Hans Lungwitz

Psychobiology and Cognitive Therapy of the Neuroses

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Preface

With the expansion of the cognitive therapy developed in North America, new international interest has been aroused in the work done by the independent founder of this form of therapy in Europe, Hans Lungwitz (1881–1967). Unfortunately, Lungwitz's cognitive therapy could not be brought into general use due to the confusion caused by World War II and the scientific reactionism that followed in some Central European countries. It is all the more welcome that the basics of his theory and practice are now appearing in English.

Lungwitz's cognitive way of thinking was not only fundamental, but it sets standards. During its foundation, in a time of change, collapse and renewal (with the establishment of psychoanalysis and behavioural therapy), it was so far ahead of its time that we only now have the circumstances that permit its pathfinding methods to be brought into full use. Nevertheless, cognitive therapy has to be learned and understood. This is the reason for the repeated request by its founder that one ought to study it before subjecting it to criticism.

The material concerns the results of basic psychobiological research on human perception, cognitive theory, speech, behavioural and neurobiology, as well as the lifelong experience of the author with the cognitive therapy he used from 1924 on. The basic material is described to the necessary extent. It can be checked in the "Textbook of Psychobiology" (see literature references).

The text follows the German publication, which appeared as a textbook in 1980 with the title "Psychobiologie der Neurosen" (Verlag Rombach, Freiburg). It provides extracts from the entire works on the taxonomy of neuroses, structure of the neurotic experience, and basic facts about cognitive therapy.

Some passages on the discrimination of feelings taken from Volume I of the Textbook of Psychobiology were inserted at the beginning of the chapter on neurosis of feeling, since a deeper understanding of neurosis is missing without this material. On the other hand, a long paragraph on the legal concept of incapacity has been deleted, since it only refers to German law.

The appendix was expanded with a comment on psychobiology (by Austeda), and a table showing important dates in the history of Lungwitz's cognitive therapy by the editor has been added. The terms that appear in the "Terminology of Psychobiology" section are marked with an asterisk (*) at their first mention in the text, and can thus be looked up before they lead to misunderstandings. Illustrations and figures have been added to make certain points more clear.

The translation allows the English-speaking reader to make a comparison of Lungwitz's cognitive therapy with the version found in the United States of America, and usually attributed to Beck and Ellis.

A dispute about priority that could come about due to the fact that cognitive therapy – seen geographically – developed twice, and independently, would be pointless. The autonomous discovery of cognitive therapy in the United States in addition to the earlier form in Europe remains an undisputed, outstanding effort. As

regards the question of whether one system or the other was first, this work should make a contribution to cognition, and not set off battles about directions and schools as is the case with some theories of psychotherapy; such an event would be as unpleasant as it would be superfluous.

According to Lungwitz, the most far-reaching convergence to psychobiology had been reached in his life-time by psychology, psychotherapy and anthropology in the USA, starting with the behaviorism of J. Watson and the holism of A. Meyer-Abich. In this context, Lungwitz also refers to neuropathology as described by William Cullen (1710–1790) in Edinburgh: all vital appearances take their origin from the nervous system and alteration of the nervous system effects anomaly of the vital function. Consequently, Lungwitz says, neurosis is a purely functional neurobiologic disease. "With the metaphysical we can dispense" (Lungwitz, H.: Psychobiologie der Volksseuche Neurose, 1951).

The editor would like to acknowledge helpful discussions with Dr. H.-D. Dominicus, Prof. W. Machleidt and Dr. N. MacLean. Dr. P. K. Bauer, A. Furjan, H. Schlaack and Dr. W. Zabka helped in the preparation of the drawings. Several figures have been printed by permission. Last but not least, this book was supported by grants from the Hans Lungwitz Foundation.

Bad Salzuflen, July 1993 R. Becker

1. The taxonomy of the neuroses

1.1 The types of neurosis

"Nervousness" is commonly used as a description for the mild forms of neurosis; namely, degrees of excitability of the reflex systems approaching the normal, but already of pathological grade. Less frequently, it is used to describe still normal degrees of excitability of the reflex systems that approach the abnormal, especially in the anxiety and pain reflex systems.

"Neurosis"* is the collective term for the purely functional illnesses, the leptoses*, lying between the normal and the phrenoses* (so-called psychoses). Like every illness, neurosis is infantilism, and (in contrast to the hadroses*) purely functional: certain specific reflex systems, including their thought cells* and, disposed in this way, have remained functionally at a fetal-infantile, mainly early infantile evolution stage, while the other reflex systems of the organism have matured to a higher level. These systems undergo functional hypertrophy as the organism develops, and wax and grow at their evolution stage, so that the *evolutionary difference* between the morbid and the healthier and almost healthy reflex systems becomes increasingly large, with the neurosis emerging sooner or later from latency, depending on the specificity of the organism, especially in (not owing to) evolution crises; in the beginning (presymptomatic) it can at least be diagnosed by the specialist, but it is also often already evident in childhood, at the latest in puberty. The neuroses of childhood do not differ in principle from the neuroses of adults; they differ only in their ways of function and experience, which are simply infantile. Figure 1 illustrates this.

Functional infantilism expresses itself particularly at the cerebral cortex as the organ of consciousness, namely, how the ill person "interprets the world" (*Weltanschauung**). Neurosis is *morbidity of the personal attitude to the world.* The disharmony in the neurotic's attitude to the world depends on the evolutionary differences: in the focus of morbidity it is chaotic-animistic-magic (primitive-demonistic); in the more mature areas, depending on the degree of maturity, it is mythical, mystic, humanist to psychological-causalist (diluted demonistic, according to age), but these maturer stages are never completely healthy; there are morbid nuances, depending on the admixture of infantilist elements. They lie in the shadows of primitivism, e.g. the neurotic defends his infantile all-oneness-absoluteness against all differentiation, and details of the maturer stages that in fact put an end to his all-oneness; as a result, they have to be magically deprived of their differentiation and their singularity and brought into line with the all-oneness; he is also of extremist, radicalist outlook. The "child" in the neurotic predominates over the "bigger and big

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* See the section "Terminology of Psychobiology" in the Appendix

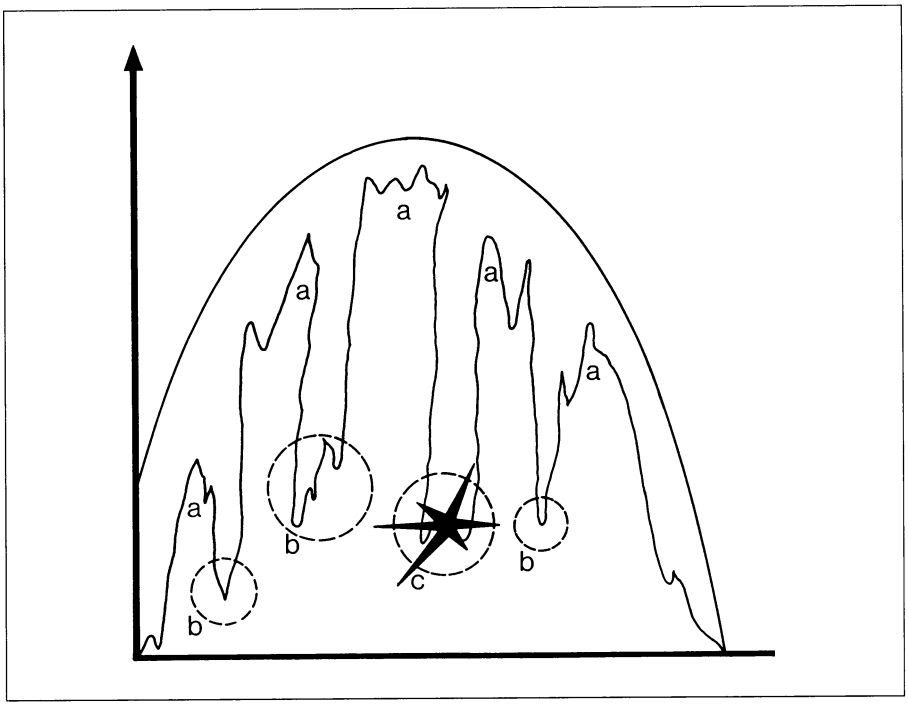

Figure 1. The harmonious evolutionary front of the healthy, shown as an ideal-typical growth sphere, and the disrupted evolution of morbid thinking. In the neurotic, the evolutionary peaks (a) correspond to almost normal experience and the valleys (b) are focuses of functionally abnormal thinking; these are circled. In their actual function (c) the neuroses blossom and influence the healthier parts of the organism.

one" the more the morbid functions flourish and the evolutionary difference increases. Functionally he is a dwarf giant or a giant dwarf. The infantile *sense* becomes infantilist *nonsense,* and faith becomes superstition. What the neurotic does, namely, his internal and external reflex expressions, are altogether spastic in the morbid area; they express the morbid outlook reflexly. *Thus the morbid outlook is the site of application for exact* (radical) *neurosis therapy;* the clarification of outlook, namely, cognitive therapy* has to be followed through to cognitive thinking, otherwise the patient calls rightly on the demonism of psychological-causalist thinking, even if it is diluted, to justify his primitivist demonism, his neurosis. The more fruitful the cognitive therapy, the more the functional evolution difference evens itself out, the more the morbid brain functions differentiate and correct themselves, and with this the morbid manifestations of expression and the spasms in the internal and external organs.

Figure 2 gives an overview of the evolution of personal attitude to the world *(Weltanschauung).*

The Evolution of Weltanschauung

Development age	Total attitude	Essential interpretation	Basic statement
highly mature	perceptive knowing wise concept sphere highly differentiated	cognitive realic free of metaphysics post-causal post-demonistic	The world is the conscious. The subject-object relationship is indissoluble and purely time-space based.
early mature or juvenile	intentional extensively matured concept sphere, modal (perceiving) sphere and feeling sphere	psychologic-scientific dilution of causal conditional teleologic (final)	The world is a multifactorial condition system. Body-mind problem.
adolescent	optative-intentional change from wish to will as elevation of the biologic level	motivic-causal roughly causal	Everything has a (its) cause.
late infantile	optative (wish age) diminution of sympathogenity of the sensory reflexes to the benefit of ideogenity	mystic mythic animistic-magic sagas of gods and heroes, magic-fairytale age	There is something "behind" everything and everybody (i.e. the metaphysical).
	INDIVIDUATION: Awakening of Me-You-World Loss of all-oneness-absoluteness		Contrariness enters the world.
early infantile			
foetal	sensitive highly sympathogenic sensory reflexes, predominantly feeling experience	all-oneness-chaotic diffuse magmatic implicated precausal predemonistic	The world is an undivided entity.

Figure 2. How a person thinks. The level of the thinking stage reached is specific for each individual. The changes from one way of thinking to another flow together: interference thinking. Seen from the level of the genetic thinking stage reached, it counts itself as right, and the stage before as wrong; for example, "correct" and "false" causality. Senile thinking (not shown) is the contemplative; it de-differentiates itself more and more, and dissolves in ultimate chaos.

There are various types of neurosis:

a) depending on the species of the dominant reflex systems in the morbid area, there are *hunger, anxiety, pain, sorrow* and *joy neuroses,* with the *congestion* and *mixed neuroses* in addition;
b) according to the structure, *neuroses of feeling, sensory perception and concept;*
c) *according to whether they belong to the trophic or the genic, the trophoses** and the *genoses**.

These various types of neurosis are described below. In the Textbook of Psychobiology (Vol. 6. chap. 5) it is stated that the neuroses are diseases of personal attitude to the world, and the types of attitude to the world are described. The morbid outlook types are summarized in figure 3, according to the predominant basic feeling.

The Pathologic Outlook Types

Type	Predominant Basic Feeling	Radical Motto: It's all...	Absolute Aim: The Person, the World is something that...
Nihilist	Hunger	nothing.	must be annihilated.
Negativist	Anxiety	no.	must be denied.
Severist	Pain	no-yes.	must be destroyed.
Pessimist	Sorrow	gloomy yes.	must go under.
Optimist	Joy	exuberant yes.	must rise again.

Figure 3. The nomenclature is pathographic ("severist" derived from the Latin severus = severe). Following on from determinant infantilistic feelings, it describes the one-sided, limitless and all-embracing in the hypertrophic basic attitude of morbid thinking. The other healthier feelings, sense perceptions and thoughts (concepts), are blended-in to the prevailing abnormal feeling, so that the neurotic experiences himself and the world – insofar as he or she is ill – either nihilistically, negatively, severely, pessimistically or with optimism, and this to such an extent that he "must" round off the world magically, and bring it into absolute balance (vide Procrustes).

Apart from *hyper*functions there are *hypo*functions; hyperfunctions can change to hypofunctions; accordingly, the forms of the neuroses can change. The hyperfunctions are described in this volume. There is an extensive description of the reflex structure of the organism in the Textbook of Psychobiology; the following is repeated briefly.

A reflex system is composed of the peripheral receptor sites (the sensing nerve endings), the centrally leading (sensing) nerve tracts, the peripherally leading (motor) nerve tracts, and the organ of manifestation (connective tissue differentiated variously, glands and muscle cells). The function of the reflex system is the reflex. We differentiate between interganglion, spinal, medullary, and subcortical reflexes, according to the layout of the reflex path. A complete reflex system runs

over the cerebral cortex, e.g. its sensing tract (chain of neurones) extends via the spinal cord, etc. up to the cerebral cortex; there, with the cortical neurones, the motor pathway begins, ending at the organ of manifestation. The complete nervous system consists of the sympathetic-parasympathetic (the so-called vegetative, autonomic), the sensory (so-called voluntary, animalist), and the idealic system; the latter is the layer of idealic thinking or (sive) conception cells of the cerebral cortex. A complete reflex system contains sympathetic-parasympathetic, sensory and idealic parts. The autonomic organs of manifestation are connective tissue, elastic tissue, glands and smooth muscle (including heart muscle); the sensory organs of manifestation are the striated muscles, and the idealic system is only indirectly connected with the motor system (Textbook of Psychobiology, Vol. 1. Part 2). The nerve stream is the "erone stream"*.

Depending on the reflex switching, more less abundant adjustments move out of the autonomic part into the sensory tract (sympathogenic pass forms); the same holds true for the idealic tract (ideogenic pass forms) (more detail is to be found in the Textbook of Psychobiology).

The reflex systems are grouped into the *trophic* (feeding, working) and the *genic* (plantonic and sensual). The organs of nutrition (mouth, stomach, intestine, with their related organs, breathing organs, heart, vessel, renal system), as well as, partially, the sense organs (skin, eye, etc.) are attached to the former. The sense organs and some internal organs are partially attached to the latter, that is to the platonic, e.g. the heart (heartfelt affection), with peripheral connections from the genital region and the reproductive organs, etc. to the sensual, and partly also the sense organs. Sensory muscles also belong to each group. The two groups are variously folded into one another, so that genic reflex systems and the organs of nutrition, and trophic reflex systems and the reproductive organs are inherent in one another, which means that the trophic (the trophic part of the organism) is, strictly speaking, only "mainly trophic" and the genic system only "mainly genic".

We designate the reflex systems according to the type of feeling (see p. 40), and speak of *hunger, anxiety, pain, sorrow and joy reflex systems, with congested and mixed reflex systems* in addition. The reflex systems are classified genetically into structures, each of which consists of hunger, anxiety, pain, sorrow and joy reflex systems, individual structures having a part in larger structures, and finally in the organism. The manfestations of expression are thus movement units consisting of narrowing-twisting-widening or bending-twisting-stretching. All morbid manifestations of expression are cramped-lamed, as stated in the Textbook of Psychobiology (Vol. 6. p. 113 f). The hypertrophic species reflex systems are also predominant in the manfestations that occur. Figure 4 gives an example of the structure of the smooth

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* Psychobiological erone theory describes the origins of viewing and consciousness as cognitive theory. It is presented in the Textbook of Psychobiology (Vol. 1. chap. 5, 8; Vol. 4. chap. 4, 7) and we need not elaborate here. In the following, "adjustments" is used instead of "erones" (editor's note).

