. 17 gives an overview of the frequency of the prominent ego functions with destruction delusion. *The negation respectively destruction ego led in 78.0%, that is in 3/4 of all cases with destruction delusion.* This fact speaks for the correctness of the assumption that there is indeed a particular destruction delusion form, which by a particular ego function and which we have defined as *destructive negation*.

*

We conclude our discussion about the relationship between the delusion forms and the experimental ego functions with the following two statements:

First of all. The clinical delusion forms are determined by the particular ego functions. If the patient changes his or her ego function, then the form of the delusion changes with it.

Secondly. It is justified to treat the clinical delusion forms based on the four elementary functions of the ego in four groups of delusions. These are: I. Projection, II. Inflation, III. Introjection, and IV. Negation respectively Destruction delusions group.

Other Psychiatric Results of Experimental Ego Analysis

In the following we briefly summarize some results of the experimental ego analysis when these investigations have proven of particular interest for clinical psychiatry. These are: I. integration and disintegration in delusion formations, II. stuper, III. confusion, IV. quarreling, V. erotomania and VI. hallucination and ego function.

I. The Role of Integration and Disintegration of the Ego in Delusion Formations

Integration (*Sch* = ± ±) with delusion patients is rarely encountered but nevertheless is on a temporary basis. In 5 cases of 180 delusion formations we could determine it experimentally. (Cases No. 169, 170, 171, 172, 173.) We interpret the appearance of this highly differentiated ego form as follows: The

delusion patient is conscious that he stood before disaster: to lose his consciousness completely and to be totally confused. This idea of disaster forces the ego to set in motion all four kinds of his defense functions maximally in order to defend against the disaster of being confused and complete ego loss. This however the patient only temporarily achieves. Quite often the ego easily fails the more that it exerts itself to mobilize all powers against the danger of the ego loss. In two cases we could follow this tragic step to utter confusion also experimentally -- almost like a mental movie camera:

Case 6o: An 18 year old girl, who was attached homosexually to her older sister, developed first greatness and then persecution ideas. She ran away from home (V. G. P. I: *Sch* = ± —), felt abandoned and developed greatness and persecution ideas (V. G. P. II: *Sch* = 0 ±). She stayed in this condition about six to seven weeks. Then she collected herself, fought her delusion formations by integration (V. G. P. III: *Sch* = ± ±) but without success. She was interned. When we could test her again after six months, she was completely confused and supplied the ego form of disintegration (V. G. P. IV: *Sch* = 0 0). She had to be interned again. After another four months she was released from the institution again on a trial basis. At this time she did not develop relations thoughts but omnipotence ones (V. G. P. V: *Sch* = + 0). Suddenly already on the next day, however, again her persecution ideas broke out and she became a public danger (V. G. P. VI: *Sch* = 0 —) and had to be interned again. Table 24 summarizes the results of her mental conditions.

Table 24. The Process of Going Insane with an 18 Year Old Girl. Diagnosis: Paranoid Schizophrenia

V.G.P.	*Date*	*S*	*P*	*Sch*	*C*	*Ego Condition*
I.	4/1/1938	+ —	— +	± —	0 0	Runs away
II.	4/23/1938	+ —!!	+ +	0 ±	0 +	Omnipotence ideas (*p* +) Persecution ideas (*p* —)
III.	6/10/1938	+ —	+ ±	± ±	0 ±	Integration. Fights the delusion
IV.	1/17/1939	+ —!!!	+ 0	0 0	+ ±	Disintegration, confused
V.	5/19/1939	± —	0 —	+ 0	+ +	Omnipotence ideas
VI.	5/20/1939	+ —	0 +	0 —	— —	Persecution delusion, interned
				Unrealist Block		

Case 61: With the second case, a 16 $^{1}/_{2}$ year old high school student, from

April 25, 1939 to May 9, 1939 we can follow the whole process with the test from the beginning of the first paranoid delusion formations up to the internment in a condition of being completely confused. Table 25 gives information on the mental steps of the process up to the completely *disintegrated* confused condition.

In the first case we succeeded with the test to obtain both phases, that is that of integration (*Sch* = ± ±) and that of disintegration (*Sch* = 0 0), in the second case only that of disintegration and that *disintegration with the increased turning of the aggression against her own person* (*s* —!!! with the girl, V. G. P. IV; and s —! with the young man, V. G. P. VI) indeed the condition of the going insane, the being confused is made visible. [48]

Table 25. The Process of the Going Insane with a 16 1/2 Year Old High School Student Diagnosis: Paranoid Schizophrenia

V.G.P.	*Date*	*S*	*P*	*Sch*	*C*	*Ego Condition*
I.	4/25/1939	+ —	+ —	0 —	+ 0	Accusation ideas
II.	4/30/1939	+ —	+ +	± —	— —	Running away, poriomania, suicide thoughts
III.	5/1/1939	+ ±	0 +	— 0	+ —	Hallucination, absences
IV.	5/5/1939	+ ±	0 —	± —	+ 0	Fights the persecution ideas with establishment of an association against women
V.	5/8/1939	0 —	+ +	+ —	— +	Sinfulness ideas: Masturbation, suicide thoughts
VI.	5/9/1939	+ —!	0 —	0 0	± ±	Completely confused. Ego loss. Is interned

The appearance of the integration and disintegration with delusion patients is thus an indication that the patient is in danger to lose himself and to be completely confused. This finding, which we already communicated in 1947, is confirmed by the material of E. Stumper.

Case No. 169: Consciousness disturbance with a latent epileptic (*Sch* = ± +).

Case No. 170: Confusion, anxiety before military service (*Sch* = ± ±).

Case No. 171: Hypochondriac ideas of disaster with several attempted suicides (*Sch* ± ±; *Sch* = —!! ±; —! —).

Case No. 172: Substupor (*Sch* ± ± and *Sch* = 0 0) with a persecution delusion patient (*Sch* = 0 —).

Case No. 173: Confusion (*Sch* ± ± in the V. G. P. and *Sch* = 0 0 in the E. K. P.) with a delusional patient with an idea of sinfulness.

Case No. 174: Stuporous phases, suicide thoughts: *Sch* = 0 0 (4: 13).

Case No. 175: Occasional stuporous hebephrenia (*Sch* = 0 0, 2: 10) with accusation delusion (*Sch* = 0 —) and delusion of improvement (*Sch* = + —).

Case No. 176: Episodic confusion conditions (*Sch* = 0 0, 2: 9).

Case No. 177: Ego change (*Sch* = 0 0, 6: 10) with a paranoid with ideas of being poisoning and with anger outbreaks.

Case No. 178: "Debility" (*Sch* = 0 0) with a homosexual with childlike inventive persecution delusion.

Case No. 179: A drinking-addicted prostitute, who is *in a twilight condition of poriomania* (*Sch* = 00) and with attempted suicides and cheating death.

Case No. 180: Drinking addiction with destruction, this -- presumably-- with an epileptic man (*Sch* = 0 0, 6: 10).

II. Stupor and Ego Function

Stupor according to E. and M. Bleuler is not "a homogeneous syndrome, but an outward manifestation of different conditions in which maximum apathy, inhibitions, blockages, overwhelming fright or anxiety, brain torpidity of any kind" dominate. [49] One sees stupor particularly with schizophrenia and epilepsy, with organic illnesses and also with manic-depressives. With our 180 delusion patients, stupor or substupor was noted in 13 cases. According to clinical experiences, we could not determine a specific ego function behind stupor by experimental ego analysis.

Such were introprojection (No. 75, 89), destructive projection (No. 93, 95), destructive estrangement (No. 137, 158) in two cases each; negation (No. 60), integration (No. 172) and disintegration (No. 174) in one case each was the leading ego function.

III. Confusion and Ego Function

About the relationship between the ego functions and confusion we must maintain the same as with stupor. Altogether confusion was only nine times indicated in 180 patient histories of delusion formations. The prominent ego

functions were very diverse:

Total projection (No. 2, 36), destructive projection (No. 110, 113) and integration (No. 170, 173) led in two cases each and pure negation (No. 70), estrangement (No. 163) and disintegration (No. 175) in one case each.

IV. Quarreling Delusion and Ego Function

For the question of the relationship between the ego functions and both quarreling delusion and respectively that of quarreling, we can communicate the following. In the *six* cases of our material were in two cases each total *inflation* (No. 39, 40) and introprojection (No. 81, 86), in one case each the inhibited Inflation (No. 121) and the inhibited projection and also the estrangement (No. 133) was the decisive ego function. In three of the six cases also inflation dominated and likewise in three cases projection in any form. *We surmise that the desire to quarrel has a profound relationship to ego diastole.* With the boundless need for ego expansion depends, on the one hand, on the complete lack of understanding for the rights of others and, on the other hand, on a pathologically increased narcissistic self-confidence.

On the basis of depth psychological treatment of two querulents we must mention a particular kind of developing of the quarreling delusion, namely that which occurs *as a replacement of erotomania*. In both inflative-paranoid cases was megalomania with a *bisexual* erotomania for years the prominent delusion form. The 30 year old high school teacher wanted to be the greatest poet of the world. The 35 year old psychiatrist believed that she was the most talented psychiatrist of all her colleagues in the institution. Both stood continuously in the condition of *homosexual* inflation next to a heterosexual orientation. To the degree that the bisexual erotomania phases subsided, the *quarreling phases* flourished. We had the impression that the quarreling with them actually performed a *healing of the defect* of the inflative erotomania-megalomanical paranoids.

V. Erotomania and Ego Function

Erotomania as a symptom appeared with 23 of 180 delusion patients (12.7%). Ego-psychologically they form two groups.

a) *The diastolic* group of the sexual maniac is characterized:

1. by the *obsession* (*inflation*) *of bisexual stirrings* (*Sch* = 0 +! : No. 31, 46, 47) or by total projection with bisexual contents (*Sch* = 0 —! : No. 20, 34). Bisexual obsession can become also inhibited (No. 123) or lead to an ego loss with

confusion (No. 174, 176, 178).

2. Quite often homosexuality does not become manifestly lived out; the patients however to that degree that they are possessed by homosexual, bisexual or hermaphroditic *being desires* they become completely incapable of working and -- quite often -- *quarrelistic*. Their delusional ideas are of a being power nature.

b) The *systolic* group of the sexual maniac is characterized:

1. By the dominance of the ego systole (*Sch* = + 0: No. 54, 55, *Sch* = + —: No. 86, 87), that is by introjection or introprojection, or however by destruction with estrangement (*Sch* = —! ±: No. 130, 142, 144). Here dominates thus not being power but having power.

2. Also the clinical manifestation of the "systolic" erotomania corresponds to that of exhibitionism, fetishism, and masochism. In these cases the power of the sexual *taking into possession* (ego systole) in active or passive (masochistic) form is the leading tendency in the sexual area.

VI. Hallucinations and Ego Functions

By hallucination psychiatry well understands the psychiatric deceptive bodily perceptions that develop *totally new perceptions* that are not from real perceptions. While the delusions represent "pathologically falsified *real* perceptions," the hallucinations are *"perceptions without corresponding stimulance from the outside."* [50]

The relationship of the hallucinations with the delusion conceptions is today still another point of issue in psychiatry. *Delusion* is a pathological falsified judgment, delusional ideas are pathological falsified conceptions, and *hallucinations* are pathological deceptive *perceptions* without a stimulus from the outside.

Judgment, conception and perception are however different psychic functions. The delusion originates from the conception world, the hallucination from the perceptual world. We already mentioned that K. Zucker made the attempt by conception experiments with schizophrenics to produce the direct relationship between delusion formations and hallucinations with schizophrenia. From the so-called "made-up thoughts" of the paranoid exist smooth transitions to the hallucinations. In the conception experiments K. Zucher received from his patients the answer "that hallucinations and conceptions were *qualitatively* identical."

This statement was tested by us by means of experimental ego analysis. Of

the 180 delusion patients we found with 40, thus with 22.2%, *next to* delusional ideas also hallucinations. Our investigations went now into two directions. First of all we looked for answer to the question whether a certain affinity *exists* between the *ego psychology delusional forms and the hallucinations.* Secondly we determined the frequency conditions of the experimentally determined leading ego functions with the hallucinations.

Table 26 answers the first question:

Table 26. Hallucination and Delusion Form

Hallucinations, with the different ego delusion forms	*Number that concerned ego function*	*Number of simple voice hallucinatiing*	*Number of body hallucinations*	*Sum of all hallucinations*	*% in relation to the delusion form*	*% in relation to all hallucinations*
I. Projection delusion	85	22	10	32:85	*37.6%*	32:40 = **80%**
II. Inflation delusion	26	4	—	4:26	15.4%	4:40 = 10%
III. Introjection delusion	4	0	0	0:4	—	—
IV. Negation delusion	53	3	1	4:53	7.5%	4:40 = 10%
V. Integration delusionn and disintegration delusion	12	0	0	0:12	—	—
Total	180	29	11	40:180		

The lessons from this table are:

1. There is an outstanding affinity between the hallucinations and the projection delusion forms, thus persecution, relationship, observation, injury delusion and the *projective* destruction delusion, delusion of sin, etc. Of the 40 delusion patients with deceptive perceptions belong 32, that is 80%, in the group of projection delusions. On the basis of our investigations one can determine thus the identity of the projective ego functions with the hallucinations and the projection delusion formation. This refers presumably to the identity of the sources, thus the identity of the ego function that functions behind the hallucinations and the projection delusion forms. One can state based on experimental ego analysis that the projective delusion idea in particular and the deceptive perception generally come about by the same ego function, namely projection.

2. Of all hallucinating delusion patients, 20% lack the projection delusion form. Likewise 10% are associated with the *inflation delusion form* (megalomania, religion delusion, erotomania) and in 10% the *negation delusion form* (jealousy delusion, despair delusion, alienation delusion, hypochondria, and destruction delusion) and are related to the hallucinations. Provisionally we cannot determine yet whether at the time of these hallucinations, projection nevertheless was also working. This question could be answered only by test recordings *in* the hallucination phase. Such experiments are however still missing.

3. The distribution of the kinds of hallucination was: 29 cases with voice hallucinations and 11 with body hallucinations.

We found body hallucinations quite often with *total projections* (*Sch* = 0 —!; Cases No. 9, 11, 27, 28, 29, 31) and with the introprojections, thus with delusion of sin (*Sch* = + —!: No. 76, 77, 89). A case (No. 101) belonged to the group of the negated projection (*Sch* = —! —) and another (No. 63) to the group of the total negation (*Sch* = —! 0). Also the simple voice hallucinations were most frequent with total projection (No. 2, 3, 4, 7, 12, 18, 19, 20, 21, 22, 23, 24, 25, 26; altogether 14:40).