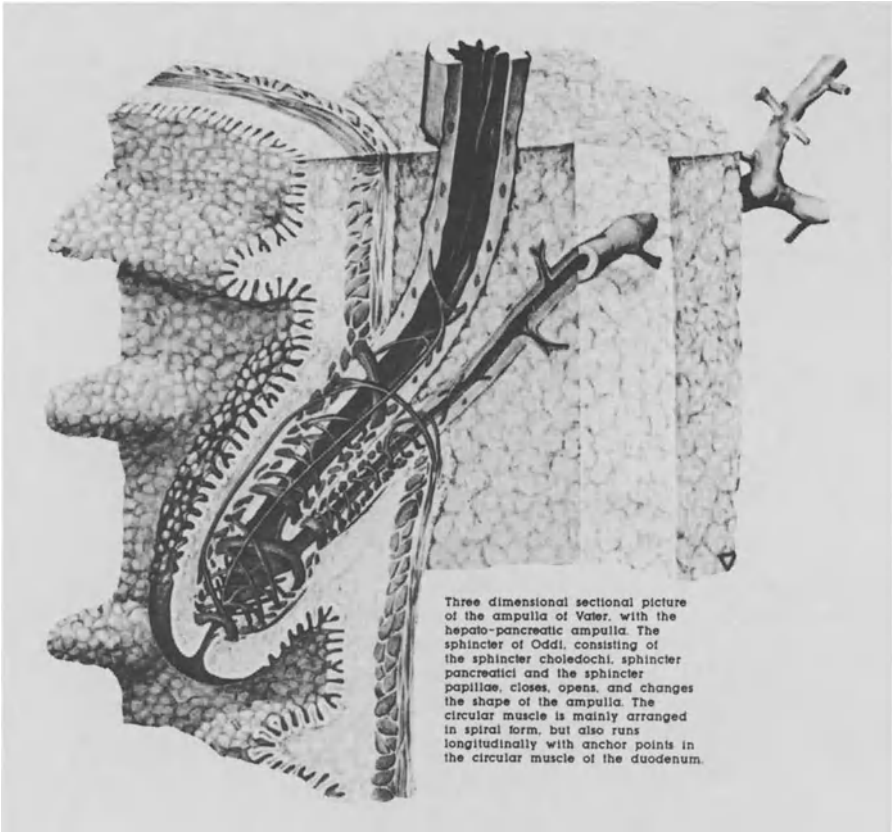


Figure 4. Each bundle of muscle fibres has its definite function in connection with experience, according to its specific structure and innervation (reflex connection). We differentiate hunger, anxiety, pain, sorrow and joy fibres in accordance with the individual basic feelings, in the following sequence: long and short circular muscles, oblique muscles, long and short longitudinal muscles. The boundaries blend into one another, as the illustration shows. The smooth muscles shown here with the peristaltic functions of narrowing, twisting and widening, correspond to the structure and reflex connections of striated muscles with the bending, twisting and stretching function sequence (see figure 15, p. 86). The sectional diagram and its description were prepared without knowledge of the statements made in this connection; they were not "built in" to the illustration.

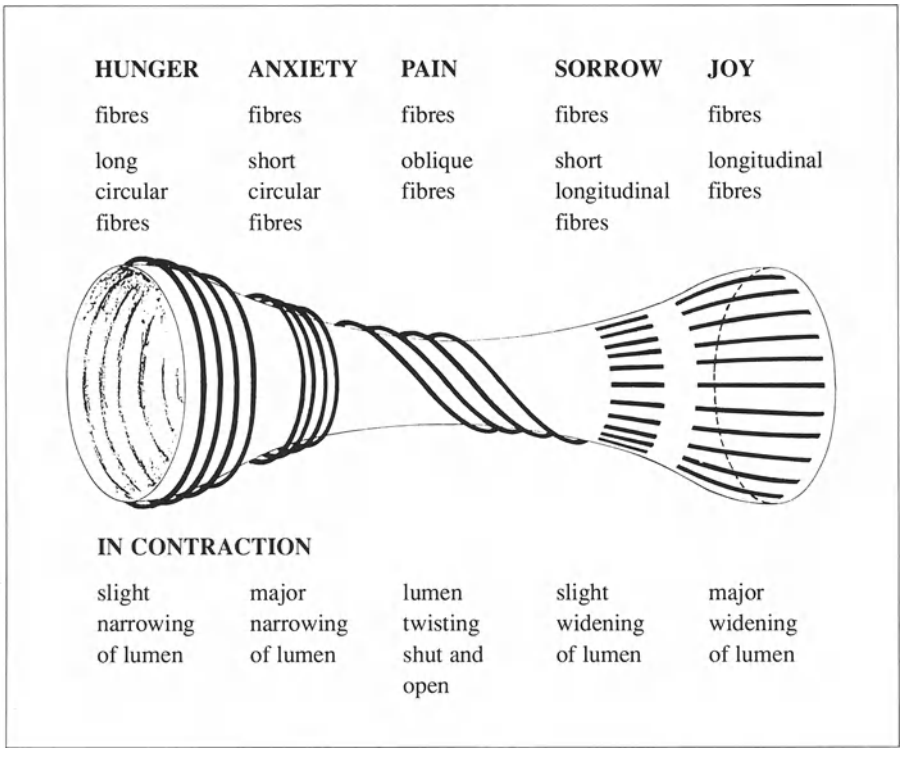


Figure 5. Schematic representation of the smooth musculature in a tube (e.g., a blood vessel), with its structure and function, and the connection between experience, innervation, and the five basic feelings hunger, anxiety, pain, sorrow and joy.

muscle and figure 5 its function. The structure and innervation of the striated muscle is similar (see figure 15, p 86).

The cerebral cortex is the organ of consciousness. The cortical nerve cells – with the exception of the associatory neurones that only conduct – are so specific that at the function peak the conscious, the actuality (specific for each thought cell), is "there". The thought cells are autonomic or (sive) sensile, sensory or (sive) modal and idealic; they are cells of feeling, sensory perception and concept, and cells of all three types belong schematically to a complete reflex system; this leads to a given feeling being genetically associated with a given perceived object and concept. It is true that each thought cell is directly or indirectly associated with all the others via collaterals, but with the retention of the basic structure of the cortical systems described.

Cortical nerve cell scheme

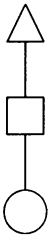
Reflex system		Thought cells	Manifestation in Consciousness
Idealic part		Concept cell	Concept
Sensory = modal part		Sensory cell	Object of sensory perception
Vegetative = sensile part		Feeling cell	Feeling

Figure 6. The three object types: feeling, object of sensory perception, and concept. For further explanation, see Section 3.2 (p. 182 f.).

Hunger is the general designation for all individual feelings of hunger, anxiety for all individual feelings of anxiety, etc. We classify the feelings* (like sensory perception*, the concepts* and the reflex systems) into the *trophic* and the *genic*, and thus speak of trophic and genic hunger, trophic and genic anxiety, etc. The feelings are localized "in" the organs, i.e. each feeling is allocated to "its" organ, and is an "organ feeling", although the feelings allocated to the internal organs have to be differentiated from those allocated to the sense organs as *organ feelings* and *sense organ feelings*.

The *trophic organ feelings* are the gastric, cardiovascular and pulmonary, the *genic* are the genital; to this the interplay between the two has to be added. Thus, we speak of stomach, intestine and liver feelings, etc., heart, vessel, spleen, kidney, bladder, tissue, nerve and brain feelings, etc. lung or (sive) breast feelings, and genital feelings, namely hunger, anxiety, pain, etc. In addition, the organ feelings are named after the organ-specific registrable *objects* capable of absorption, and we speak of protein (meat, egg, cheese, etc.), salt, liquid and air hunger, anxiety, etc. and again, the feeling is specific according to the type of meat, fat, carbohydrate, liquid, etc. All organ feelings can be described in one of two ways, and it is usual to describe the feelings in one way or the other, e.g., one speaks of air hunger, air or (sive) breathing anxiety, but breast pain or a "stitch in the side" rather than air pain, and the feelings we call air sorrow and joy have up to now no special designation at all – apart from "lung expansion feelings". The *output* or (sive) *expulsion feelings* are described analogously to the *uptake* or (sive) *embodiment feelings*; thus, one speaks of emptying hunger, anxiety, etc. localized in the terminal parts of the organs of emptying (intestine, bladder, genitals), and especially of stool, urine and abdominal urges, etc.

Hunger is directed towards fulfilment. Can it be directed towards emptying? If the stomach is full, the hunger stage introduces the emptying; the hunger increases in step with the emptying process, directing itself towards the next filling and initiating the uptake process. So, one can speak of *emptying hunger*, characterized by the setting in of output; but it always also remains hunger for new input. Stomach hunger is actual, as soon as the stomach emptying has proceeded far enough; up to that point the hunger reflex systems function non-actually. Thus, we generally designate stomach hunger according to uptake; but in pathological cases, it is designated emptying hunger (pressure on the stomach), for example, in too long, lingering digestion, belching and nausea, and has here a certain nuance; discomfort to sickening (not to be confused with loathing). Hunger localized in the terminal parts of the exit route is designated emptying hunger after the emptying process taking place there, especially since the new uptake process follows gradually from above and the function of the total structure gradually sinks initially to the non-actual level. So here "the fulfilment" is initially the joy stage of the emptying process (feeling of being freed). *Tenesmus* is pathologically increased emptying hunger lasting longer than the emptying: conversely pathological uptake hunger can persist when the hollow organ is full (insatiable hunger). The anus and the terminal ureter are normally only excretion openings; uptake hunger is only localized there abnormally; if water or medicated fluids are run into these tubes, or the finger, or (perverse-genic) the penis are inserted into the anus, namely, uptake hunger initiates uptake; uptake ends in fulfilment and the initiation of output, with output hunger; the latter can change back to input hunger. The uptake and output processes in the female genitals are analogous. *"Urge"* is anxiety with hunger content or hunger with anxiety content. The urge to urinate, for example, is a tactile-coordinative vesical anxiety feeling or hunger with anxiety content, connected with the feeling of a full bladder (feeling of fullness, feeling of bladder satiety); its manifestation is contraction of the bladder; initially the closing structures and related constriction muscles of the pelvic floor also act together until a point comes when the bladder contraction is stronger than that of the closing structures. The urge can appear with relatively small amounts of urine in situations of anxiety, can be over-emphasized in neurotics, and can take the form of tenesmus. The pressure feeling of real hunger can be differentiated from the urge feeling.

The feelings of uptake and output are hunger-anxiety-pain-sorrow-joy feelings (Textbook of Psychobiology, Vol. 1). Substances are the objects of sensory perception genetically associated with the individual organ feelings, to which the individual feelings are oriented. "Bread", for example, is an actuality series of such object perception cells which form an associative system with feeling cells whose actuality sequence is certain stomach feelings; so, bread is associated with these stomach feelings. Analogously, alcohol is associated with certain vessel-stomach feelings, etc. In addition, naturally, as an optic object perceived, there is association with certain visual feelings (visual hunger, etc.).

These objects of sensory perception can be *ingested* (nutrition and luxury food), and differ from *output* substances like stool, urine, etc. that are normally only associated with output feelings. This differentiation comes about in the course of

evolution from early infantile indifference (tasting stool and urine, etc.), and progresses to the segregation of objects the senses perceive cannot be ingested.

The *non-incorporable objects of sensory perception* are mainly associated with *sense organ feelings* and are thus actualities from object perception cells that form cortical reflex systems with those feeling cells belonging to the sense organs, each of whose actualities is localized in a sense organ. So, we speak of seeing, hearing, touch, taste, smell, heat-cold, movement (position, strength and direction) hunger, anxiety, etc., insofar as these feelings are characterized by the sensory function; one can also speak of eye, ear, tactile and thermic skin feelings, and of muscle feelings, but we cannot characterize taste an smell feelings as palate and nose feelings, for these are tactile feelings. As described, each of these feelings is associated genetically with "its" object as perceived by the senses, and is directed to it in this way.

All these structures differentiate themselves exactly in the course of evolution, and are purely biologic-autogenic. Alterations do not affect the basic structure as such, but do affect the intensity of the individual feelings, the degree to which the objects of sensory perception are felt (value), habituation, decreased interest, and further, the number of the correlated actualities (growth-decay), the spreading of the associations between the individual structures, and the phenomenal-phenomenologic associations (occurrence-description), the access to the motoric, the intimacy of the autonomic-sensory and the idealic-sensory contact, etc. The genetic-associative precision is easily recognized, e.g. "I am hungry to see a forest, a certain tree, a lake, a mountain, a certain countryside, a certain person, a certain work of art, etc.; I am hungry to read, etc."; further, "I am hungry for music; for music by Verdi, Mozart or Wagner;" word hunger (hunger to hear a certain language, a certain person, a certain word); "I long for a certain contact, a certain scent or taste, for a certain muscular activity (my work, a change, to write, to hammer, to plane, to visit customers, to ramble, ride, swim, etc., etc.)." Genic hunger, to see mother, to speak to a friend, to meet a lover, to kiss, to embrace, etc. Briefly, each feeling in each sense area is precisely arranged. Only in still incomplete reflex systems can the object perception cell, to whose actuality the feeling belonging to the system is oriented, still function non-actually; but also, in this case, the feeling is already implicitly oriented as a part of the system.

The *concepts* are genetically associated with the individual sensory perceptions; the foregoing explanations also hold true for the orientation of the individual feelings to the concepts belonging to the system. Thus, we have hunger for a certain memory, for certain verbal concepts (thought hunger) and, analogously, anxiety, pain, etc. (thought anxiety, pain, etc.), each associated with the phenomenal or phenomenologic concept to which the feeling is oriented. The sensory perceptions, belonging to the system, do not need to occur in actuality, but, of course, must have been genetically actual previously, otherwise one could not remember them.

The individual feelings are thus specified according to the organ where they are localized, and according to the object perceived and the concept with which they build a genetic-associative system, to which they are oriented in this genetic way. Genetically, the feelings are always the first to be actual, then the objects perceived,

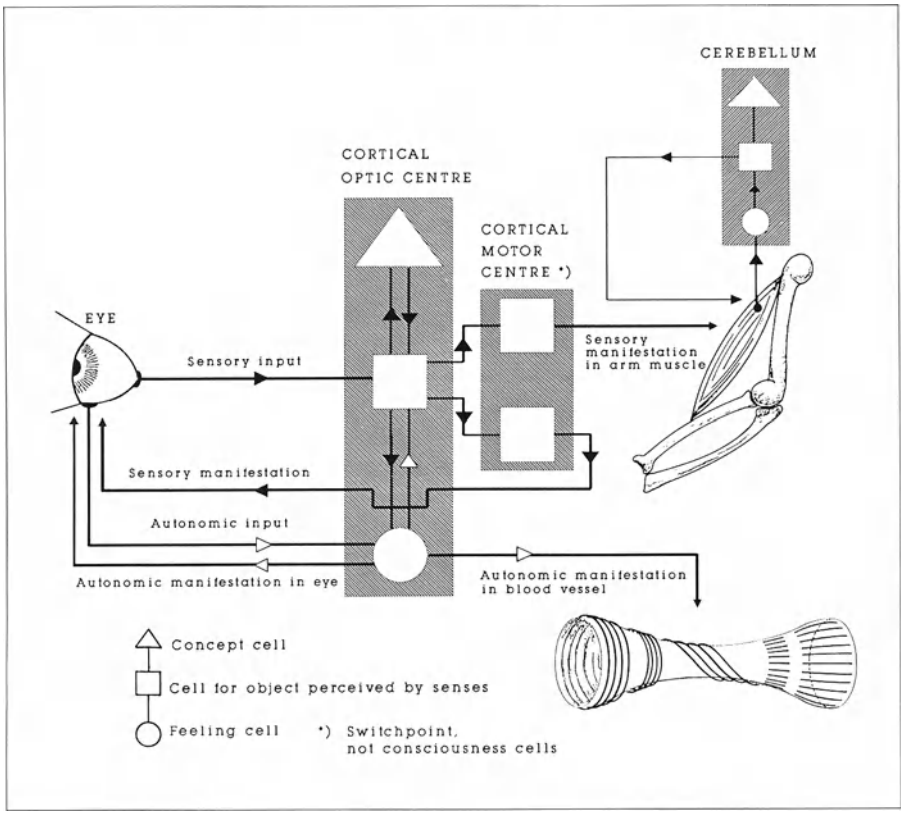


Figure 7. Greatly simplified example of the functioning of cerebral cortex reflex systems. The vegetative manifestation, for example, of a feeling of anxiety in the optic area, is the contraction of certain (circular) smooth muscle fibres in the organ of sight (iris sphincter, blood vessels etc.), with corresponding circulatory changes and secretion of fluid: glassy look. Or: spasmodic contractions of elastic, circular, bulbar fibres, and spasm of the retrobulbar venous and lymphatic drainage: "eyes popping out with anxiety".

Sensory and idealic (the latter indirectly via the sensory) manifestations of anxiety in the eye accompany aversion to seeing: averting the eyes (looking away, looking past, shifty look). The opposite is anxious fixation ("looks mesmerized"). In addition, there can be wandering attention; empty, "unthinking" look, etc., The cerebellum registers on muscle-joint actions, namely, position, strenght, and direction. The afferent reflex pathway reaches the sensile sphere of the cerebellum from the sympathetic receptor in the muscle; from the sensory it reaches the modal. In an anxiously closed-in situation, anxiety about arm movement can appear, such as a feeling of paralysis, anxious rigidity, etc. The arm is "as if it's lamed", "no strength in it", "as if it was fixed". The sensory anxiety manifestation in the arm muscle can show itself in constrictive bending movements; flexing the arms and lifting them in front of the head; and with this, an anxiously ducking posture of defence and protection, with bending of the torso, the head drawn down between the shoulders, etc. Other functions of the reflex system can be described in the same way, according to other types of feeling.

and then the concepts; in the completed system, the feeling can follow the object perceived or the concept, or the object perceived the concept. Therefore, the actualities can alter according to which thought cell the actual function wave runs. In a certain hunger reflex system the hunger feeling is oriented to bread, and is thus a stomach hunger, and a bread hunger (appetite for bread); in an anxiety reflex system oriented towards the street there is visual anxiety, a street anxiety; in a pain reflex system the feeling of pain is directed to a specific food; it is a gastric pain that can become actual after the intake of food; in another pain reflex system it is directed at an eating utensil, and is visual pain on looking at a knife, fork, etc. In a sorrow reflex system, the sorrow is orientated to a certain melody (acoustic object perceived series) and is a hearing sorrow feeling associated with the melody; in a joy reflex system the feeling of joy is orientated to a certain contact (tactile object perceived series) and is a touching joy associated with this contact, and so forth. Naturally, all the reflex systems belonging to it take part at the peak function of a structure; the examples are only to show the preciseness of the system structure. It can be established in both the normal and the abnormal; the associative insecurity (chaotic) of the early infantile stages goes over to a consolidation during the waxing of the morbid reflex systems, and this can be seen in the symptoms (associative compulsion). Figure 7 demonstrates the function of the cerebral cortex reflex systems where the feeling, object perception and concept spheres are involved.

> It is, however, emphasized that there is really no causal nexus between feeling, sensory perception and concept; there is only a temporal connection in sequence. Also, the organ does not cause the feelings localized in it, rather, the feeling is an actuality of the autonomic reflex systems, whose reception or expression apparatus is the organ or the organ part concerned; they function nonactual-actual-nonactual, according to their specific rhythm. The stomach, for example, does not "make" stomach hunger, etc.; with increasing function, the stomach hunger reflex systems take up more hunger elements (adjustments) "from the stomach" in their sensing nerve endings according to their specific functional periodicity, and with decreasing function, fewer. At the peak of the function curve the actuality "stomach hunger feeling" is there; the organ of expression of the hunger reflex system is the elastic fiber or muscle cell belonging to it; the contraction to hunger width follows and the hunger elements are given off. So, stomach hunger is an actuality of gastric hunger reflex systems that function actually according to a specific rhythm; but their function is neither set in motion nor inhibited "by the stomach". The same holds true for stomach anxiety, pain, etc. Stomach pain can *attach* itself to a food, depending on the reflex structure, namely one time to this food, another time to that food, and not every time, but the food can cause neither the pain reflex system nor its function. The function period is specific, "autonomic",in both normal and pathological cases, but takes its course naturally in certain (system genetic) temporal connections. One says, "the mechanical stretching causes pain"; but in reality, one can say only that the actual function of the pain reflex system *can attach* itself to the mechanical stretching; the stretching itself is already an expression of pain reflexes. These can increase from non-actual to actual functional intensity, and this all only happens according to the

specific structure of the individual, namely, in individuals possessing this sort of hyperfunctioning pain reflex system.

He who overloads his stomach (one could think of mechanical stretching in this connection) and gets pains, is ill in this specific way. Many "gluttons" get no stomach pain (so what is "the causality"?). Another case is when a patient on the blandest of diets, or even without taking anything to eat, gets stomach pain; yet another patient has stomach pain with a stomach ulcer, i.e. as a concomitant symptom (the ulcer, does not "make", or "cause" the pain), etc. Or, one discusses how "migraine headaches" could be explained. One author blames the increased cerebro-spinal fluid pressure through which "undoubtedly increased tension of the dura mater is caused"; the sensing nerve fibres with their terminals there "could bring the raised tension of the dura to consciousness of the psyche by setting off headaches". But the increased pressure is already a consequence of angiospasms (where serum is extruded, "exudes"), so it is also due to vascular pain reflexes, and increased tension in the dura is not any different; so there is nothing more than a series of hyperfunctions of the pain reflex systems in the form of a symptom complex, into which the causality is fictively inserted by bothering the psyche. Another author is of the opinion that "the mechanical stretching" of the blood vessels that "are sited at the most important point in the mechanism of the attacks" is the cause of the pains. But, as said, the "stretching" of the blood vessels is already an expression of anxiety and pain spasms, and these reflexes specifically obtain their own actual degree of function; there can really be no question of "causing". Thus, psychobiology theory is: in typical cases migraine proceeds with actual function by pain cells (there is also migraine without actual headache) that are allocated to "the head" (certain sites); the organs where these pain reflexes are manifested (like the always participating anxiety reflexes) are brain vessels, especially pia and plexus vessels, and with these angiospasms (as elsewhere), congestion, and extrusion of serum into the tissue, increased intracerebral pressure, etc. take place. With reduction of the function of the morbid reflex systems the headache and angiospasm naturally stop until the morbid functions resume (periodic). Naturally, the headache is not the only symptom, but all the others are to be understood analogously. That these (like all other) morbid sequences of function take place "under certain circumstances" is self-evident: these circumstances lie in the framework of the specific-special system genesis, so that one migraine sufferer has an "attack", i.e. the acute wave, after certain "heavy" food, another after smoking, after taking alcohol, after sex, during "sedentary work", during menstruation etc., but these circumstances are not causes; they are only symptomatic details of the morbid function wave, not "the causality category doing its absolute duty"; this causality is only interpreted into the associative, purely temporal relationships, without gaining any cognition besides the real facts. Certainly, if the patient avoids dangerous situations, giving up smoking for example, he will avoid his migraine or at least reduce the frequency, but this is not evidence of causality, rather, all that is happening is that the morbid experience is taking a different, special course, without actual function of the pain reflex systems. It is clear that the avoidance of the danger is not true therapy, and is only a diversion. In many cases the migraine situation cannot be avoided (e.g., with menstruation).

The system-genetic relationship of the complete reflex system, i.e. that existing with the autonomic, sensory and idealic part, is naturally also present at the *organs of manifestation*. In this way, system-genetically, the sensory perception and conceptual actuality series "bread" belongs to the feeling "stomach hunger for bread", and certain system-genetically determined sensory hunger muscles and their functions belong to the stomach hunger muscles and glands and their functions: movements directed towards bread, visual seeking, reaching for bread. These consensual muscles function in such a way that the sensory peak function follows the autonomic at once (often under strong sympathogenic influence) or after a time (after some hunger), or conversely, the sensory peak function precedes the autonomic, as when bread is bought before the feeling of hunger becomes actual. Analogously, the action of the stomach anxiety muscles corresponds to that of the system-genetically related skeletal muscles, i.e. in the way of approaching and also hesitating that follows the reaching-for. The stomach torsions correspond to certain sensory torsions, e.g. grasping, cutting, biting the bread, the "bread-slice"; certain sensory stretchings (loosening) correspond to the beginning stomach expansion (sorrow expression, filling bit by bit), and the completed expansion of the allocated sensory muscles (laying the eating utensils aside, leaving the table) correspond to the completed stomach expansion (manifestation of joy, satiety, filling). Autonomic-sensory synergism is a general fact; the idealic functions participate in this in their individual ways.

At or near the external openings, the musculature changes from smooth to striated, and internal functions connect themselves with the external, or the other way round. Intake into the inside, e.g. in the mouth, begins with the sensory functions; output from the inside, e.g. at the anus, ends with sensory functions. So, the sensory muscle actions are orientated to objects perceived by the senses that can be taken into the inside, and after a certain transformation can be given up from the inside, that are incorporated and expelled, but in addition to such objects perceived by the senses that are not incorporated, but have some connection with those that can be, namely worked into them, or exchangeable with them in nature, or in valuables (money), or are tools, etc., whose use (manipulation) brings in pay-life support (trophic), or are used in the manner of platonic or sensual love (genic).

The (each individually specific) connection of system *feeling : object perceived by the senses that can be incorporated: object perceived by the senses that cannot be incorporated* agrees with the connection of the internal organ : a threshold (on the body surface) with an object perceived by the senses that can be incorporated : an object perceived by the senses that cannot be incorporated and, in that case also, with the connection of *organ function : incorporation : processing* (manipulating). Analogously, *organ function : expulsion* (disincorporation) : *processing*. In the trophic, incorporation is eating, drinking, inspiration, briefly, nutrition, and processing is job activity, work, acquisition; analogously the expulsion of stool, urine, sweat, expiration, etc., and processing is the removal of the expelled. In the genic, incorporation is the intake of genic substances (e.g. in luxury foods), and in sensuality, finally, the intake of the penis and semen; processing (manipulation) is platonic creation (artistic, etc.) and handling the work, giving presents, friendly tenderness and sensual caressing, the gaining of and relationship with friends and a lover;

analogously, expulsion is the output of the genital juices and products, in the end the child, and processing is the disposal of the expelled, the rearing of the child. The concepts correspond to the objects perceived by the senses, and the idealic functions participate "ideogenically". All these processes are hunger-anxiety-pain-sorrow-joy feeling structures, and are thus labelled according to the feeling species; as, on the other hand, the manifestation characterizations are also used to label the feelings, i.e. work hunger, work-shy, work enthusiasm, work laziness, work joy, etc.

The system-genetic connections do not only exist in the optic. The Textbook of Psychobiology (Vol. 1 26, 2) shows that the internal organs are represented in all sense centres, as feelings, and can be innervated via the feeling cells belonging to them; in the completed system, the genetically-associated sensory actuality series can precede the internal functions (excitation of feelings), following but not caused by them. These relationships are especially clear in neurotic cases, e.g. hearing music that he experiences as painful, a patient has ear, head, nerve, tooth, stomach, intestine, liver, heart pains, etc., according to the reflex structure, with corresponding manifestations (e.g. tears, etc.); a patient with eating anxiety (sitophobia) can only eat during radio music (distraction from the anxiety feeling, namely suggestive alteration of the feeling sequence as a result of hearing music, not caused by music; if the mucosa of the mouth is contacted "by fibrils" in a sieved soup, a patient gets throat and stomach cramps; a patient gets rheumatic pains in a draught; a patient gets nausea, diarrhea, palpitations from "bad" smells and tastes; asthma in cold, warmly humid, hazy, sultry wind; dizziness, nausea, vomiting when driving, etc. But the connections are also known in the normal situation, e.g. urine urge at the sound of running water, etc. The sensory muscles can also be innervated to contraction over all the sense centres, via the motoric area of the cerebral cortex, but the movement sequences described above, namely processing, incorporation through the mouth, etc., that is to say, the change of an optic object perceived by the senses to another takes place only in the optic; a bang, a call, a melody, a scent, etc., cannot be grasped by the hands and put into the ear or the nose; one can only relate to the actuality of the other (non-optic) sense areas according to the relevant innervation (e.g. go after a bang, a call, a melody, etc.). The acoustic process analogous to optic incorporation is the transition of one sound to another; this is also so in the other sense areas. All of these processes are associated with "their" optic equivalents and represent these, so to say, in the specific type of the sense experience concerned. The unconscious intakes and outputs are to be differentiated from the conscious: the intake of individually specific adjustments into the nerve endings, and their output at the motor end of the reflex path.

The following scheme shows the neuroses, according to the type of reflex systems predominant in the morbid area, the structure of the morbid reflex systems, and the allocation to the trophic or the genic (previously published in the Ztschr. f. d. ges. Neur. u. Psych. 1926, Vol. 105, p. 636):

Instead of feeling, object perceived by the senses, and concept neuroses, one can also say *sensile* or (sive) *autonomic, modal* or (sive) *sensory* and *idealic* neuroses. The autonomic neuroses are also called *organ neuroses*, the sensory *compulsion neuroses* (in the narrower sense all neuroses are "compulsive"), the idealic *thought neuroses* (thinking in the narrower sense as much as conceptive thinking).

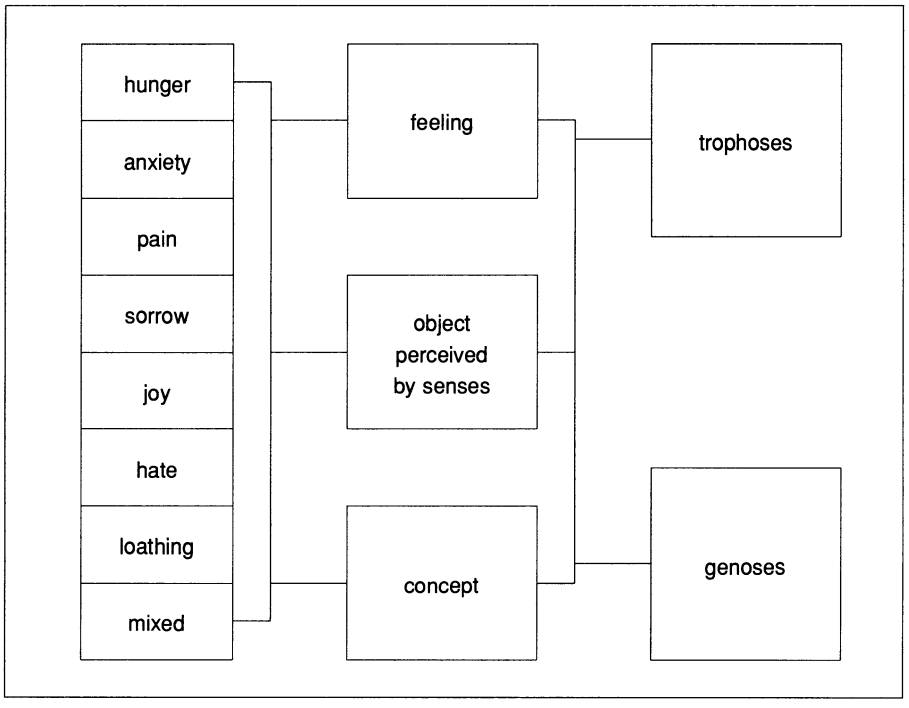


Figure 8. Scheme of the neuroses. See text for description.

The hate and disgust neuroses are *congestive neuroses* (hate = congested hunger, disgust = congested joy-satiety); the other feelings also occur in congested form, but the hate and disgust neuroses stand out especially clearly.

The *mixed neuroses* are *mono, di or triphasic*, e.g. anger, envy neuroses, etc., and hunger-anxiety, or sorrow-joy, or anxiety-pain, or anxiety-sorrow neuroses, etc. Another type of mixed neurosis is the trophosis with large genic "content" and genosis with large trophic "content": these *mixed neuroses* can be differentiated from the others as *heterophasic* (cf. 1.3).

The *trophoses* and the *genoses* are the neuroses that were previously summarized under the term *"neurasthenia"* or *"hysteria"*.

The hunger and anxiety neuroses are the *schizoid*, the sorrow and joy neuroses the *cycloid* neuroses (schizoidia, cycloidia), the pain neuroses belong to one or the other group (Textbook of Psychobiology, Vol. 6.).