4. *The introjection and the integration and disintegration delusion patients did not hallucinate.*

*

In the preceding tables we indeed designated the delusion forms ego-psychologically; they however were arranged based on the *clinical* delusion forms and only afterwards "renamed" ego-psychologically. We have tested however the relations between the hallucinations and the experimental ego functions in another way. Thus we simply added together with the hallucinations the frequency of the leading ego functions *in the experiment* in the 40 cases of delusion with hallucinations.

We plotted the results of this experimental ego analysis in Fig. 21. The experimental results agree nearly completely with the *clinical*.

1. *With the hallucinations any projection form was the leading ego function in 82.5%.*

Total projection (*Sch* = 0 —! ! ! ; 0 —! ! ; 0 —! ; 0 —) leads in 52.5%, the introprojection (*Sch* = + —!! *;* + —! *;* + —) in 12.5%, the destructive projection (*Sch* = —!! —!! *;* —!! —! *;* —! —!! *;* —! —!) likewise in 12.5% and the projection held back with compulsion in 5%. All projection forms led thus in 82.5%.

2. The total negation (*Sch* = —! 0) and the destructive estrangement (*Sch* = —! ±) were the leading ego functions in the experiment in 5% each, together thus 10%.

3. Total inflation (*Sch* = 0 +!) led in 2.5%, inhibited inflation, (*Sch* = — +, or —! +! ; or — +!) was in 5%; the inflation ego was the decisive ego function altogether in 7.5% of all hallucinating cases.

4. *For the first time in an experimental way is thus proven that deceptive perceptions (in 82.5%) occured reliably through a projective ego function.*

5. Whether also in the cases in which negation and inflation were the leading ego function behind the hallucinations, nevertheless, a projection is very probably working. This would however still have to be proven experimentally. If one in the future would test the patients during the hallucinations, then one could have a more accurate answer than pure speculations on some points of issue of today's psychiatry. In the first place we think on the question why one patient is content with the delusion formations and why the other one beside the delusion also must hear voices. The question also would have to be answered in this way whether the delusion and the hallucinations are characterized indeed by “ego relatedness” as that in particular J. Wyrsch stresses in opposition to E. Bleuler. “What he hears” -- this author writes -- “is a call. What happens to him is calculated and is aimed at him. Which he sees is staged for him.” [51]

The tendency to attribute the delusion formations to ego disturbances is not new. Thus Berze [52] has tried to represent the ego disturbance with delusion as “primary insufficiency of psychic activity” as a “hypotonia of consciousness.” Berze fought the interpretation of E. Bleuler, who stressed the “loosening of the association tension” in relation to experience psychology. Berze believed to have found the basic disturbance in the primary insufficiency of the psychic activity.

Gruhle has suggested that even the schizophrenic prevailing mood as primary symptom of the schizophrenia is based on an ego disturbance. [53] Störung understood the schizophrenic delusion tendency likewise as an ego disturbance and believed that this is a projection for the helpless anxiety in the world. [54]

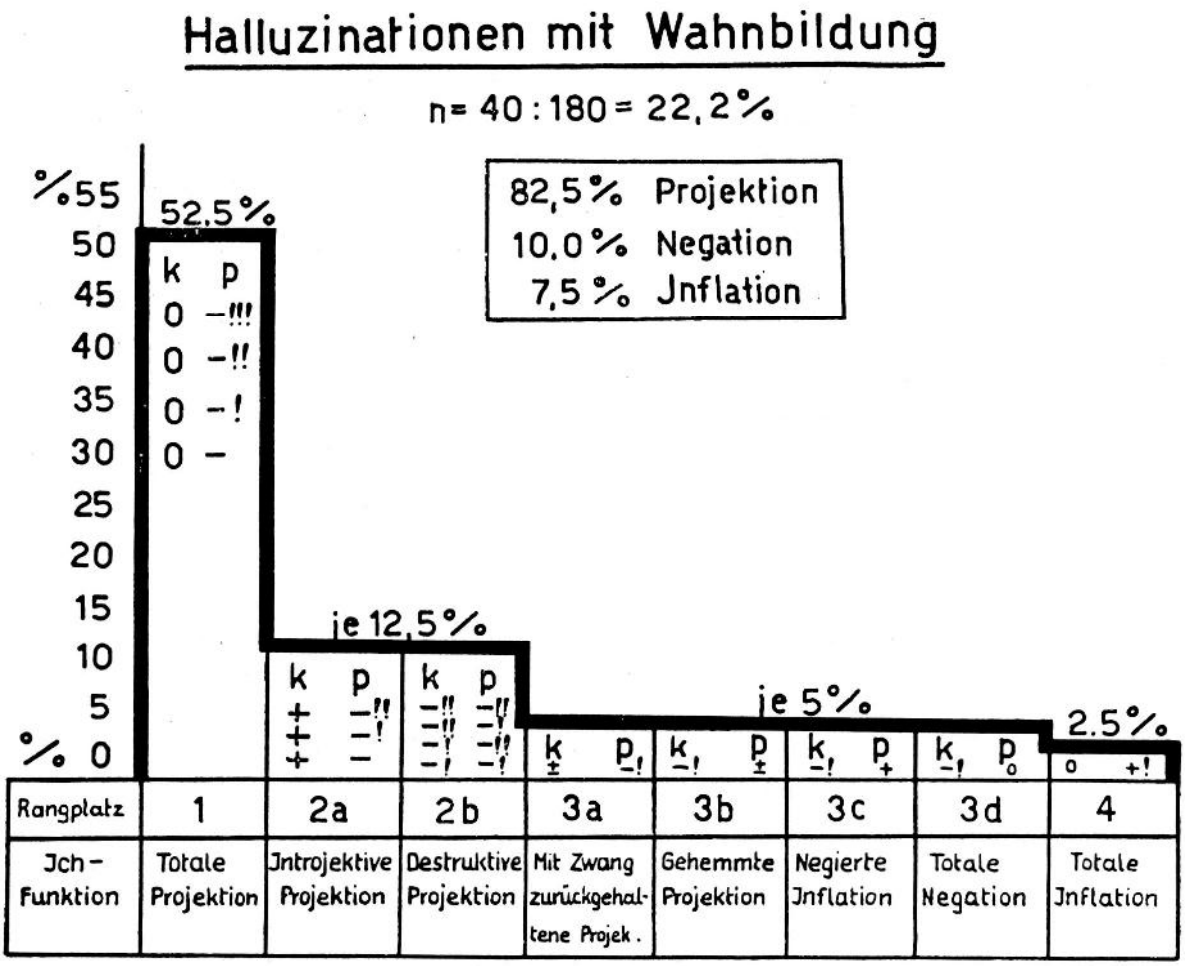


Fig. 21. Hallucinations with Delusion Formations and Ego Functions

[*Halluzinationen mit Wahnbildungen* = Hallucinations with Delusion Formations]

Thus the thinking here is consistent with the interpretation of psychoanalysis. 0. Hinrichsen wants to represent the ego disturbance with the delusion formations as the only typical experience of the schizophrenics. [55] K. Gyarfas and G. Schulz have tested the schizophrenic process symptoms and the post-processes of ego organizations. They speak for "ego distance" and "ego closeness" of a schizophrenic process. In the "ego distance" they see this as prognostically good, in the "ego closeness" however as a bad sign. [56]

With good reason J. Wyrsch notes in addition that by ego disturbance is understood here only as a *formal* peculiarity of experiencing, namely the ego quality however that is present in all psychic acts as an "ego point." [57] Wyrsch asks: What happens to the patient with the ego disturbance? His answer: "At first he merely suffers it. One hears spoken occasionally of convalescents that in the first period of the illness that they stepped before the mirror in order to see whether

they are real and if all of this is happening to them. ‘Who pushes me to think? Who tortures me and my body?’ ” Wyrsch remarks in addition that the patient is better able to answer the question of ego disturbance as science, “If all that they experience of the ambiguity of reality and hallucinations or in disturbance of their actions, thinking and will that unite in the relationship and influence of delusions, and thus people who experience independently nevertheless again and again the world and the fate opposing them, now becoming merely suffering.” [58]

Already from this incomplete enumerating it becomes evident how much the role of the ego disturbance in the delusion formations has been employed in psychiatry. Now however all these were opinions and only speculations and no real *ego analyzes* in that sense as they are by means of the experiment with our procedure has made possible. Only an experimental ego analysis is capable of making *visible* the mental processes of the delusion and the hallucinations and of supplying the firm basis to a theory of delusion formations.

The Participation Theory of Delusion Formations

Summary

In the light of the experimental ego analysis we can now summarize the basic ideas of the delusion formations in the following:

I. *Delusion is the product of an ego function that is characterized by a pathological distribution of power and an unrealistic manner of participation.* The falsification of the judgment with delusion is the result of a pathological distribution of power. The failed participation in addition supplies the drive. *The participation had to fail however because it was abnormally increased quantitatively.*

II. *Power is the force to be and to have*. The ego is however not the producer, but the manager and distributer of this power. The ego is the bearer and carrier of the power, which each human brings with him or her into this world as *being* and *having possibilities*. The ego is that court that makes conscious (*p*-function) these being possibilities and, under the right circumstances, is able also to realize (*k*-function) these having possibilities.

III, *The driveful original function of the ego is: the drive to participation, thus to being one, the same and related to the other. Participation* is that prototype of the distribution of power with which the ego’s brought-with-it omnipotence is

projected to another being of whose omnipotence however the projecting ego has a share with it by being one with it. By having part with this dual power, the ego satisfies its drive to being one with the other. A goal of each participation is constantly the overcoming of the unbearable *being alone. From there the transcending.*

IV. *The ego transcends in order not to be alone. The transcending ability is a precondition of integration and thus the participation.*

V. The participation drive is an eternal drive of humans that always controls the soul from birth to death as the demand that is the most difficult to satisfy. The participation drive is satisfied -- for a short while -- in the formation of the dual union with the mother. After the collapse of this unity humans always look for objects with which with this misappropriated mother they would be able to replace the broken unity. A main part of the ego functions of each human exists henceforth in the substitute formations for the lost participation with the mother. *The history of the ego is the sequence of these participation substitute formations.* A large part of these substitute formations are pseudo-participations.

VI. The primitive nature man projects his brought-with-him omnipotence onto his totem ancestors, totem animals, and totem plants, with which he feels henceforth related for life. Through these mystic participations (Lévy Bruhl) the primitives succeed in feeling one with certain objects of the environment by which he overcomes then his being alone.

We can prove on the basis of the investigations of our co-worker E. Percy (Lambarene) that the mystic participations are formed indeed by the *projections* of the omnipotence. *The strongest ego function of these Bush Negroes is projection.* Table 28 gives an overview of the ego functions of these Bush Negroes. With both groups of people, with the primitives and the delusion patients, the prominent ego function is *projection,* that is the shifting out of the omnipotence.

VII. *Why are these primitives nevertheless not delusion patients?* E. Kraepelin has stated that dementia praecox* constitutes on Java exactly the same as the majority of all mental disorders with the Europeans. Wherein nevertheless does the difference lie? Kraepelin writes: “In Java after an overall view of the natives patients I have no doubt that in the majority of the cases handled of the group of diseases that we call dementia praecox there were nevertheless less pronounced differences compared to the European patients. The initial depression so frequent with us was almost never detected; the illness usually

began with confused excitation and in succession then lead very soon to a drivelling stupefaction. *Auditory hallucinations were only found in a small number of cases; also delusion formations were rare and scanty. Pronounced catatonic symptoms in particular negativistic stupor appeared only exceptionally to observation."* [59] [**dementia praecox* = Dementia praecox (a "premature dementia" or "precocious madness") refers to a chronic, deteriorating psychotic disorder characterized by rapid cognitive disintegration, usually beginning in the late teens or early adulthood. It is a term first used in 1891 in this Latin form by Arnold Pick (1851–1924), a professor of psychiatry at the German branch of Charles University in Prague. His brief clinical report described the case of a person with a psychotic disorder resembling hebephrenia. It was popularized by German psychiatrist Emil Kraepelin (1856–1926) in 1893, 1896 and 1899 in his first detailed textbook descriptions of a condition that would eventually be reframed into a substantially different disease concept and relabeled as schizophrenia. From *Wikipedia*.]

We interpret these important observations of Kraepelin in the light of participation theory as follows: Schizophrenia is common over the whole earth. It seems -- according to Kraepelin -- to go very far back in the history of the development of mankind. *But the need for delusion formations and hallucination seems to be missing everywhere where the form of faith promotes the need for a mystic participation. Where the belief makes being related and being one is possible with animals and plants and with rock and things and sweeps away thus the ghost of the being alone, there delusion formations occur rarely, and indeed only rarely do the primitives fall into schizophrenia and stupefaction.*

However delusion formations and hallucinations appear always where the higher belief form forbids the possibility of a participation with the environmental objects, worshipping of idols and thus makes impossible the original need to be one with the powerful world objects. Already in 1870 Hagen noticed that the mentally ill look and find in delusion a support and a completion. [60]

VIII. With the delusion of civilized persons, the mystic participation drive is realized through substitute objects and substitute ideas, but these are unable however to satisfy the participation drive because it was simply falsified. The omnipotence of these delusion formations is attached to such objects that do not have and do not sustain this omnipotence. Therefore the assertion: The false distribution of power with delusion distorts judgments and ideas. The result of the false distribution of power is the falsified participation in the delusion world of the patients.

IX. *In the delusion formations, in our opinion, exists the disturbance between the participation drive and the distribution of power of the ego.* The delusional ego wants to satisfy its pathological increased drive to being one under all circumstances; the choice of the participation object to which it now transfers the omnipotence is however false.

X. The complete absence of the taking an attitude and testing reality, that is the failure of the ego systolic *k*-function ($k = 0$) makes the supremacy of the diastolic being power, thus the *p*-function possible (*Sch* = 0 —! ; *Sch* = 0 +!).

XI. *The delusion formations show in the experimental ego analysis a certain development course.* The ego follows in the delusion formations a very specific roadmap that coincides with the steps of the physiological ego development. We differentiate ego-psychologically: A. *elementary* and B. *complex* delusion forms.

A. *The elementary delusion forms* are:

1. total *projection delusion* (*Sch* = 0 — !);
2. total *inflation delusion* (*Sch* = 0 + !);
3. total *introjection delusion* (*Sch* = + ! 0);
4. total *negation delusion* (*Sch* = — ! 0).

The common source of these four elementary "phases" respectively elementary functions -- both in normal ego development as well as in the delusion formations -- is the drive to a mystic participation that appears in our opinion with delusion patients as an abnormal increased need. If the person could remain in the primordial mystic participation phase with the mother forever, then the division into the two parts of the world as an ego-world and a you-world and consequently could create both the healthy development of the ego as well as eliminate the necessity to develop a delusion world.