1.2 The trophoses and the genoses

The trophoses are the neuroses of the nutrition and work areas, and the genoses those of love. The trophic and genic reflex systems are manifoldly folded into one another;

there are genic parts in the trophic system and trophic parts in the genic, so that, strictly speaking, the trophic system is only mainly trophic, and the genic system only mainly genic, thus the trophoses are only mainly trophic illnesses and the genoses only mainly genic ones – but the "mainly" decides the diagnosis. From the fact that reproduction, gestation and birth take place in the genital region, in the genic area, one should not conclude (as in the libido theories of *Freud* and *Jung*) that the human being is a purely sexual being, and that there are only genoses. As said above, the trophic contains genic, and the genic contains trophic; as the embryos grow with specific metabolism, the embryonic cell implicates the total genic and trophic of the future individual, as it shows in itself: cell nutrion, cell division. According to the specificity, in the case of a neurosis a trophosis with genic participation develops, or a genosis with trophic participation.

In the trophoses, the genic disturbances are so overshadowed that diagnostically and therapeutically they may not be overlooked, but they may be considered insignificant; conversely, the trophic disturbances in the genoses also lie in the shadows. A stomach neurosis, asthma etc., is to be diagnosed and treated as a trophosis, so long as the patient's love life is not greatly out of order, or virtually in order. In contrast, as a genosis, to the extent that the disturbances of the love life are in the foreground, the respective stomach and respiratory complaints thus label the hypertrophy of the respective genic gastric and pulmonary reflex systems associated with genital reflex systems. Many patients cannot, of course, make such an exact self diagnosis, neither can the pyhsician allow himself be satisfied with the patient's report, no matter how carefully he has paid attention to it, but must instead investigate in more depth and explore the facts of the matter psychobiologically. Often the patient first brings a side symptom forward, which is perhaps the most troublesome for him, or he believes it to be the main thing; he is often also the sort of anxious type who conceals the main symptom as his personal secret – in the foolish expectation that he can be "made well anyway". Many a patient puts his doctor to the test, and is then "satisfied" with him if the doctor does not realize what is happening ("the doctors don't know anything either").

So, strictly speaking, all neuroses are heterophasic mixed cases and "pure" trophoses and genoses do not occur, but we speak of such mixed cases as tropho-genoses, or geno-trophoses only where the genic symptoms with the trophoses or the trophic symptoms with the genoses present themselves to a marked degree, even as far as being equivalent. In this way, a prostitute can be "frigid" in "business sex" (here, she uses her sexual organ perversely as a business organ), and in sex with her lover (pimp, etc.) capable of voluptuousness, and even of conceiving and giving birth (poor child!); such cases belong to the trophoses, certain impairments of sexuality are always present, but can recede far into the shadows. Other prostitutes are frigid and impotent under all circumstances; they belong to the mixed cases. In the one case the business stands in the symptom foreground, and in the other, the sexual. Other women are only frigid as sexual beings, they do not connect any acquisitive interests with their sex life; in their jobs, including that of a married housewife, no especially obvious symptoms are to be found; they belong to the genoses. A patient, aged 27, "must lick women irrespective of the aversion to doing so" (cunnilingus compulsion);

it emerges that from early childhood he held urine to be a magic water (life-death water, "poison"), and had anxiety to pass it, to "lose it", in the persistence of fetal drinking of urine-containing amniotic fluid he felt the compulsion, at least partly (magically: part = whole) to lick it up again from "the (toilet) bowl" and thus overcome the enemy-demonism "of the bowl spirit" that stole the urine from him, to protect his omnipotence –, and so he "had to" lick up the urine from the "female pelvic bowl", that was to *this extent* not genital for him: the symptom was trophotic; irrespective of whether the licking took place or not, it impaired coitus, but *then* it was quite satisfying. The patient also had "always" to "wrestle with death" in his profession: a trophotic with moderate genotic input.

According to the etymology of the word, *hysteria* (hystera: womb) characterizes certain "nervous" female disturbances interpreted as being of sex life. They are not supposed to be found in men, or at least no points of comparison allowing hysteria to be diagnosed are to be found in male nervous symptoms; male hysteria would really be a contradictio in adjecto. "Neurasthenia" was therefore bestowed on the man, and the phrase used was "the neurasthenia of the man is the hysteria of the woman". But, in fact, the man can also be hysterical, and the woman neurasthenic. The genitals of the man and the woman are analogously constructed: the uterus corresponds to the prostate, the clitoris to the penis, etc. Thus, if one regards the uterus as the "seat of hysteria", then one must grant hysteria to the man also. Furthermore, only a certain, but in no way exactly described group of nervous disturbances of the woman have been labelled hysteria, and these mainly in the sphere of genic feeling: other functionally genic illnesses, especially those of the object perceived by the senses sphere, with their sensory means of manifestation, namely, the genic compulsion neuroses, were not included with hysteria; such as the morbid forms of masturbation, exhibitionism, sado-masochism, so-called homosexuality, the genic forms of fetishism, etc.; they were described under "sexual psychopathology". Prior to psychobiology, although one sometimes established "relationships between hysteria and consciousness", there was no clear definition of the genic concept neuroses. Now, in women, the feeling sphere is often more richly developed in relation to the object perceived by the senses sphere, and especially the concept sphere than in men, and in women the love life occupies more room than in the man (consider pregnancy and child rearing). Therefore, one "saw" hysteria more in women than in men, who were even held to be free of hysteria. The term "hysteria" is not sufficiently extensive or precise. I prefer to drop this word and use the word *"genosis"* as the general term to describe all genic neuroses, including the illnesses described in sexual psychopathology (anatomical hermaphroditism is an anomaly, and thus belongs to the hadroses).

A similar situation applies to the word *"neurasthenia"*, "weak nerves"; the sense of the word is too general, and really says nothing. In use, it is too uncertain. But the neurasthenic prefers to avoid being called a hysteric, the hysteric would like to be called a neurasthenic, a sign that neurasthenia is held to be "more respectable". One likes to bring neurasthenia into a causative relationship with work: one is overworked, one has nothing but work and its higher duties on his mind, one has become neurasthenic for this reason, and therefore deserves special recognition! The

hysteric, in contrast, is a "crazy lady"; she should sort out her affectation, she ought to get a good beating, etc. (consequently, a physician known to me preferred "back-side punishment" as "therapy", and although he had little success, he was in great demand with hysterics, who welcome this kind of therapy as much as did the French "sinners" of the 18th Century the "upper" and "lower" punishments; incidentally, there are also male hysterics, i.e. genotics of this type). I label all trophic illnesses *"trophoses"*.

The *genotic* symptoms are characterized in a way that one describes with words like lustful, greedy, voluptuous, passionate, entranced, affected, theatrical, foppish, moody, etc. *(phenomenal peculiarity)*. The *trophotic symptoms* are apparently more believable, more serious, less "absurd", less "foolish", less "romantic", unreal in another apparently more sober way, more consequent in the inconsequence than the genotic symptoms, and, in addition, free from concupiscence; in short, the differences that exist between genic and trophic in the normal also make themselves evident in the abnormal as infantilism in their specific (pathologic) modification; the genotic symptoms are often so strongly mixed with the trophic, and the trophotic with the genic, that the differential diagnosis needs a detailed investigation. One could argue: in young children the trophic and genic are still undifferentiated, and then the trophic appears more readily than the genic; in this way the infantilist, hypertrophied infantile could also contain the trophic and genic undivided. The first part is correct, but either the trophic or the genic part hypertrophies more, so that in growing and aging the morbid structures increasingly show their predominant affiliation to trophic or genic.

Some psychotherapists hold the view that the neurotic symptoms are "made", or "arranged", and brought out as more or less refined tricks when this seems advantageous to the neurotic. It is not said whether these ("endopsychic") arrangements are made unconsciously by the mind, or the unconscious, or the "deepest layer of the mind", the "existential layer" (O. Schwarz) – or consciously and intentionally, as indicated by the labelling; but the mind can certainly make such cunning artifices – who understands the "metaphysical"? In reality, there can be no discussion of "making" the trophotic or genotic symptoms. The ill person is also a reflex being, and his symptoms are functions of the sick reflex systems that he simply has, and can neither conjure up nor conjure away. He "can't help" being ill, just as the healthy person cannot help being healthy; the sick person *is* sick, he is not a healthy person "playing sick", he cannot "make himself ill", and he also cannot "make" himself well. The unreal changeability of the neurotic symptoms is a pathological peculiarity, and there should be no misunderstanding that it lies in the (mental) power of the patient to be neurotic or not. This does not alter the fact that the neurotic behaviour is connected with all sorts of consideration, the patient himself, as a demonist, doubts the demonic cause of the symptoms, against which he lets his demonic "energy" work (in vain, etc.), – nonsense!

Furthermore, in making the differential diagnosis "trophosis or genosis", the *situations* under which the symptoms appear are important. Under "situation", we understand the momentary functional entirety of all the reflex systems of the organism. Directly, the person can be observed in his sensory perceptive surroundings:

we call these the *external* situations, and, by logical conclusion, know that the person observed experiences of "his" external situation analogously to that of the observer, and that, from the external behaviour of a person, we can draw legitimate conclusions about his internal functions, namely, also his feeling and life concept, in short his *internal* situation: we have to (there is no other possibility). The situation is either trophic or genic; the person nourishes himself, he works, and he loves. One could be of the opinion that the symptoms appearing in the trophic situation are trophotic, and those appearing in the genic situation genotic. In many cases, this is so, and the localization and motoric of the symptoms can agree with the normal. A neurotic heart anxiety, e.g. that appears before or during contact with the lover or prior to coitus, etc. is a genotic symptom – in contrast to a neurotic heart anxiety that appears before a meal, or an exam, or a lecture, or a business discussion, etc. In other cases, genotic symptoms occur in trophotic situations, and trophic symptoms in genic. For example, the urge to masturbate is a genotic symptom in a meticulous student engaged in class work; genotic functions play a large part in the over-industriousness of an impotent person. On the other hand, the continued reflections on cooking of a woman intra coitum are trophotic, but connected with genotic symptoms (anxiety about lust, receiving); in contrast, the appearance of nausea or retching on looking at the love partner, or intra coitum, is a gastric genotic symptom (analogous to pregnancy sickness); it is not connected with the trophic stomach function or the intake of food, as is the case with a trophotic nausea or vomiting. So, trophotic symptoms can be perversely associated into genic situations, and genotic into trophic, so that knowledge of the situation alone is not sufficient for the differential diagnosis. Incidentally, in similar circumstances – depending on the function rhythm of the morbid reflex systems – the symptoms can appear more or less severely, or even remain latent.

Most of the time the therapist has to rely on the patient's description of his symptomatic situation, apart from the fact that the patient attending the therapist and in front of him is naturally not symptom-free. The description is to be extended exploratively, and brought into the *whole personality* of the patient, which is also to be explored carefully, beyond intuitive consideration. Integration of the symptoms into the whole personality is also essential in direct observation of the patient. Certainly, in many cases the differential diagnosis can be made without any problem, but in many others it can only be made after more precise investigation, and in these, too, the diagnosis is to be ensured exploratively. If, for example, it emerges that a woman is "materially minded", i.e. shows the trophic hyperfunction "money-greediness", one has to interpret her greediness for gifts in her love-life as misassociated money-greed, and thus as trophotic; in another woman, lust for gifts in the form of a genic eagerness for loving recognition is genotic (in love, things are normally given as gifts; in business they are purchased). A street-walker can demand money from the lover for coitus (trophotic), and after she has it, ask, "what sort of present will you give me?" (genic). But if a wife demands housekeeping money, this is not payment for her love, but a part of her job as a housewife; apart from this, parents and children make mutual gifts of their love to one another.

We observe a woman who feels timid about going into a shop to do her shopping. Trophosis or genosis? The result of exploration shows that from genetic

early childhood origins she has refused sensuality, and only got married "to free her husband and herself from the lusts of the flesh" ("one expunges the sin by committing it!"); if she goes into a shop, although she wears no wedding ring, people "might" see she is married, and "does that sort of thing"; she "feels herself prostituted, so to say" – her symptom is genotic. In another case, the anxiety about shopping is trophotic: anxiety of the patient about the test of whether she might be able to shop "alone"; have enough knowledge of the goods, enough money, etc. (a small child does not yet go shopping alone, and the patient experiences herself in her anxiety situation as a large scale infant, a dwarf that has conjured itself into a giant, will lose this magic as soon as "the others" notice it, and change into "a nothing", "be destroyed"; cf. Lohengrin etc.).

Knowledge of and research into the external situations where the symptoms appear is also important, insofar as in it, the abnormal outlook of the patient lets itself be seen especially obviously and extensively. The objects perceived by the senses are described in direct processes, the feelings and the concepts in indirect processes. The feeling and concept neuroses exist in genetic-associative connection with the objects perceived by the senses (each to their own). An asthma wave occurs according to the specific function rhythm of the morbid reflex systems, to whose actualities certain objects perceived by the senses also belong. "The asthma" can be defined according to this; if it appears as asthma of work (in certain job situations), it is trophotic; if it appears, for example, ante or intra coitum, it is genotic; in both cases the "tasks at hand" (knowingly or unknowingly) are experienced as "problems", as antagonistic demonic power that the patient uncovers, ascertains and thus banishes and deprives of its power with his own demonism, namely, anxiety protection from the task, avoidance of the life-death dangers; these states are more easily explained by the object being perceived by the senses situation than by the feeling symptoms as such. Naturally, a trophosis is not to be treated as a genosis, or a genosis as a trophosis. No matter how much the overlapping, both types of neurosis must be separated in regards to the diagnostic-therapeutic aspect. This separation has been made as clear as possible by psychobiology and cognitive therapy.

The *genoses* are the neuroses of *sensuality* (sexuality) and the *platonic*. The platonic embraces child-parent love, friendship, love of humanity, religious love, hobbies and love of art and science. The platonic differs from the sensual in that it belongs to the genic part of the organism but is only connected peripherally with the genital region – so that the specifically-sexual quality is wanting; the platonic is thus non-sensual, non-sexual love.

With precise exploration it always emerges that *the genotic symptoms* are *grouped around* the *genital* and the *trophotic around one or other trophic organ.* Neuroses where the symptoms are not centralized around the genital (as genic central organ) are trophoses. Neuroses with symptoms not centred around one of the three trophic organ systems or their individual organs are genoses. Neurotic vomiting is diagnosed as genotic because the connection with morbid genital function emerges with more precise exploration: the genital is the *headquarters (main site),* the genotically ill stomach is a *subunit (branch),* even if the latter "is brought into discussion much more" than the former, or even if its dysfunction is the most

troublesome or the only complaint made by the patient. In a relatively intact genic, on the other hand, neurotic vomiting that then also has a different imprint (see above), is to be regarded as trophotic. An insomniac who continues to think without a break at night, to write business letters, wallows in sorrows, etc., is trophotic; here, the lovelife is more or less injured, but to an irrelevant extent. In contrast, insomnia following coitus or in another way "depending on matters of love", is genotic, and palpitations, outbreaks of sweating, etc., are anxiety symptoms appearing as subordinate symptoms of the disturbance of genital function in this case. The sorrow neurosis of a school child who has been ordered to keep his seat, and his "taking it too much to heart", is a trophosis. The sorrow neurosis of a young woman who has been "left on the shelf" in love is a genosis. The sorrow neurosis of an older child or an adolescent about burgeoning and increasingly sexuality is a genosis, and so on.