The crisis in the dual union gives only the fateful impetus both to the normal ego development as well as to the development of a delusion world. The first phase with both developments is:

1. The Total Projection Phase

The total projection phase begins with the crisis in the dual union with the mother or respectively his or her substitute person. The collapse of the being one

and being the same with the mother brings danger. The threat of the person by being alone becomes unbearable. The desire for reestablishment of the participation is there, but the person cannot achieve it in reality. After the collapse of the original participation the ego remains *powerless* since it left a large part of its own power with the participation object. The ego becomes thus powerless, the lost participation object however become omnipotent. (On this see Phase I in Fig. 22). In this impotence the ego feels itself impaired, observed, influenced or even persecuted by the abandoning object (mother respectively mother replacement). The abandoned child accuses the omnipotent mother because of the being abandoned. The mentally ill adult develops observation, relations, injury, even persecution ideas. With the help of these falsified conceptions and judgments the delusion patient depends still further on the object abandoning it. The patient's participation with the lost dual partner becomes a pathological and negative falsified participation in which he or she, when "persecuted" by his or her "persecutor," remains further in the relationship but now in a delusional relationship. The patient's being one with the partner is replaced by *being had* and *persecuted* by the lost partner with whom before he or she had felt still related. Thus exists a *projection delusion* in the experiment that emerges from the exaggerated *total* projection: *Sch* = 0 —! , 0 —! !. A third of all delusion patients remains in this initial phase of total projection (32.2%). They form the psychiatric group of "projective paranoids." [61]

2. The Total Inflation Phase

The phase of *total inflation* is ego-psychologically characterized as follows: First of all a pathological manner of the distribution of power exists in the *total power doubling of the ego.* The ego separates itself from its abandoning participation object so that it does not only withdraws the part of the power, which it has transferred out before into the dual object, but tears also a large part of the foreign power of the dual object to itself at the moment of separation. (On this see Phase II in Fig. 22.) *Thus henceforth the ego will be doubly powerful, i.e. omnipotent in being.* The child becomes in the total inflation phase simultaneously the love-receiving child and also the love-donating mother. The child owes all its *"ego ideals"* respectively all its *"being ideals"* to the inflation condition. This inflative phase of the child coincides with the excessive masturbation in the first infantile and the second juvenile puberty. The greatness ideas in the second puberty of being a poet, a philosopher, and a discover with simultaneous being a child are further physiological manifestations of this inflation phase.

The adult delusion patient is likewise in this phase doubly powerful.

Through falsified conceptions he believes he is able *to be simultaneously* man and woman, God and human, angel and devil, Lord and servant without feeling any opposition. The clinical diagnosis is set at *megalomania, bisexual erotomania* or later at *quarreling delusion* and religion delusion.

Secondly it was ego-psychologically determined that actually the ego by the total doubling (inflation) tries thus to produce the *old* participation situation in which it henceforth plays the two roles of a dual union. In masturbation this doubleness of the role playing is physiological, in the inflation delusion pathological. Both supply the ego form of total inflation in the experiment: *Sch = 0 +! ;* 0 +! ! ; 0 +! ! !.

If the delusion patient remains stuck in the phase of total inflation in the long run, then his diagnosis becomes "inflative paranoid," that is denominated "paranoid with megalomania" or "paranoid with bisexual erotomania." Their frequency among the delusion patients accounts for 10.5%. A part of these inflative delusion patients continues further in their delusion formations. If they have strived delusionally so far on the "*p*" scale of *being possibilities* for the reestablishment of the participation unit with the help of projection und inflation mechanisms, then they try henceforth by the *ego systole,* that is *on the "k" scale of having,* the having possibilities, to replace the misappropriated dual union.

Thus the delusion forms of introjection and negation occur.

3. The Total Introjection Phase

In the *introjection delusion* the distorted ideas refer no longer to the expanded, diastolic being possibilities of the persecutor or his own person, but the person makes the attempt of compensating himself by *having power* for the loss of the personal participation.

The introjective delusion patient lives in the false conception that he incorporated the power of the lost dual partner into his own ego. He possesses thus by *"having"* all the power of the lost dual partner in his own ego. (On this see Phase III in Fig. 22.) Freud calls this process *"psychic cannibalism."*

In the physiological ego development the child owes to total introjection the establishment of all *have ideals.* On the basis of these have ideals the child selects for himself or herself the objects of the world it must *"have."* Skills, knowledge, friends, and valuable material objects are thus taken by have power. The child feels omnipotent in the having. The magic power of thoughts with children and primitives is based likewise on total introjection. The structure of

the character by incorporation and imprinting certain traits and characteristics in the ego is the result of the introjective ego function.

The delusional ill adult develops with the help of total introjection *cosmic omnipotence ideas* or *sexually perverse power ideas* like exhibitionism, fetishism, and masochism.

In the experimental ego analysis the way is made clearly visibly on how that the delusion builder developed a different having power from the preceding being power. The succession of the ego forms: *Sch* = 0 + ! ; *Sch* = + +, *Sch* = +! 0 indicates this process. The clinical observation registers cosmic omnipotence ideas or material having delusion ideas in place of the previous greatness ideas. The patient, who wanted to be indeed man and woman before, now believes that he possesses a harem with men and women. The religion fanatic, who developed his delusion that he is a representative of God on earth, develops the delusion idea that he had built one hundred churches and in each of these churches installed ten ministers over whom he now exercised omnipotence.

Neither the being nor the have delusion formation appears to be of long duration. The statistic surveys show that the introjection delusion forms only 2.2% (4: 180) and the inflation delusion form only constitute 10.5% (19: 180) of all delusion forms in the convalescent and mental hospitals.

Both appear to be thus in the course of the delusion formations only *temporary* stopovers. Exactly the same is it also in the normal course of ego development. Most delusion patients remain stuck either in the *projection phase* (32.2% = 58:180), or they go through the inflation and introjection phase rapidly and finally will be bound in the *negation delusion phase* -- mostly in any combination of negation with another ego function.

4. Negation Phase. The Phase of Disimagination and Destruction

In the negation phase the omnipotence, that is the power to be and to have is *denied* and is quite often however directed against one's own person. This is the result of all attempts for the reestablishment of the former participation failed by means of the projection, inflation and introjection. One cannot evade the fate of being alone. The disappointment over that is boundless. All values of the world become devalued -- in particular however the value of one's own existence and essence. In this disimagination phase the person destroys all ideals, which he preserved from the world objects (mother, father, brothers and sisters, minister, teacher etc.) and from his or her own value. (On this see Phase IV in Fig. 22.) In

the physiological ego development the negation phase manifests itself partly by destructive rebellion against parents, school, religion (defiance phase), partly by repression of these demands for destruction, from which the childhood neuroses develop.

With adult delusion patients *total negation* appears first as *negativistic, catatonic form behaviors with despair delusion, hypochondriac delusional ideas, often with rigidity in these delusion ideas, with destruction and killing ideas in relation to the environment* (*allothanatomania*) *or with self-destruction ideas* (*autothanatomania with suicides and drunkenness-addicted*). We call each of these delusion forms either *destruction* or *negation delusion.* Their frequency with delusion patients reaches 22.7% (41: 180). Quite often however forms the negation with projection (*Sch* = — ! — !) or with the inflative projection (*Sch* = — ! ±) a complex delusion form, whose prognosis is still more difficult and their frequency in the institutions is still greater.

B. *The Complex Delusion Forms*

The complex delusion forms come about in such a way that the ego decreases the *ego danger* that can be caused by any unifunction with the help of opposite ego functions. As such were considered:

1. *Inflative projection delusion* (*Sch* = 0 ±) that mainly develop in heboids with simultaneous persecution and megalomania;

2. *Introprojection delusion* (*Sch* = + —), which in particular one meets as delusion of sin with melancholia, autistic depressive schizophrenia;

3. *Compulsion delusion* (*Sch* = ± 0), which mostly defends against a paranoid process in the background, similarly as

4. *Projection delusion held back with compulsion* (*Sch* = ± —).