The neuroses can already be manifest in a *young child* in such a way that the parents also "notice something" (naughtiness, etc.), and the doctor makes the diagnosis. Also, there the trophosis can generally be differentiated from the genosis, the genosis being the more noticeable; in a young child the trophic is normally defined earlier than the genic. The four- or five-year-old girl who, in embarrassment, tells her aunt that at night she saw her father going to her mother in bed and therefore "can't get to sleep" is genotic; after a shorter or longer latency of the symptoms, ("the child sleeps perfectly, the medicine has worked wonders"), it will develop into a "pronounced" insomnia; that, of course, does not have its cause in that experience (rather as so-called "psychic trauma"), but is passed down genetically and manifest at that opportunity, and has become diagnosable as genotic; in the experience of the young child, trophic and genic are, of course, not yet differentiated, or only incipiently. A little girl who suffers form oxyuriasis, and scratches herself on the anus and vagina, is not a masturbator, but has a trophic disturbance, during the overcoming of which "masturbation" disappears (but genuine masturbation can also come about in this way); on the other hand, the little one who lays herself down in front of Daddy with her legs spread, and will only let him powder her, or tickles sensually around her genitals, is genotic. A childhood asthma that accompanies the nightly "groaning" of the parents, is genotic; it can remain, even after the child has been moved out of the parents' bedroom into another room, and can recede to early masturbation, or be set off by it. A child that squeezes its heel sensually against the anus and perineum is genotic; it is doing a sort of para-masturbation; another has anxiety about passing stool, a trophotic symptom. Whether a pampered or obstinate child is trophotic or genotic must be diagnosed from case to case, from the demeanour and the symptomatic situation, and the neuroses or other illnesses of the parents. The crossover connections, i.e. the normally existing relationships between male and female individuals in trophic and genic, and abnormal trophotic and genotic are to be taken into consideration; the platonic can also be hypertrophied, and sensuality can play a part. The advancing differentiating trophic can cover up genotic symptoms for some time.

The "world catastrophe" of the little child, the move from singularity into the world of plurality (occurring in about the third year of life), is also a developmental shove for the childhood neuroses; the adult neurotic, if ill, has also not yet gotten

over this crisis. Normally, the trophic maturation precedes the genic, and the trophic master exam is passed before the genic one. In neurotics, trophic reflex systems can remain static and the genic differentiate in an almost healthy way, or the genic reflex systems can remain static and the trophic differentiate in an almost healthy way, but in the trophotic individual the genic is always more or less adversely affected or part of the illness, and in the genotic, the trophic. The "certificate" of passing the exam is not evidence of the absence of neuroses, although all healthy people have their "certificates".

1.3 The perversions

Perversions are convoluted arrangements, connections and associations. All morbid tissue is disordered in itself and in its relationship to the more or less healthy tissue of the organism. Tumor tissue has an abnormal structure, and the relationship with the surroundings deviates from the norm (cf. "metastases"); this is also the case in inflamed, decayed, altered tissue – and also for purely functionally morbid tissue and morbid reflex systems, including the thought cells. Thus "perversion" is part of every illness; one can speak of hadrotic and leptotic perversion. The word perversion is, however, used in a too narrow sense to describe certain sexual deviations. We want to use the word in *clinical* terminology for the description of the structure of the perversely connected reflex systems, not taking into account the fact that all morbidity is, constitutionally, biologically, a disorder, and perverse. So, we speak of trophotic and genotic perversions and perversities. The contact connection of the cortical neurones is described in general with "association". Thus, the morbid thought cells are perversely associated, as well as their actualities; in the almost normal type, as *desociation* (decoordination), and in the far from normal type as dissociation (discoordination or incoordination); the removal of order from eccentricity, etc., up to incoherence, isolation and part of the nerve pathway being non-functional, disorientation, stereotypia, etc., with the amoeboid movements of the nerve cells and the spasms of the cerebral vessels with ischemia and more or less extensive reduction of brain function and clarity of consciousness playing a part. The incoming sensing nerve pathways end at the cortical neurones; these are also the first neurones of the outgoing (motor-secretory) nerve pathways; so, in perverse associations, there is always a perverse sensing-motor connection. For the sake of simplicity, the word "association" here also embraces the subcortical, etc. nerve connections; this is all the more appropriate, with regard to the neuroses, as thought or (sive) outlook illnesses, because cortical function disturbances stand in the foreground.

For the structure of the reflex systems, see the Textbook of Psychobiology, Vol. 1. 15. Depending on the number of fibrils that compose it, each reflex system has several organs of reception and expression. These are arranged to one another in two ways: certain reception mechanisms are in the neighbourhood of the expression organs belonging to the same reflex system, and are part of the organ they belong to *(collocative association)*; other reception and expression mechanisms belong to various organs of the same or different organ systems, e.g. mouth-gastric, genital-ga-

stric, so that reflexes take place from the mouth to the gastric, and from the genitals to the gastric *(dislocative association)*. In this way, all organs are directly or indirectly connected by nerves; first and foremost; those belonging to their own organ system, e.g., the digestive tract organs, and then the organ systems with each other.

A main pathway and secondary pathways can be differentiated in the association network of each reflex system. The collocative association is normally the main pathway and the dislocative the secondary. A feeling cell belonging to the gastric, e.g., a hunger cell, receives its main influence from the gastric sensing receptor (nerve ending), and secondary influences from other parts of the digestive tract and from other organs, e.g., the lungs, the heart, or the genitals; the motor pathway leads collocatively to the gastric and the secondary pathways to other organs; they can also attach themselves to sensory paths. Thus, this reflex, in whose course the actuality "gastric hunger" can appear, normally finds its main expression in the contraction of certain gastric muscles and glands (belonging to it) and its secondary expressions in actions of other glands (coordinated with it), or smooth or striated muscle (proportionally sympathogenically innervated). The sensory reflex systems are analogous. The idealic neurones participate only indirectly in the motoric (ideogenic adjustments). The feeling is localized at the site of the organ belonging to the feeling cell, namely, the organ that sends the main inflow to the feeling cell and where the main outflow ends. The object perceived by the senses is analogous, each being specifically localized in the area of the environment described after the sensing organ; objects visually perceived in the optic field; objects perceived audibly in the acoustic field, etc. Analogous trophic and genic actualities are described in the first volume of the Textbook of Psychobiology (26 and 27).

Perversion is the *misdirection of a main pathway to a secondary, and a secondary pathway to a main one.* Here, the other secondary pathways are more or less deviated from the norm. The sensing-motor connection is "misdirected". In its main pathway, the sensing nerve fiber reaches a thought cell to which it is normally only indirectly or directly connected via a secondary path; in addition, the association network of the thought cell concerned is of abnormal weave; accordingly, the main motor path leads to a perversely connected organ. In this way the actualities are also perversely associated. In popular speech one says quite rightly of the neurotic, "he's screwy", and rotates one's finger beside the temple. In the border zones of the morbid area, the cells and their associations are nearer and nearer the norm, until the more or less healthy state is reached. In morbid areas, all associations are, of course, not necessarily perverse, if one does not interpret participation in the morbid structure as even slight participation in the perversions (which can be well supported). In the course of the illness, the perverse associations can be altered, extended and contracted in many ways, each of them being specific; a change can also take place during therapy, namely, an alteration at the morbid level in horizontal therapy, and restructuring and improvement in vertical therapy. The perversion is the remains of infantile associative chaotic insecurity, aged and fixed in place. All perversion is compulsive.

The perversion can remain in the field of collocative arrangement, or be dislocative. The nerve of the perversely associated thought cell can thus lead to the same organ or organ part where the incoming fibre originates; locatively, the expres-

sion movement, apart from its pathological intensity and rhythm, is then not quite normal, but clinically not deviant, or barely noticeable as so. Stomach pain, for example, can be actuality from feeling cells that are associated perversely with one another and with object of sensory perception and concept cells; they all send their nerves together to a certain gastric field, e.g., the pylorus areas, so that spasmodic closure takes place there that purely, locatively differs in no way from analogous normal torsion; sense fibre F does not go to the gastric pain cell P belonging to it, but to P', whose nerve goes to muscle cell M', instead of to muscle cell M, its normal destination. Such perversions are, however, always connected with more extensive dislocative arrangements, e.g., the sense fibre F ends at pain cells that belong to the intestine or liver, etc. or the heart, kidney or lung etc., so that travelling over perverse connections, egastric adjustments (taken up from the gastric) have their spasmodic expression in these other organs.

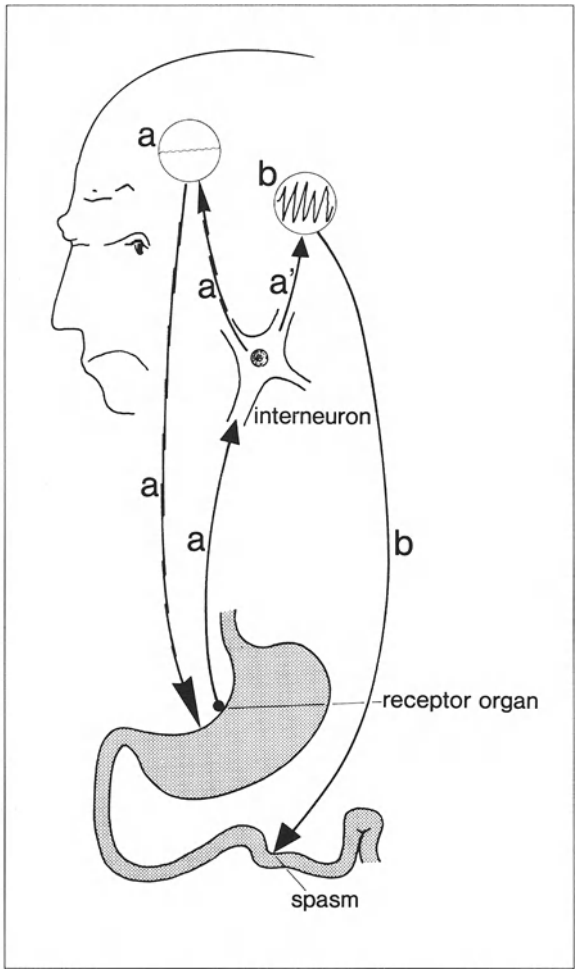


Figure 9. Functional diagram of a perverse reflex. The sensing pain fibre a reaches cortical feeling cell a, whose actuality would be a stomach pain, so far as it came into higher function. However, instead of this, via interneurons, etc., the associated secondary pathway a' has become the main pathway and innervates feeling cell b with a reflex to the small intestine. The patient experiences jejunal pain instead of stomach pain.

For example, over spinal and other connections, the sensing pain fibre originating in a part of the stomach arrives at a pain cell belonging to the jejunum; the actuality is thus a jejunal pain, and the motor pathway ends at a certain muscle fibre or gland of the jejunum. If one now looks according to the localization of the pain for "the illness" ("the cause of the illness" or "cause of the pain") in the jejunum, one finds only spasms, not the "initially " diseased organ, which is the stomach. The spasmodic actions are naturally not "the cause" of the pains, but the expression of perverse pain reflexes. In reality the patient ought to have gastric pains. This is shown in figure 9.

"Appendix pain" can be the actuality of pain cells that are connected perversely to the gastric pain reflex systems; the same holds true for renal and cardiac pain, etc. "Shoulder pain" is often not a symptom of local rheumatism (meaning: "caused by rheumatism"), but "referred" radiating pain, i.e. the actuality of perversely connected pain cells – on the left side, for example in angina pectoris and aortic crises; on the right, in liver, gallbladder and gastric crises, etc. Headache with constipation is the actuality of pain cells belonging to the head (head-cerebral vessels etc.) connected perversely to the intestinal pain reflex systems. The patient "really" ought to have bowel pains, and he has them, to the extent that the perverse association to the head pain cells is absent. Often, the headache eases as soon as normal bowel movement occurs. With the easing of the intestinal blockage the function of the involved anxiety and pain reflex systems declines; then, of course, it re-occurs. Headache with gastric neurosis is analogous and constitutes perverse switching of gastric pain reflex systems to pain cells belonging to the head. The patient reports that the headache suddenly disappeared when gastric bleeding began (remission of anxiety and pain spasms), but recurred (cf. remission of headache in dysmenorrhea as soon as the blood is "through"). And so on. Like pain, every other feeling can be "perverse".

A feeling is localized "in" the vegetative organ of expression belonging to it. Perversely, epulmonary adjustments mainly flow into a gastric feeling cell, e.g., a hunger cell (a normally secondary or actually not connected sensing fiber originating in the lung has a main connection to this gastric hunger cell); the actuality of this cell is gastric hunger, localized in the gastric, but it is like a lung feeling, more or less like air hunger, and the expression is a gastric movement for air (air swallowing). Even if the stomach is full, the perverse air hunger (that cannot be sated from the stomach) can be actual. Or, the sensing fibre originating in the genitals is connected perversely to a genic gastric feeling cell, e.g. an anxiety cell; the actuality is a gastric anxiety localized in the stomach, more or less similar to genital feeling. In a perverse love anxiety (genic loss of appetite, etc.) the expression of the perverse genic reflexes is contraction of anxiety muscles and glands in the stomach that belong to them, and so on.

We remember that "trophic" is really only "mainly trophic", and "genic" only "mainly genic", i.e. that everything trophic has a genic component, and everything genic a trophic, but these components are normally well overshadowed, In this way, the trophic reflex systems and actualities are just trophic, and the genic are only genic. The feelings belonging to the individual organs are "organ specific", so the

genic actualities belonging to the trophic organs are not to be confused with those belonging to the genitals. Equally so, the trophic actualities belonging to the genic organs are not to be confused with those belonging to the trophic organs. Every gastric hunger (etc.) normally has a slight genic "content" – like every trophic actuality, but the actualities of the genic gastric hunger cells are, of course, not genital hunger for love, but genic gastric hunger of a type not greatly different from trophic gastric hunger, directed towards the genic part of the meal, contained in the meaning of descriptions like "favourite meal", etc. The same holds for the other feelings. Much more pronounced, up to equivalence, are the genic portions of the heart, mouth, lips (kissing, tasting), and sense organs. The connection of the genic reflex systems of the organs of nutrition with the genital, and the trophic reflex systems of the genitals with the organs of nutrition, normally takes a secondary pathway.

The situation is different in neurosis, in perversion. In the vegetative area, let us look at the gastric genoses. Here, genic gastric reflex systems are hypertrophied, and there is always an abnormally profuse, at least partly main-pathway connection with genital reflex systems: an abnormally strong egenital inflow, so that the actualities show the genic character significantly, but in individual organ-specific ways. Genotic gastric hunger (see above) is a gastric hunger appearing as perverse hunger for love, and is the more markedly genic the stronger the egenital inflow to the hunger cell. Such gastric hunger is directed to substances that can certainly be taken into the gastric, but in the infantilistic experiences of the patient have just as high a sensual content as the feeling of hunger; such substances can be, specifically, all possible nutritive and luxury foods, drugs, and also sex products (semen, menstrual blood, etc.). Depending on the reflex switching, such a perverse experience runs mainly in the feeling sphere in such a way that intake is not considered, or in the object perceived and concept spheres with intake of such substances and the resulting conceptual image ("dirty fantasy", etc.); however, the patient (and layman) often knows the perverse-genic ingredient of the substance – apart from the sexual things – as little more than that of the description. The anxiety, pain, sorrow, joy stages following such a perverse hunger stage are also perverse; they are, of course, gastric feelings, but with a high genic content "coloured with love".

Conversely, trophic reflex systems of the genitals can be functionally hypertrophic and connected perversely with one another and trophic reflex systems of the gastric, etc. These pathological feelings are, of course, genital feelings, but made similar to the gastric feelings according to the profusion of the egastral (etc.) components, i.e. perverse nutrition feelings that are the more markedly trophic the stronger the egastral inflow. These morbid genital feelings are system-genetically associated with objects perceived by the senses that can be taken in or given out by the genital, but in the infantilistic experience of the patient, without him necessarily having to know about them, and they have just as high a trophic content as the genital feelings. To this extent, the sex organs function as a sort of branch of the nutrition organs; in this perverse way, the products of sexuality are "nutrients", the penis is a trophic filling pipe, the love partner is a "feeder". Female and male prostitutes follow the "horizontal profession", married couples who are ill in this way live in a providing and business-like marriage, they are "children manufacturers", breeding for money

and other advantages (and breeding ill, at the least, neurotic children). In the trophic-platonic perversion of feeling, the friendly, artistic, etc., feelings have too much acquisition content; in the platonic-trophic perversions the trophic feelings have a too large friendly, non-businesslike content; in the sensual-platonic perversions the platonic feelings are too strongly impregnated by the sensual, and in the platonic sensual perversions the sensual feelings are too strongly platonic.