These complex delusion forms are to be found relatively rarely. With all four forms the ego has the common tendency to invoke opposite functions to mitigate its danger by a common dangerous delusion illness. This is different with the fifth and sixth complex delusion form:

5. *Alienation delusion* (*Sch* = —! ±), which is of the phenomena of depersonalization that brings derealization with it and as jealousy delusion, delusional hypochondria, killing and destruction delusion (allothanatomania) or as self-destruction delusion (with suicide, drinking addiction), is found relatively frequently.

6. The *destructive, negativistic projection delusion* (*Sch* = —! —! *; Sch* = —!! —! etc.) *represents the delusion form bringing the most danger.* It appears *clinically* as catatonic form negativistic behavior with delusion patients with relations and persecution ideas, with delusional hypochondria or as a depressive paranoid with doomsday ideas, very frequently with body hallucinations, and fairly often with destruction ideas (with allothanatomanic and autothanatomanic forms), for example with criminal delusion patients (murderers), with suicides and drunkards with delusional ideas. Quite often also organic patients produce destructive-projective delusional ideas. This complex delusion form is relatively frequent in institutions.

In Illustration 22 *a-f* we try schematically to represent the four elementary stages of the ego. In these schismatic figures the ego as A; the object with which the ego tries to participate as B and C.

The phase of *mystic participation* (fig. 22 a, Zero Phase) is the condition for which humans long from birth to death. This original phase represents still completely a "driveful" condition, in which one can hardly speak of his or her own ego. One does well if one speaks here about an *ego striving*. -- *This ego striving however is"ego-like" precisely in its function of the distribution of power, a function that one meets only with the ego.*

With the average person the *projection phase* is the beginning and the negation phase the last stop of the ego development (*Sch* = — — = drill ego). Between the initial projection process and the final process of negation, thus the renouncement and the denial, the ego stays only very briefly in the phase of inflation and introjection. These two latter functions are however precisely the phases in which people form their being and have ideals. In the projection phase people *still* have no ideals and in the negation phase no *more* ideals since in this phase all ideals are denied. The renouncement of these ideals is called *disimagination* that leads then to the graying of the ego. Only very few people can continue in his ego development and by integration to his highest task: *to undertake the bridging of all opposition as pontifex oppositorum* [the bridge between opposites]. The laws of ego development are thus largely the *Basic Law* of ego structure that one meets also with the sick ego and with delusion formations. *The ego also makes the same steps during the process of delusion formations as in that of healthy development.* Therefore it is justified to speak of projections, inflations, introjections and negations delusion forms too. Similarly as the healthy ego in its development lingers with preference at any stage of its cycle, also the delusion patient can remain fixed during his illness on any function stage and develop only persecution or only inflation or only introjection or only negativistic destruction delusion ideas. Precisely this circumstance

entitled psychiatry, on the one hand, to speak of the projective or the inflative paranoid, that is of a "paranoid schizophrenia" and, on the other hand, to distinguish these disease forms from those of introjective (respectively introprojection) melancholia and the negativistic catatonia and mania.

In the light of ego psychology however all these "labels" represent the same sick ego in different development phases.

Only a psychiatry that is based on an experimental ego analysis is capable of correctly understanding and prognostically evaluating the transformations and mixtures of the schizophrenic illness with the manic-depressive. Disease forms that the psychiatrist today calls paranoid, inflative schizophrenia and that both melancholia, catatonia, mania are ego-psychologically only different from each other because the ego preferred different ego functions, depending on whether it lingered in the projection, inflation, introjection or negation phase.

Because *the kind of the ego function decided the kind of the delusion formations.*

Only because the ego is conditioned in its development history and is constantly on the path of the functional cycle from projection to negation can a psychiatric illness be transformed from the paranoid to the catatonia, from the depressive to the manic, and even from the schizophrenic to the manic-depressive. A fact that was also determined by hereditary psychiatry (Luxenburger). Experimental ego analysis supplies us with the key to understand these transformations.

A psychiatry without the application of experimental ego analysis stands at the same old stage that internal medicine stood before the application of radiology. This psychiatry gropes uncertainly, often also blindly around in an ill soul whose processes experimentally can be made just as visible as are the lungs, the heart, the head or the kidney are able to be analyzed with the help of radiology.

Original Phase 0 (zero) = *Original Participation*

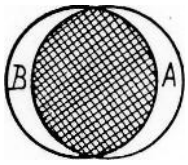


Fig. 22a. Sch = 0 — Dual Power

0: The ego (A) has projected its omnipotence on the object (B). A profound dual union develops with a "dual power" with which A has a portion.

Participation of the child with the mother. Dual union between child and mother.

The total transcending and integrating lead to a total participation.

I. Projection Phase

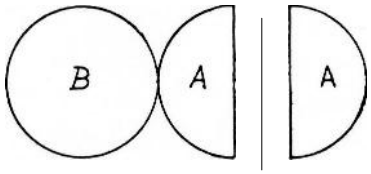


Fig. 22b. Sch = 0 —!

I: After the collapse of the participation (the dual union) the ego (A) in its power is strongly reduced, since it left a part of its power after the separation moment in B. Thus B becomes omnipotent, A however becomes powerless and feels persecuted and injured from the omnipotent B. *Projection delusion.*

Fig. 22. The Elementary Stages of Ego Development

II. Inflation Phase

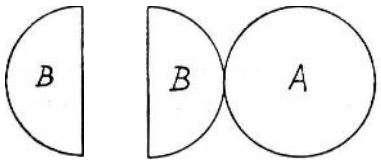


Fig. 22C. Sch = 0 +!

II: After the collapse of the dual union and after the projection phase A tries to double its own omnipotence in such a way that it actually draws an important part of the power of B. Thus the being power of A *doubles* and *it will become omnipotent,* however the object (B) becomes powerless. *Megalomania, inflation delusion.*

III. Introjection Phase

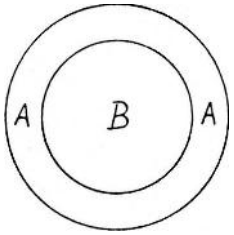


Fig. 22d. Sch = +! 0

III: After neither the projection nor inflation has realized the desired participation on its being *scale*, now A tries *to incorporate* completely the object (B) into its own ego. From the being power thus becomes a *having power.* A now feels -- like a cannibal after incorporation -- omnipotent in the "having." *Cosmic, material or sexual omnipotence. Introjection delusion.*

IV. Negaation and/or Destruction Delusion

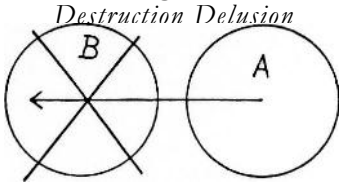


Fig. 22e. Sch = —! *0*

IV: Since also the "omnipotence of having" was not able to achieve the satisfaction of the demand for participation, A devalued at first all the values of B, wants to destroy B and then, in addition, itself. The omnipotence of the ego becomes *destruction power. Destruction delusion* (despair delusion, hypochondriac delusion, killing and suicide thoughts, delusional drinking addiction).

V. Spiritual Participation

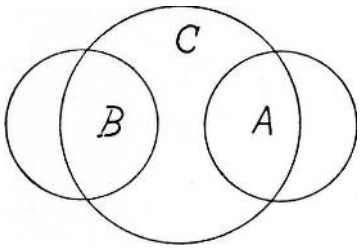


Fig. 22f. Sch = ± ±

V: Neither total projection nor inflation, neither total introjection nor negation are able to transform the being alone into a security of the participation. They lead to *falsified,* delusional participations. The desired participation can be realized only in such a way that both A and B establish the *being one* and *being related* with a *third, higher, spiritual authority and hand over to this higher court the omnipotence* (C). *Religion, art, science, humanity.*

Fig. 22. The Elementary Stages of Ego Development (*Continuation*)

The Participative-Projective World

The "*p*" Dimension

Humans exceed in delusion about the boundaries of natural reality both in perception and the world of ideas as well as in judgements and behavior. The ego transcends and moves *"trans"-real* in a *participative, projective world dimension of being* that we will concisely call the *"p" dimension*. This "*p*" dimension is the fourth dimension in which -- *in contrast to the body -- the soul* is able to extend itself.

By "dimension" one understands generally the extension of a body in space by length, width and height. Space is thus detectable in *three-dimensions* according to Euclidean geometry. In the concept "space" is the juxtaposition of the concept "time" set in succession. Time is the limited duration as a part of the eternity in a non-reversible movement.

"Reality" [*Wirkliche*] works by the assignment of its place in space and time, and it is set up by the ego in consciousness. The "material" of the sensual receives its first order thereby in that the ego takes up this material both in the form of space and in that of time (Kant). Apart from the *principle of space and time* extends the material nature reality, this worldliness is dominated by the *principle of causality*, becomes the sequental connection of cause and effect. The being of the ego in this world means that it follows the law of spatiality, the temporal, and causality.

If the ego embarks and transcends into the otherworldliness, then it frees itself from the laws of spatiality, temporality, and causality. We stated: *The ego moves into the* "p" *world dimension, in which the principles of space and time as also that logical causality lose their validity.*

In the world of the "*p*" dimension the ego can be *"one"* with things in space and time far away from each other and not be related to one another causally but only *finally* be connected. The *finality of space* and timeless acausal "*p*" dimension we consider the *participation.* The extension of the ego in this *transreal "p" world* of being one and the same with the other happens likewise independently of the principles of space, time, and causality and is managed by the *projection function*.

The *"p" dimension* of the ego possesses thus the following characteristics: 1. It is spaceless; 2. timeless; 3. independent of the causal law; 4. it stands simply

and solely under the final law; 5. it strives for *being one and for participation;* 6. and it reaches this by projection. All these characteristics are those of the unconscious (according to S. Freud).

*The ego of a delusion patient lives in this acausal, spaceless and timeless world of the "*p*" dimension in which reigns the final law of the participation. The final is: Being one and being the same.*

Now we ask the question: Is a human always a delusion patient if he extends himself partizipatively and projectively in the "*p*" dimension? We must answer this question in the negative since the ego moves in dream and also in belief in the dimension "*p*." On this is reported in the two last chapters of this book. Here we must mention however still definite "trans-real" perceptions and ideas that we encounter in modern art, especially in the so-called *surrealistic* painting, sculpture and literature.

The word *"Surrealism,"* which in 1917 was used for the first time by Guillaume Apollinaire [62], points out that this art represents something from "beyond reality," that is something that was only in the unconscious -- thus in dream or in delusion -- as mental reality is able to appear. The surrealistic art is in painting, sculpture, and architecture the interior declaration of the unconscious. It carries all characteristics of the "*p*" world dimension. It is thus created by the *participative, projective* primal process of the ego. In the surrealistic art the things are painted indeed independently of the laws of space, the time, and logical causality and formed in stone or wood. They represent situations of being *one and being the same* of the "frontal view" and "profile" of two heads, of man and woman, of a person and a plant, of a person and an animal and so on. The original and unconscious projective participation drive of a person as the outstanding need is satisfied in these works of art. The finality of this art exists precisely therein that it creates things that stand in nature reality far away from each other spatially and temporally, causally and logically and through their projection on one another has never in this way created unity and identity, a *p*-dimensional participation par excellence.

Also the theories of modern physics show a "break with materialism." Physics goes in the direction of "dematerialization of elementary particles," the matter, by imagining the essence of the electrons that orbit a planetary nucleus in pure *unsubstantial form* without any physicality. Through the disposition of the atomistic substance theory, modern theoretical physics moves in a world of ideas that stands very close to the projective-participative world of the "*p*" dimension and in a world of ideas that extends far away from the limits of the material nature of reality.

These facts have only been touched on here therefore in order to show that the world of the "*p*" dimension is not alone the ideas and perceptual world of delusion patients. The "*p*" dimensional world appears also in the modern artistic and scientific world pictures and penetrates into a new world orientation. Does that mean a dehumanization by the "loss of the middle" in the sense of Sedlmayr? Or is this surreal and transreal world view giving signs of the general "dematerialization" of the future world picture? Who can see into the future?

Fate Psychology takes the view that only an *integration,* that is the bridging of the given opposites, can lead to a harmonious whole picture. The purely material "*k*" dimensional world picture of the past epoch with its sole dominant causal law can accurately sketch only a half image of the world as does the modern "*p*" dimensional world with its acausal final law. We believe that a truthful picture can only be sketched of the world by the integration of the two half images, that is by bridging of the opposition between the dimensions *"k"* and "*p*," between causal law and final law.

In addition, the world needs persons with an integrated ego. Where however are these persons to be found?

End Notes

[1] FRIEDRICH KIRCHNER und CARL MICHAELIS : Wörterbuch der philosophischen Begriffe, neu herausgegeben von [Dictionary of Philosophical Concepts, newly restored by] JOHANNES HOFFMEISTER. Felix-Meiner-Verlag, Leipzig 1944. p. 760.

[2] *Ibid*, p. 583.

[3] BIRNBAUM, K.: Handwörterbuch der mcdiz. Psychologie [Hand Dictionary of Medical Psychology]. G. Thieme, Leipzig 1930. Artikel von [article of] KRONFELD über Wirklichkeitssinn [on the meaning of reality].

[4] JUNG, C. G.: Wirklichkeit der Seele [Reality of the Soul]. Rascher-Verlag [Rascher-publishing house], Zürich-Leipzig 1934. p. 24.

[5] *Ibid*, p. 27.

[6] HOFFMEISTER, J.: Wörterbuch der philosophischen Begriffe [Dictionary of Philosophical Concepts]. Begründet von [Established by] F. KIRCHNER und C. MICHAELIS. Meiner-Verlag. 1944. p. 760.

[7] DRIESCH, H.: Wirklichkeitslehre [Reality Teachings]. Ein metaphysischer Versuch [A Metaphysical Experiment]. E. Reinicke, Leipzig 1917. p. 11.

[8] *Ibid*, p. 305.

[9] HUSSERL, E.: Ideen zu einer reinen Phänomenologie und phänomenologischen Philosophie [Ideas Pertaining to a Pure Phenomenology and a Phenomenological Philosophy]. Erstes Buch [First Book]. Hrg. Von [Edited by] Walter Biemel. Husserliana III. Martinus Nijhoff, Haag 1950. p. 63.

[10] *Ibid*, p. 64. Vgl. hiezu die Einleitung dieses Buches [On this, see the introduction to this book].

[11] HUSSERL, E.: Ideen zu einer reinen Phänomenologie und phänomenologischen Philosophie. Erstes Buch. p. 67.

[12] *Ibid*, pp. 68-69.

[13] *Ibid*, p. 73.

[14] *Ibid*, p. 72.

[15] Schicksalsanalyse [Fate Analysis]. 2. Aufl [edition]. Benno Schwabe, Basel 1948. pp. 307-308.