Thus, principally, we have the basic structure of the vegetative perversions, and also of the *sensory* and *idealic* perversions. There are no vegetative neuroses, that is to say, perversions "as such", without sensory-idealic accompanying perversions and vice-versa. But only one or the other disturbance is in the foreground and determines the diagnosis. Naturally, the sensing, sensory nerve pathway always starts from "its" sense organ (the optic from the eye, the acoustic from the ear, etc.); in perversions, however, it takes a main pathway to a thought cell other than the normal and, correspondingly, the motor pathway and its mechanism of expression (striated muscle) is other than the normal. Also, here, the perversion can remain in the collocative area, or take a dislocative course; it is recognizable in the false attitude, or at least in the cramped, compulsive type of the neurotic actions differing from the normal variations of expressive movement after the reflexes switch-in (specific function rhythm), coordination, intensity and extent, rhythm, etc. The perversely connected object perception cell also receives other inflow from the vegetative sphere, from system-genetically associated, and morbid feeling cells, so that the character of the thought cell and its actuality also deviate from the normal. The same applies to the morbid concept cells.*

To the abnormal experience and portrayal, and to the disordered outlook, belong more or less abnormal false associations of both the morbid actualities among themselves and to the relatively healthy areas; in the best case, the associations can be almost normal; the patient lives in "his" special, abnormal world apart.

The abnormal character of the experience, in the sense of perversion, is obtained from the behaviour and statements of the patient. The *food trophotic*, for example, does not know how to deal properly with nutrition and meals; he reacts to them in a way that is peculiarly deviant from the norm. Like their individual series, the arrangement of the actualities is "reversed", food preparation takes place in unclear-peculiar confusion, in an unhappy disorder extending up to apparent bewilderment and perplexity, compelled by regulations (automatic-mechanistic); the same is true for laying the table, the sequence of courses (eat everything all mixed up; pedantic selection of quality and quantity, the "health aspects" "diet", etc.).

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* It is conceivable that the perversion corrects itself within the motor system, reaching the normal motor line due to a new false switching process, with one error cancelling the other – but the two errors remain. Further on, the perversion can only be inside the motor system: the collateral, normal secondary path is the main path, and leads via perversely connected motoric neurones to organs of expression in a completely different place. But such complicated structures are of more theoretical interest.

Secondary matters become principal matters and, conversely, the patient "doesn't know what he's doing". Some patients eat normally inedible things like pencils, chalk, hair, finger nails, nasal secretion, and maggoty cheese together with the worm. Stool eaters and urine drinkers classify the excretion substances as intake substances (genetic separation has not taken place), and in this way show themselves to be perverse. If the pulmonary component of the meal is particularly large, they approach an airy, gas-like loose character; the solid and fluid parts recede relatively far into the background. Air itself can appear to be a "gastric nutritient" ("lives on air", air swallower, stomach blown up with air, flatulence, meteorism, elevated diaphragm, shortness of breath and the breast space is reduced, etc.). If the vascular component of the meal is abnormally large (perverse association of the vascular reflex systems with thought cells whose actualities are the meals – normally the solid ones), then they approach the viscous to fluid character; solid meals "do not come into the question"; the patient lives on soft foods, soups, drinks; in this way he also "liquifies" solid food. The normal eating arrangements are also disturbed (deviant) in vegetarians, eaters of raw food, and all the other sorts of food sectarians, including bread, potato, meat and sauce fanatics, etc. In addition, there are "crazy ideas", e.g. that the food could contain "poison" ("magic poison" is meant), i.e. all food is poison and deadly, meat is poison, "making" uric acid, gout and arteriosclerosis, and it is absolutely damaging to health, bringing out the "lusts of the flesh" and fatal sensuality, or meat eating is a sin (innocent animals are murdered), a deadly sin that will be punished with sickness and death (revenge of the demons driven out at death, "eat not the forbidden fruit", etc.).

The trophic perversion also shows itself in the unusual attitude of the patient to the eating and cooking utensils, to things to do with work, to and at work, in his profession, to money, to professional colleagues, to professional groups, to the state economy as the total national economics organisation, and to world economics. The wrong attitude varies according to the hypertrophic species of the reflex system but is always cramped and compulsive; it leads to false to almost normal, pretending normal ("outwardly normal") aims. The money-greedy person "sees" nothing but money (as the demonic power); for him, the work to be done is secondary. The person greedy for power only works for the position of power, i.e. the confirmation of his omnipotence. The ways and means are for him irrelevant, the "aim justifies the means", and the "aim" is already reached at the omnipotence that can do as it likes; it is already contained in the infantilistic all-oneness. In contrast, the work fanatic sees only the work (as an enemy demon that has to be defeated); the pay, showing the general value of the work, is all one to him; his "work", which banishes the demonism of work, is his "mission"; it can neither be paid for with money nor judged by earthly, human standards. The one uses his community as a bodyguard, as a feeder; he takes it into his service, uses it – parasitically to his own advantage (individualist). The other "immerses himself completely in the community", "disavows" his own ego, his own personality, which in this way remains all-one and unaffected (collectivist). Both fit themselves falsely into the pyramid of higher social culture. A businessman abuses his private friends: "only he who puts his name, his contacts and his money at my disposal for my (rotten) business afffairs is my friend"; he mixes

and confuses business friends with private friends, profession with friendship (trophic-platonic perversion). The professional streetwalker experiences and treats her "lover" as her feeder (trophic-sensual perversion.)

The *genotic* behaves reversed, in an analogous way. According to his infantilistic experience the patient does not know the right way to handle his friends and lovers; he is too-much-too little his own friend; he loves himself as Narcissus did, plays perversely with his genitals (paramasturbation, paramixia, impotence, etc.), practises various other forms of sexual abnormality (sado-masochism, homophilia, etc.). The thought cells, whose actualities are the love objects, have a main pathway connection to sensing nerve fibres other than normal, and so the expression mechanism is also slightly deviant to grossly dislocated from the norm in the area of the genitals themselves, which are thus handled in the wrong way. This is also so in extragenital areas in that certain parts of the body, animals, plants or things have a hypertrophied perverse-sexual content, without the patient needing to be aware of this. Here, the disordered thought cells also receive hypertrophic vegetative inflow from the perversely connected genital region. Overindustriousness at work can thus be genotic: hypertrophied and perversely connected genic reflexes express themselves in the working movements; "the work consumes the love", the patient has "little or nothing left over for love", "no time for love"; ostensibly, he has "higher duties", "problems to solve", "a mission to fulfill that he dare not let himself be distracted from, in spite of every attempt to do so", i.e. in this perverse way, he is lovesick (sensual-trophic perversion). The patient experiences and treats his business friends as private friends; he is a giver in his profession, where things are normally bought and sold; he expects presents instead of pay; in his profession he shows only favours and good deeds (favour neurotic, philanthropist), things that in normal circumstances – as platonic – are not paid for, but "reciprocated"; he does his work as a sort of sport that brings in, not money, but prizes, as a hobby; he does not accept "payment" like "lesser beings"; working for money is an insult to him, etc. (platonic-trophic perversion).

From the behaviour, and especially the description of the patient, one can also diagnose *idealic* perversions. Here, it is a matter of pathological individual concepts, namely, of direct memory of a pathological thing being experienced, and also of hypertrophic fantasizing, perversely associated in themselves, and arranged in more extensive and more differentiated sequences (false memories, false ideas, etc.); it is also a matter of pathological concepts in the comprehension and reasoning sphere (collective concepts), namely, incomprehensible and unreasonable ideas in perverse connections, that one also calls crazy ideas, high-level nonsense, etc. In the trophic-genic perversion, the disordered genic concepts (analogous to the corresponding sensory perceptions) have an abnormal trophic content, and trophic concept sequences are perversely associated into the genic; in genic-trophic perversions, the opposite is the case. In otherwise higher or highly differentiated people the disordered "ideology" can be shaped and fixed to entire systems – according to the specificity of the patient to such of professional, social, political, ethical or artistic kinds; often, diagnosis is only possible for the specialist (even if one is dealing with insane systems), and it is all the more difficult as the deviant thinking is often woven into broad areas of more reasonable and almost reasonable thinking.

In all this, the substantial consideration in making the diagnosis is not the duration of the disordered function (e.g., the duration of a drinking bout, the quantity of alcohol an addict "kills"), but the *compulsion* (e.g., to drink even a small quantity of alcohol).

Therefore, we differentiate four sorts of perversion:

1. *Endotrophic* perversion: false lead (false connection) inside the trophic: of nutrition, work and trophic play-sport.
2. *Endogenic* perversion: false lead inside the platonic (including genic play-sport) and of the sensual, and between both areas.
3. *Trophic-genic* perversion: trophic hypertrophy with false connections to hypertrophied reflex systems in the platonic and/or sensual; mixing of trophic hyperfunctions into genic situations.
4. *Genic-trophic* perversion: genic (platonic and/or sensual) hypertrophy with false connections to hypertrophied genic reflex systems in the trophic; mixing of genic hyperfunctions into trophic situations.

The perversely connected organ can be characterized as a *branch of the headquarters*, i.e. of the organ where the false connection (the sensing fibre) originates, but the organs remain, of course, what they are, i.e. the genotically disordered stomach is not the genitals, but the stomach, although genotically it is a branch of the genitals. The air-swallowing stomach is not lung, but an air-swallowing branch of the lungs. The genitals of the professional streetwalker are genitals, not stomach, but they are a trophotic branch of the stomach; her movements in sex are genic, but trophotically "professional", and so forth. The branches always function at the cost of the headquarters. We speak of the branch symptoms as trophotic and genotic; if they are specially prominent, we label the trophosis or genosis according to the organ or sense organ affected, e.g., gastric genosis, genital trophosis.

The false transmission of the nerve flow is comparable to the false transmission of a bank's capital in the way false instructions may be given in bank headquarters (see 1 and 2 above), or in the way bank headquarters may place too much capital in a branch office and have too little available for itself. The false transmission is also comparable to false distribution of troops in a battlefield. The false transmission is, of course, not a "psychical act" or the effect of one, etc., but a purely biological and pathobiological structure and functional property.

Many patients know nothing about their perversion. They only have their symptoms: the conscious (complaints) and unconscious, the known (disease insight) and the unknown. It is part of the duty of the therapist to assess the status and clarify it to the patient (but this clarification is still diagnosis, not yet therapy; the latter consists of clarification of the sense-nonsense of symptoms in relation to outlook).

1.4 The neuroses of feeling

For an exact diagnosis, apart from assessing the dominant *way of thinking* in the disordered experience areas and in the disordered portrayal, the main feelings present in the neurosis have to be recorded, as well as where they are felt, i.e. which *feeling*

species are present, and to which organs they are assigned *(localization of the feelings)*. Psychobiology says, in general, the following about this.

The feeling species

The feelings are the actualities of the feeling or sensile cells of the cerebral cortex. Together, the feeling cells make up the sensing thinking sphere; this is the cortical centre of the sympathetic and parasympathetic nerve systems. The sensile sphere is divided into the various fields belonging to the sense centres, thus, it has optic, acoustic, tactile, etc. centres, each with a special sensile sphere as a field of the total feeling sphere.

Like all other cells, each sensile cell has its specific function curve. The appearance of the object, the actuality, coincides with peak of function, in this case the (specific) feeling. If the function curve runs relatively flatly, the actuality has less clarity, less intensity, and is a "mood", as specific as the feeling, as specific as the actuality in general. The mood is a not yet sharply defined feeling, a feeling of little clarity or intensity; the foetal and early childhood feelings are mainly moods, not yet differentiated, diffusely localized sensile actualities. For (changing) mood, one can also say "spirits"; someone is in good or bad spirits, i.e. in a good or bad mood. One often uses the word "spirit", especially in the plural "spirits", to describe nervous moods, also called *"irritations"* (anxious, sorrowful, etc., irritation).

In addition, the feelings or the feeling reflexes are also labelled *affects*. By "affect", we understand a specially intensified sympathetic reflex sequence, with or without sensile actualities, a sequence that, according to both the intensity and the biological development stage, is morbid. An affect action is an abnormal action of mainly the skeletal muscles, with relatively large sympathetic inflow; affect movements occur in neurotics and the insane.

We differentiate between *basic feelings* and *mixed feelings* (nuances of feeling, interference feelings). The *congestion feelings* (pleonastic feelings) differ from these according to the degree of satiety.

The labels, like all descriptions of the feelings, are of an objective or conceptual type, words as subjects or concepts; apart from some special words, words that describe something concrete, with the word "feeling" added, are often used to describe the feelings, e.g. "attitude"; these are sequences of sensory expression that belong genetically to certain species of feeling, in which the feeling species, in each case predominantly one, are involved (sympathogenic inflow). Apart from those labelled after the motor system, the individual feelings are labelled after localization (e.g., gastric hunger, cardiac anxiety, breast pain, etc.), and the situation to which a feeling is directed, (e.g. hunger for food, thirst for knowledge, exam anxiety, homesickness, sorrow about marital and financial loss, regret about..., joy about...).

The *basic feelings* are: hunger, anxiety, pain, sorrow, joy.

Hunger is the hollow, empty feeling; it "corresponds to" a hollow, round, empty, concrete individuality, a hollowly arranged concrete actuality series. One also describes hunger almost synonymously as requirement, thirst, desire, craving, greed,

curiosity, urge, lack, need, wish, want, etc. Congested hunger is *hate*, and its expression rage.

Anxiety is the opening feeling (opening as structure). It "corresponds" to a hollow, round border, but this is narrower than that in hunger-hollowing. It is the feeling of being cornered, beset, of compulsion, of inhibition, of astonishment, of defiance, of withdrawal, shame, shyness, carefullness, care, etc., and so belongs to the stage of the experiences, where the experience continues, but more slowly, in a way that one describes as a must and at the same time resistance, or delay; whether I can, should, may or may not do something, etc.

Pain is the threshold feeling, the feeling of separation, of departure, of decision, of turning, boring, winding, overcoming, burning, beating, fighting, suffering (sympathy), embarrassment, etc., briefly the feeling of crossing the threshhold. One speaks of "mental" and "physical" pain. We do not recognize this differentiation. Pain is pain. There is pain with accompanying anatomical change (e.g., cutting, straining, squashing, inflammation, etc.), and there is pain without such physical alterations.

Sorrow is the feeling of smallness, of being a piece or a part, complete separation, being rejected, of being beaten down ("depression"), of being pressed down, of exhaustion, of trouble, of affliction, of disappointment, of defeat.

Joy is the feeling of largeness, of completeness (of the work), of reaching the target, of success, of victory, of happiness, of bliss, of pride (to be differentiated from anxiety pride), of being free and redeemed, of eminence (pride), of elevation, might, superiority, satisfaction, content, reparation, fulfilment ("feeling full"), satiety, pleasure, etc. Congested joy is *disgust* (oversatiety, being weary of feeling full).

Mixed feelings (nuances of feeling) are strictly speaking, more or less all feelings. There is no 100% "pure" feeling, just as there are no sensile cells exclusively receiving neuronal inflow corresponding exclusively to a specific feeling such as hunger. We label the basic feelings after their predominant feeling components.

The quantitative relationship of the individual components in the cell and the altering of this relationship (breadth of variation) is specific; this relationship corresponds to the actuality, the conscious, as a *biologically homogenous symbol* of all its constituent parts. The actuality – here, the feeling – is thus "mixed", "nuanced", according to this relationship. The more numerous the anxiety components in a hunger feeling, for example, the more anxiety content the hunger feeling has; we can then speak of an "anxious hunger". The same applies to the other feeling species; we speak of painful, sorrowful, joyful expectation (= anxiety), of burning desire, of anxious pain, of painful sorrow, of sorrowful joy, etc.

All nuances are understood from the fact that the sensile actuality is a biologic symbol of the total number of individual components making them up (adjustments). The combination of the adjustments present in the cell corresponds to the current total situation; with this, all of them alter themselves coincidentally. So, all systems are constantly in function; the ups and downs of the function curves can be compared to the surging of the sea. The individually existing peak of all function curves can be entered into a complete curve (somewhat similarly to all the crests of

the waves of the sea) in such a way that this complete curve is the symbolic presentation of all the individual curves, and each point in the complete curve is the point of intersection of all curves. This point of intersection is the actuality, the symbolic presentation of each complete situation.

If we follow the hunger and joy curves in this way, it can be seen that, in the course of an experience, the descending hunger curve – and the ascending joy curve – have a point of intersection, and that in each of the actual cells the hunger ingredient retreats to the increasing benefit of the joy ingredient, irrespective of the peaks of the other curves symbolically participating in the point of intersection, i.e. irrespective of how large are the anxiety, pain, sorrow ingredients, and whether the sensile actuality is still a feeling of hunger, anxiety, pain, sadness, or even joy. Thus, every actuality is constituted in the sense of biologic symbolism, and is a symbol of the complete situation in question. So, we can differentiate nuances of feeling that belong to the descending hunger curve (ascending joy curve) from those belonging to the ascending hunger curve (descending joy curve). The curves run, incidentally, in such a way that the ascending part is less steep and is longer than the descending part, as can be seen in figure 10. Thus, as the joy curve ascends, the hunger ingredient increases again beyond the point of intersection in such a way that the hunger stage of the next experience attaches itself to the joy stage of a current one.

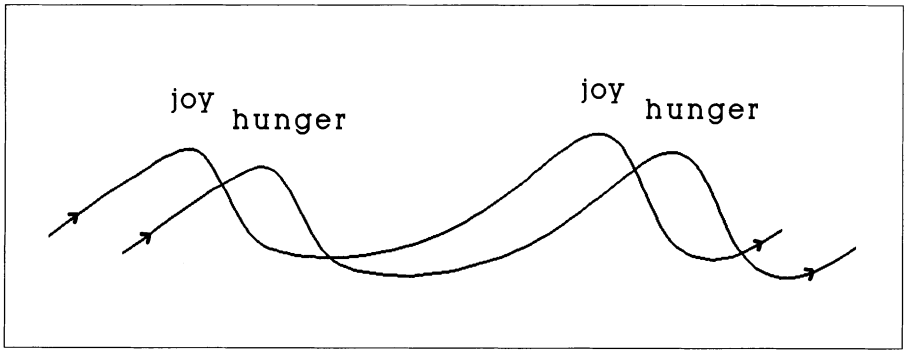


Figure 10. Curves showing the feeling sequence in hunger and joy. See text for description.

The following mixed feelings are listed; the list is, of course, not complete. The most frequent components of the nuance are given for each feeling species. Each nuance is, of course, specific.

Hope: hunger plus joy (joyful hunger, joyful courage, good courage, confidence).

Worry: hunger plus anxiety, as well as pure anxiety (anxious hunger, discontent, doubt, often with strong sorrow components).

Avarice (also ambition, etc.): pain plus hunger (hungry pain, often with strong anxiety components). Hunger plus pain (painful hunger) is greed.

Envy (begrudging and jealousy): pain plus anxiety plus hunger.

Anger: hate (blocked anger) plus anxiety. A similar, but pain-containing nuance is *scorn, irony.*

Annoyance: pain plus sorrow (painful sorrow) or sorrow plus pain (sorrowful pain).

Regret (guilt feeling, contrition, etc.): sorrow plus anxiety (and pain).

Solace: sorrow plus joy.

Abhorrence: anxiety plus disgust or disgust plus anxiety.

As stated above (p. 18, the names for sensory expression sequences, like *types of behaviour* or *attitude*, are also often used to label the predominantly participating feeling species, just as descriptions of the feelings (with concrete and conceptual words) are an indirect process. This is especially so for the nuances of feeling, for which special names scarcely exist, due to their multiplicity. Conversely, behaviour types are labelled after the predominant feeling species they contain. Some examples follow, without separation of the normal and morbid forms.

The behaviour types or attitudes that are predominantly *hunger expressions* are often named after hunger or one of its near-synonyms: lust for work, work impulse, thirst for knowledge, curiosity, strength of will, covetousness, greed for power, vindictiveness, desire, demand for..., etc. It is however clear that, as already stated, the hunger feeling, like all other feelings, is named after the correspondingly felt concrete situation, and that synonymous or near-synonymous names for hunger such as demanding, requiring, etc., are those of the respective expression and behaviour types.

The *anxiety group* contains, for example, carefulness, mistrust, concealment, mendacity; despondency, cowardice; loneliness and escapism; conscientiousness (anxiety and anxious pain, the task should be completed as well as possible), inconsistancy, hastiness, slovenliness (anxiety about becoming more deeply involved in the task); economy (anxiety about giving), a sort of waste (anxiety about possessing); abasement("I won't manage to do it"), subservience; rebelliousness, a sort of defiance, obduracy, stubborness, etc. The word "fear" is frequently used almost synonymously with the word "anxiety". Fear describes an attitude that is certainly very similar to that of anxiety, but is really expressed more as painful abasement and self-denial, while the anxiety attitude is (a sort of) inhibition. Differentiation by saying that fear always "has an object" and anxiety appears "without an object" is not correct.

The *pain group* contains, for example, compassion, pity, cruelty, brutality, pugnacity (with weapons or words), nimbleness, artfulness, smartness, diligence; fierceness, obstinacy, aggression, irritation, embarrassment, sensitivity (often with a strong anxiety content).

The *sorrow group* contains, for example, being "down", battle weariness, phlegmatism, indifference, pessimism, absorption, bearing a grudge, being woebegone, sadness, clumsiness, sluggishness; a type of attachment, thankfulness, loyalty (often also anxiety about change, thankfulness is also often joy, and is sorrow to the extent that the movement is slowed); a type of obstinacy as anxiety-containing sorrow, also with quite a large joy content; trust as joy-containing sorrow.

The *joy group* contains for example, cheerfulness, happiness, mightiness, grandeur, self-confidence, recognition, stability, magnanimity, well-wishing, generosity, etc. The expression of anxiety-containing joy is a sort of wastefulness (anxiety about owning), a sort of regret (to have accumulated possessions, to experience joy); with more pain content, but also containing a significant amount of anxiety are over-presumption, overestimation of self, pomposity, boasting, etc., submanic and manic behaviour (overcheerfulness, comical, silly behaviour, boasting, etc.).

The feelings, like all other objects *are described pragmatically, ethically and aesthetically*. The pragmatic description classifies according to right or wrong, the ethical (moral, religous, juristic) according to good and bad, and the aesthetic according to beautiful and ugly. All of these go into the classification according to healthy and sick, normal and abnormal. But no matter what the description of the feelings, the five basic feelings and their nuances are described.

Illness is infantilism, sick feelings are infantilistic, i.e. actualities of "retarded" sensile cells (they have remained at the infantile differentiation level) that have changed metabolically (in the sense of waxing, hypertrophy), but have not become more highly differentiated. The sick feelings are differentiated phenomenally (in the sense of infantilism) from the healthy, and are characterized individually with special compound terms like overjoyed, excessive pain, neuralgia, rheumatic pains, overanxiety, etc., or by the mode of expression (restlessness, fidgeting, angriness, unapproachability, arrogance, irritation, sarcasm, dejection, laziness, affected deportment, childish glee, etc.).

Localization of the feelings

Certain sensile cells in each cortical centre are assigned to each *internal organ*; these are cells of the various feeling species, namely hunger, anxiety, pain, sorrow and joy cells. So, in the optic centre, and also in the acoustic, tactile and other centres, there are sensile cells that are assigned to the digestive organ (i.e. to the individual parts of the entire tract, including its attachments), and others to the respiratory organ, the heart-vessel-kidney tract, and the reproductive organ. The number of feeling cells in each centre assigned to the individual organs, as well as their degree of development and function, varies; not all feeling cells are developed to a state of wideawake function; here, the hunger cells, there the anxiety, pain, sorrow, joy or congestion cells, or cells whose actualities are nuances of feeling can be predominant in number and development; there are countless variations, also in the sense of pathology. The feelings assigned to the internal organs are the *organ feelings*.

The sensile cells assigned to the sense organs, on the other hand, are situated only in their corresponding centres, namely, the sensile cells assigned to the eye, ear, skin (as the tactile and thermic sense organ), etc., are only in the optic area, acoustic area, tactile area and thermic area, etc. The sensile cells assigned to skeletal muscle and bone are situated in the static, kinesthetic and the topical centre; we describe these three centres together as the coordinative centre

(see fig. 7, p. 19). The sense organs and the skeleton, with its muscles, can thus be described as the *external organs*. We name the feelings assigned to them *sense feelings*.

The actualities of the sensile cells assigned to both the inner and the outer organs are mainly labelled according to the organ or its function. The feelings assigned to the *inner organs* are thus named after the individual organs belonging to the four organ systems; these organs, or parts of organs, are the sites where the corresponding feelings are localized. Many of these feelings, especially the pain feelings are only morbidly actual.

1. *Gastro-intestinal tract:* mouth feelings (hunger for the solid and thirst for liquid, also to the vascular tract for the gaseous; anxiety, etc.); gastric feelings (gastric hunger, gastric anxiety, pain, sorrow, and joy (satiety feeling), gastric disgust as congested feeling, etc.); gastric, liver, pancreas feelings, etc. (mainly actual as symptoms).
2. *Vascular tract:* cardiac feelings; vessel feelings; tissue feelings (tissue hunger, thirst, etc.; the nerve-brain feelings also belong here, like thought hunger and anxiety (feeling of emptiness in the head), certain headaches ("while thinking", cf. "the problem is quite a headache"), certain nerve pains, joy in thinking, etc.); spleen, kidney and bladder feelings.
3. *Respiratory tract:* the feelings localized in the chest cavity as a respiratory organ (breathing or air hunger and anxiety, etc.).
4. *Genital tract:* genital feelings.

The feelings assigned to the *external organs* are:

1. *Visual feelings* (visual hunger and anxiety, etc.).
2. *Hearing feelings:* (hearing hunger and anxiety, etc.)
3. *Touch feelings:* (contact hunger and anxiety, etc., not to be confused with objects perceived by touch, i.e. the tactile concrete objects).
4. *Smell feelings.*
5. *Taste feelings.*
6. *Thermic feelings:* (thermic hunger, etc.), not to be confused with objects perceived thermically, i.e. the degree of cold and warmth as thermic concrete objects.
7. *Kinesthetic* or *situation feelings.*
8. *Static or strength feelings* (pressure and weight feelings).
9. *Topical or directional feelings* (orientation feelings). The last three groups are also labelled together as coordinative or muscle-bone feelings, movement feelings, rhythm feelings, etc.

In general, the localization of the feelings is not so precise as that of the objects perceived by the senses. The feeling "cardiac anxiety" is, for example, "in" the area of the heart, namely, diffusely in a more or less extensive area. The more intense (the clearer) the feeling, the more precise its localization. Apart from intensity, the most precisely localized is pain; the least precisely localized is sorrow. The more the process of development of the sense cells and thus the differentiation of their actualities, the more precise the localization. We know, for example, that young children cannot give exact information about "where it hurts".

All feelings are localized within the boundary of the body; none extends beyond it. The feelings make up the so-called *inner world.*

Localization is an important *differentiation point between similar feelings.* In this way gastric hunger differs from air hunger, air anxiety from genital anxiety, headache from chest pain, etc., from the localization. The situational relationship within which a given feeling appears characterizes the feeling, at least to a certain degree of precision, as an actuality of sense cells of a *definite* centre. In this way "gastric hunger" is the label for the actualities of a large number of sensile cells situated in the various centres. If an experience that belongs to a specific gastric hunger feeling takes its course in the acoustic centre (e.g., noises of cooking with preceding or intercurrent gastric hunger), then we must accept that this feeling is an actuality of acoustic gastric sensile cells. When a feeling is less intense and unclearly localized, the best possible identification of where it belongs is given by psychobiological analysis of the movements of expression corresponding to the feeling. *Localization, situational relationship (situation) and movements of expression (motor)* are the most important facts in identifying where such similarly named feelings belong; they are not necessarily adequately phenomenally differentiated.

[Editor's note from: Textbook of Psychobiology, Vol. 1, 26, abbreviated and simplified. For further information on the feelings, please refer to the textbook.]

The sick reflex systems are always totally sick, but in the neuroses of feeling the functional hypertrophy of the vegetative part predominates. In the sick area, mainly the feelings are hypertrophic, and the concepts and sensory perceptions less so. Morbid feelings never occur in the presence of a healthy perception of objects and healthy concepts (belonging to the system); the reverse also holds true. The autonomic pathways can be more or less switched off even in the case of peak function from the sensory and idealic pathways – depending on the specificity, i.e. the specific function rhythm; the contact can thus be more or less eased, and even temporarily interrupted or broken off (diastasis). The diseased feeling excitements remain more or less complete in the vegetative area, "in the inside"; a changeover of the sympathogenic parts to the sensory pathways, an "expression of feeling", only takes place according to the degree of intimacy of the contact. A person can thus seem "calm", judging by outward appearances, and be only internally highly excited. However, during autonomic peak functions the related sensory and idealic paths are normally also in a higher state of excitement, and one who knows human nature can also detect outer manifestations of this inner excitement. In abnormally strong feeling excitement, sensory and idealic consciousness can be reduced, or be clouded or interrupted, especially in cortical ischemia, spasms of the cerebral vessels as expressions of acute anxiety and pain reflexes. Here, in a sort of vicious circle, the feeling actualities can also decline in intensity (clarity), and the function of the feeling cells sinks to nonactual levels (fainting, "magic sleep", i.e. "falling asleep" during the unbearable pains caused by torture, etc.). The sensory actions are correspondingly reduced, if subcortical or subcerebral reflex short circuits with tonic-clonic cramps do not take place. The vegetative-sensory switching can be suddenly so intimate that sensory "feeling breakouts" take place (abreaction); it can also break off suddenly (e.g., in a shock experience), so that the inwardly excited person is outwardly relatively calm, and appears and acts in a seemingly "cold blooded" way.

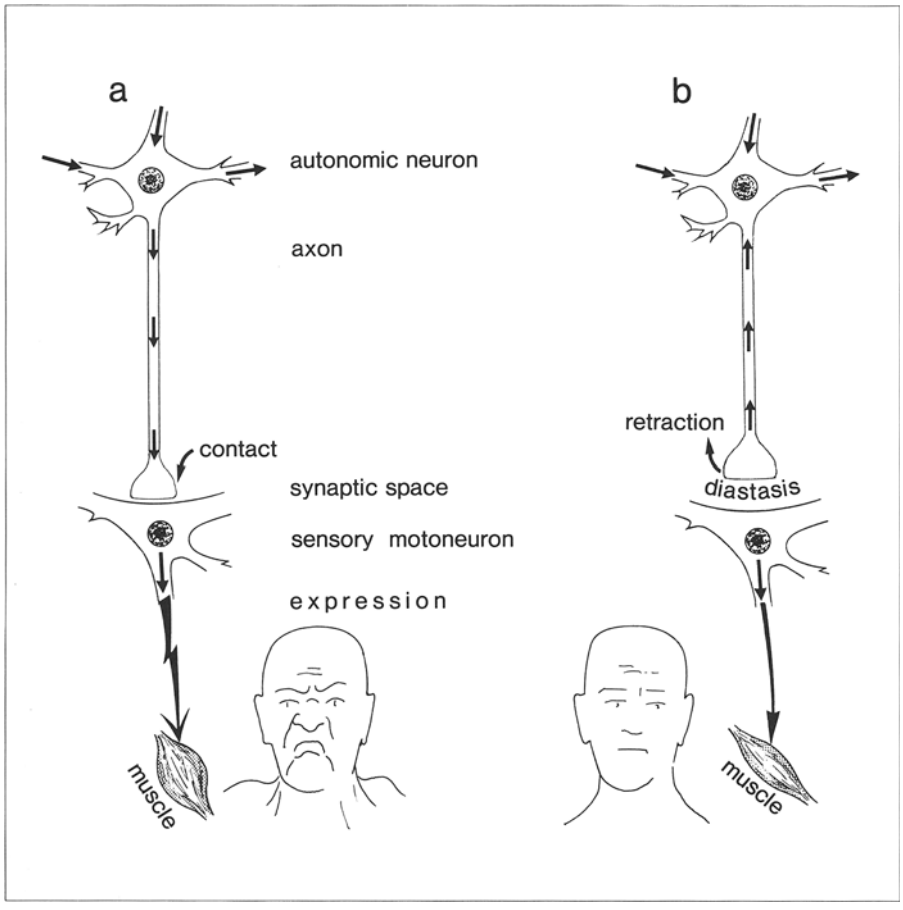


Figure 11. Functional diagram of autonomic-sensory excitation (interneurons not shown). a) intimate contact: narrow synaptic space → relatively strong feeling discharge via the sensory-motor system. b) loosen to reduced contact: further to diastatic synaptic space → the feeling excitation remains mainly in the autonomic nervous system and is expressed, for example, in the heart, the vessels, etc. The patient remains calm externally.