[16] FREUD, S.: Ges. Schr. [Collected Works], Bd. [volume] V, p. 519.

[17] Triebpathologie [Drive Pathology], Bd. I, p. 415 ff. [and the following pages]

[18] KRAEPELIN, E.: Psychiatrie [Psychiatry]. A. Barth, Leipzig 1909. Bd. I, p. 310.

[19] BLEULER, EUGEN: Lehrbuch der Psychiatrie [Textbook of Psychiatry]. 7. Aufl., umgearbeitet von [Edition reworked by] MANFRED BLEULER. Springer, Berlin 1943. p. 50.

[20] JASPERS, K.: Allgemeine Psychopathologie [General Psychopathology]. 5. Aufl. Springer, Berlin-Heidelberg 1948. p. 80.

[21] *Ibid*, pp. 80 and 89.

[22] *Ibid*, p. 89.

[23] SCHMIDT, G.: Der Wahn im deutschsprachigen Schrifttum der letzten 25 Jahre [The Wahn [Delusion] in the German-language Bibliography of the Last 25 Years] (1914 bis 1939). Zbl. Neur., *97,* 113 (1940).

[24] HAFFTER, C.: Psychopathologie der Schizophrenie [Psychopathology of Schizophrenia]. Referat an der Herbsttagung der Schweizerischen Gesellschaft für Psychiatrie [Paper at the autumn conference of the Swiss Society for Psychiatry], 25./26. November 1944 in Zürich. Schweiz. Archiv f. Neur. u. Psych., Bd. 56, H. 1, 1945.

[25] SCHNEIDER, KURT: Nervenarzt [Neurologist], II*,* 461 (1938).

[26] KANT, 0.: Z. Neur., *146,* 599 (1933), und Z. Neur., *150,* 272 (1934).

[27] KLAESI, J.: Arch. Psych., *107,* 408 (1937). Ferner [Furthermore]: Psychotherapie in der Klinik [Psychotherapy in the Clinic]. Monatsschr. f. Psych. u. Neur., *124,* Nr. 4, 5, 6, 1952.

[28] SCHILDER, P.: Entwurf zu einer Psychiatrie auf psychoanalytischer Grundlage [Design for a Psychiatry Based on Psychoanalysis]. Leipzig, Wien,

Zürich 1925.

[29] CITRON, H.: Monatsschr. f. Psych. [Monthly for Psychology], *96,* 93, 1936.

[30] SCHULTZ-HENCKE: Der gehemmte Mensch [The Inhibited Man]. Leipzig 1940. Ferner: Z. Neur, *175,* 409 (1942/43).

[31] SCHNEIDER, CARL: Die schizophrenen Symptomverbände [The Schizophrenic Symptom Groups]. Springer, Berlin 1942.

[32] SZONDI, L. Triebpathologie [Drive Pathology], Bd. I, p. 257 ff.

[33] Vgl. Hiezu [See on this] «Triebpathologie», Bd. I, pp. 258 und 259.

[34] ZUCKER, K.: Arch. Psychiatrie [Psychiatry Archive), *IIO* [an ISO (International Organization for Standardization) image in an archive file], 465 (1939).

[35] HAFFTER, C.: Zit. Arbeit [cited work), p. 62.

[36] MATUSSEK, P.: Untersuchungen über die Wahnwahrnehmung [Studies on Delusional Perception]. Arch. f. Psychiat. u. Zt. Neur., *189,* pp. 279-319 (1952).

[37] BINSWANGER, L.: Ausgewählte Vorträge und Aufsätze [Selected Lectures and Essays]. Bd. I. Zur phänomenologischen Anthropologie [On Phenomenological Anthropology]. Francke, Bern 1947. p. 202.

[38] KUNZ, H.: Die Grenze der psychopathologischen Wahninterpretationen [The Limit of the Psychopathological Delusion Interpretations]. Z. Neur., *135,* 671, 1935.

[39] WYRSCH, J.: Die Person des Schizophrenen [The Person of the Schizophrenic]. Studien zur Klinik, Psychologie, Daseinsweise [Clinical Studies, Psychology, Mode of Existence]. P. Haupt, Bern 1949. p. 161.

[40] Triebpathologie, Bd. I, p. 367, Footnote.

[41] KRAEPELIN, E.: Psychiatrie, Bd. I, p. 321 ff.

[42] *Ibid.*, p. 315

[43] HARNIK, J.: Introjektion und Projektion im Depressionsmechanismus [Introjection and Projection in Depression Mechanisms]. Int. Ztschr. f. Ps.-A., *17,* pp. 441-448 (1931).

[44] STUMPER, ERNST: Triebstruktur und Geisteskrankheiten [Drive Structure and Mental Disorders]. Abhandlungen zur experimentellen Triebforschung und Schicksalspsychologie [Papers on Experimental Drive Research and Fate Psychology] (hsg. von L. Szondi), Nr. 2. H. Huber, Bern-Stuttgart 1956.

[45] Vgl. Hiezu [See this in] «Triebpathologie», Bd. I, p. 401 ff., Fall [Case] 37.

[46] Experimentellen Triebdiagnostik [Experimental Drive Diagnostic]. Huber, Bern. p. 234 ff.

[47] Triebpathologie, Bd. I, Fall 32, pp. 375-379.

[48] Experimentellen Triebdiagnostik : Syndrom des Irrewerdens [Experimental Drive Diagnostic: Syndrome of Going Insane]. Abb. [Fig.] 24, p. 89.

[49] BLEULER, E.: Lehrbuch der Psychiatrie [Textbook of Psychiatry]. 7. Aufl. [Edition], umgearbeitet von [reworked by] MANFRED BLEULER. Springer, Berlin 1943. p. 83 f.

[50] *Ibid.,* p. 32 f.

[51] WYRSCH, J.: Die Person des Schizophrenen. Paul Haupt, Bern 1949. p. 158.

[52] BERZE, J.: Die primäre Insuffizienz der psychischen Aktivität [The Primary Insufficiency of Psychic Activity]. Leipzig 1914. — Die Schizophrenie im Lichte der Assoziations- und Aktionspsychologie [Schizophrenia in the Light of Association and Action Psychology]. Allg. Ztschr. f. Psych., *75* , 1919.

[53] GRUHLE, H. W.: Bumkes Handbuch d. Geisteskr. [Bumkes Manual on the Mentally Ill], Bd. XI, Teil V. Berlin 1932.

[54] STÖRRING, E.: Arch. Psych., *98,* 462, 1932.

[55] HINRICHSEN, 0.: Z. Neur., *III,* 24, 1926. Psych. Neur. Wschr., *384 and 399,* 1937.

[56] GYARFAS, K., u. SCHULZ, G.: Beiträge zu den schizophrenen postprozessualen Ich-Gestaltungen [Contribution to the Schizophrenic Post-Processes Ego-Forms]. Mschr. f. Psych., *89,* 1934.

[57] WYRSCH, J.: Zit. Arbeit [Cited Work], p. 160.

[58] WYRSCH, J.: Zit. Arbeit, p. 161.

[59] KRAEPELIN, E.: Psychiatrie, Bd. I. I. A. Barth, Leipzig 1909. p. 158.

[60] Zit. n. [Cited in] WYRSCH: Die Person des Schizophrenen, p. 91.

[61] Vgl. hiezu die Fälle [On this see the cases] 16, 17, 18 in Bd. I der «Triebpathologie», pp. 262-272.

[62] Im Programmheft des russischen Balletts [In the Program of the Russial Ballet] “Parade.”