System-genetically, an external situation always belongs to an internal one, but the neurotic cannot always indicate it exactly. Those with healthy feeling excitement also only experience the external situation intercurrently and with little clarity; they can only describe it accordingly (cf. uncertainty of statements made by witnesses; this is especially so in neurotics).

With the relaxation or breaking off of the contact (the lead) between the sensing neurones or between the cortical sensing and the (otherwise) connected motor neurone, i.e. the feeling cell, a pathologic reduction of the clarity of the feeling occurs,

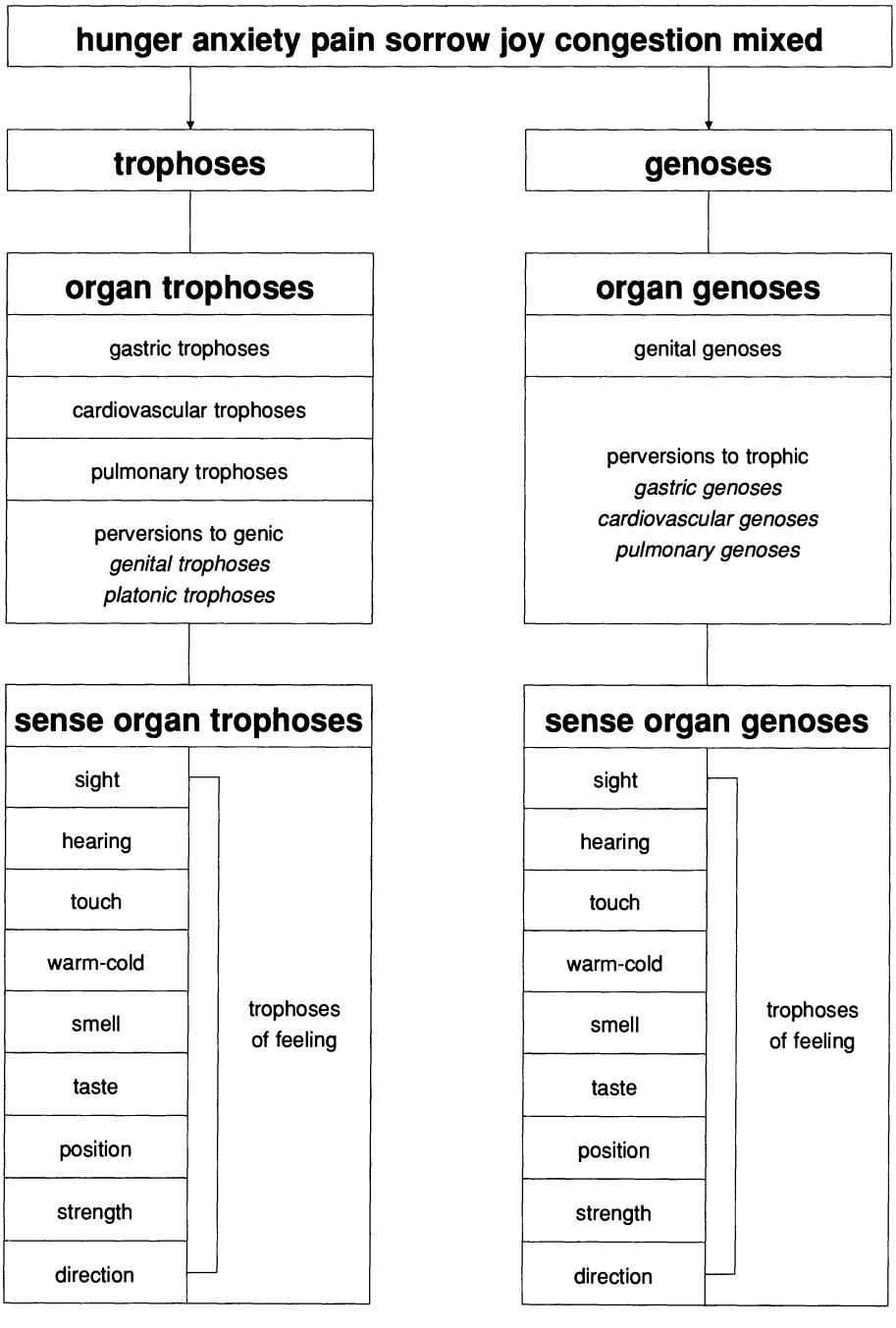


Figure 12. Scheme of the neuroses of feeling, classified according to the type of feeling, trophic and genic, the internal organ systems, and the sense organ system.

up to "lack of feeling", so-called sensitivity disturbances with corresponding disturbances of expression. The most noticeable is "lack of sensitivity to pain" with stings, burns and other injuries; however, the other types of feeling cells can also be switched off in this way and remain in nonactual function, with the result that a lack of a special sort of hunger (desire, want), anxiety, sorrow, joy, etc., persists. These disturbances appear periodically in neuroses in contrast to analogous hadrotic relaxation or interruption of the lead. They are clinically similar, but not identical to the allosuggestive and autosuggestive hypofunctions of feeling cells. In this way, some people are insensitive to pain and significant injuries during intensive compulsive thinking, so called concentration, meditation, turning in on themselves, ecstasy etc., during lasting, rhythmic, regular movements, etc. (fakirs, dervishes, etc., "artists" of this type) in these situations injured blood vessels contract and there is no bleeding. In primitives, such occurrences are normal; in humans of higher stages of culture they are abnormal, but the healthy person also often does not feel injuries when in a state of distraction or anxious excitement, and can be put into a state resembling intoxication by rhythmic movements (dancing, etc.). It is a matter of normal and abnormal situations according to the biological nature of the individual and not of "psychological riddles", "mental-spiritual effects" or other demonism.

We describe the neuroses according to the *species of feeling*. We specify the neuroses of feeling according to the *inner organ* and *sense organ* to which the morbid feeling belongs, in which it is localized and at which expression takes place. As with organ and sense organ feelings, we speak of organ and sense organ neuroses (fig. 12).

Gastric neuroses summarize all the neuroses of the gastrointestinal tract and its associated organs (liver, pancreas, etc.), cardiovascular neuroses those of the heart, vessels, spleen, kidneys, bladder, and tissue neuroses (including nerve tissue neuroses, i.e. hypertrophies of the feelings localized in the nerve tissues, nerves and brain, such as hunger for thought, anxiety, pain, joy, sorrow and neuralgias, etc.)

The tissue neuroses are the purely functional diseases of inner (intermediary) metabolism, namely, dysfunctions of the tissue cells (hypo- and hyperfunction), disturbances of assimilation (the taking up and processing of intracellular biochemical trophic and genic materials offered in the blood and lymph), and the discharge of products of metabolism. Cell spasms take place (spasms of the cell body and its pores) as the expression of tissue reflexes (that are also connected to the centripetal and centrifugal reflexes) connected with spasms of the interstitial vessels and the related glands (hyper- and hyposecretion and incretion, hormone disturbances). Here, we also have to differentiate between hunger, anxiety, pain, sorrow and joy neuroses, e.g. during the course of the cell functions, namely, contracting-twisting-dilating, one reflex species or the other is pathologically dominant; the metabolic process thus deviates from the norm biochemically; i.e. coordinatively and quantitatively. The vegetative excitements can become conscious as diffuse feelings localized in the affected tissue region, or be integrated into the corresponding stomach, mouth or lung feelings (e.g., hunger for something solid, liquid, gaseous, i.e. for the substances belonging to the area of the illness, further anxiety of, etc.). These tissue dysfunctions are the neurotic forms of the clinically known metabolic diseases, neurotic disturbances of protein, carbohydrate, fat, water, mineral, gas, etc. metabolism in the

tissues, e.g., neurotic gout (pseudogout), neurotic rheumatism, uric acid diathesis, (orthostatic) albuminuria, diabetes mellitus, obesity, thinness, lipuria, diabetes insipidus, oedema development, Quincke's oedema, etc., rickets (as a purely functional abnormality of calcium metabolism,; spastic-hormonal inability of the cartilage cells to assimilate calcium, etc), oxidation disturbances, the mass of neurotic dermatoses and types of dermatitis, etc., with associated regional or diffuse abnormal depot development (storage of uric acid, fat, lymphatic-serous-watery swellings, etc.), often with sudden outflow, analogous to constipation-diarrhea, meanness-wastefulness, often with intermittent improvement with the decline of the hyperfunction; the disturbances often appear after a shock, i.e. diabetes, loss of weight. In trophic metabolism these disturbances are tissue trophoses, in genic metabolism they are tissue genoses; the differential diagnosis, also of perversions, has to be made from the total personality of the patient. Bearing in mind the connections of the afferent and efferent vessels with dysfunctions, we include the tissue neuroses with the vascular neuroses, but also draw attention to their relationships to gastric and pulmonary neuroses.

Neuroses of feeling without organ symptoms do not exist. Not every species of feeling of every organ or tissue occurs actually, also not pathologically, e.g. many people suffer from neurotic nerve pains, but other nerve feelings (nerve hunger, etc.) do not appear; on the other hand, all the species of feelings localized in the brain (in the head) are actual. A patient is unlikely to complain of renal hunger, but he does complain of a feeling of pressure in the renal area (urgency, see p. 17, about renal pain, a heavy feeling of fullness, or a feeling of fullness in the renal area (renal sorrow and joy), as well as compulsion and easing, relaxation and being freed, as an emptying feeling. "Organ sensations" are frequently wrongly described; they are often so uncertain in species and localization that their classification is difficult; the most easily localized are the hypertrophic anxiety and pain feelings. The neurotics that seek out a doctor are usually pain and anxiety neurotics; they often have concomitant symptoms that are unknown to the patient. Hunger and anxiety are often described as pressure and compulsion, sorrow as a flat, dead feeling. It is frequently not known that normal anxiety and pain exist; in children this is more common than in adolescents and adults, where the feelings retreat increasingly behind objectivity and conceptuality. All experiences are hunger-anxiety-pain-sorrow-joy series. Everybody gets jabbed or bumped at some time, and makes innumerable twisting movements that are accompanied by minor pains, etc. The organ feelings must not be confused with the coordinative actualities localized into the internal, concerning the objects perceived by the senses, namely, the registration of inner muscular reactions according to site, strength and direction; one has, for example, gastric anxiety or pain feeling and, in addition to this, a movement perception of stomach cramps ("it's as if something is knotting, pressing, shivering, pinching, twisting"). All neurotic expressive actions are cramping.

A neurosis is never limited to *one* organ or sense organ or sensory area; it is connected to morbid functions of other organs of the same organ system or another, or another sense organ or sensory area, but one site is the centre of the illness. Gastric neurosis is always connected with liver or intestinal complaints, and often with

complaints in other organs. A gastric neurosis often starts with constipation, then higher level spasms ("preventive mechanisms") are added, up to the level of anxiety to eat (meaning: if passing a stool is something demonically evil, it is better to keep the evil substances at the upper level, and even better, not to eat them, e.g., meat, etc.). Or urinary retention has ureter and then renal spasms, up to the level of anxiety to drink; the sequence is often reversed. There are no single symptom neuroses, but rather a symptom or symptom complex (syndrome) stands in the foreground. The severity of the symptoms, i.e. the functional intensity of the diseased reflex systems is subject to periodic swings; at certain times they can be completely nonactual, e.g., variable headache in migraine, or they can more or less fade away, e.g. insomnia can alternate with periods of relatively good sleep. However, the diseased reflex systems are always present in the organism, and are involved in all functions. In the period between two waves, the migraine sufferer is not well, but is more or less latent migrainous, and this also shows itself in certain anxious-pain nuances of experience and behaviour (at least to the expert).

A further, more precise specification of the neuroses is found in the *system-genetic relation: feeling, sensory perception and concept.* In this way, according to the structure of the sick reflex systems, a definite sensory perception and concept situation always belongs to a feeling. To make a diagnosis, and for therapy, it is especially important to determine the sensory perception situation (p. 27, 28). We therefore pose the questions: in what situations, under what externally perceived objects and conceptual circumstances does the feeling excitement take place? It is often easy to answer the question; in other cases more precise information is needed. The group of reflex systems that is diseased is established, and also, we have to describe the morbid functions therapeutically, i.e. the sense of how the world is perceived. The patient often does not know the external situation, or cannot describe it with precision; for example, he says he is "always" anxious, his liver pains are really always there, the internal shivering is strongest at night, and when it is still dark, the internal embarrassment is all the more puzzling, as there seem to be no "external causes", etc. He needs a clarification; that "air" (gas) is also an object of sensory perception; that although night is "optically dark" all sorts of acoustic, tactile, thermal and other perceived objects and, of course, many thoughts can be actual, and that the feelings can be specified from these (without the "cause" being "effective"). Insomnia can thus be specified as anxiety about the dark, about sounds in the night, about the bed, about the warmth of the bed, about being embraced by the lover, about going to sleep as loss of consciousness = (magic) death, etc., and an explanation of the attitude to the world perceived is given according to these.

Examples:

Patient K. says he gets heart cramps when smoking (he says "owing to smoking"); as soon as he thinks about the cigar or looks at it the cardiac anxiety announces itself (angina pectoris). The following is clear: the anxiety feelings and their expression in the heart are system-genetically related to smoking. Smoking is a sensory process; the cigar is an actuality series of the modal cells of certain optic reflex systems; the

expressions of these reflexes are eye movements, taking hold of the cigar, mouth movements (sucking) etc., tactile, olfactory and other actualities are also part of the structure. This group of sensory pathways is system-genetically connected to certain vegetative pathways, mainly to the oral-nasal and pulmonary (smoke here is as much as a nicotine-containing breath, with finest, solid particles); besides, the cardiovascular and genic are connected. The smoking, as the function course of the total group, begins with smoke hunger, the peak function of the smoke hunger reflexes ("hunger" as a description of the function of the vegetative-sensory-idealic hunger reflex systems); in this hunger stage the hunger feeling (the demand) soon becomes actual, the cigar as the hunger-feeling sensory perception (roundness, outline), and soon as the hunger-feeling concept, combined with the corresponding internal and external actions of expression (narrowing to the hunger extent, seeking, reaching out for the cigar). Then the anxiety stage: a certain delaying, faltering, choosing. Now the pain stage: the cigar is taken out, the tip cut off, the cigar lit, and gradually burned. Sorrow stage: cigar smoked, put away, tired of smoking. Final joy stage: satisfied, full of smoke. Certain substances, particularly nicotine are taken up here as adjustments for certain reflex systems (stimulus-calming). Each individual stage contains smaller hunger-anxiety-pain-sorrow-joy sequences, each nuanced to the relevant stage of the entire process, i.e. optic, olfactory, etc. minor sequences, ending in joy about the cigar, its scent, etc. The smoking can be broken off in the pain stage; the cigar has no taste; a sorrow stage then follows (what a pity, annoyance), and a more or less actual joy stage (nothing to be done about it). Or a second cigar is smoked, etc. These functions vary in the sense of stimulus-calming. The first attempts to smoke are often associated with high excitement of the feelings; choking, coughing, palpitations, flushing-paling, nausea, vomiting, diarrhea, etc. until one has got used to it. The smoking neurotic has either not yet learned to smoke, or has not learned properly. He is a chain smoker (abuse), nicotine abstinent, "eats" the cigar, or otherwise does not know how to deal with it; for him, the cigar, the fire, the smoke, the nicotine, is the enemy demonism that has to be banned in one way or another.

In patient K. the cardiac anxiety reflex systems belonging to the smoking experience are especially hypertrophied, and in this way a high degree of cardiac anxiety is associated system-genetically with smoking; it expresses itself as cardiac cramps that are also registered coordinatively and are perceived as excited heart action. He suffers from a cardiac anxiety neurosis in association whith smoking. Even before smoking he has actual cardiac anxiety about the smoke an the cigar; this moves into the pain stage, with mild cardiac pain and a stabbing pain in the heart; the cigar is soon put aside (sorrow stage); the "recovery" sets in (joy stage); each stage has a significant anxiety content; anxious thoughts intervene about the damaging effect of smoking, especially for the heart and can systematize themselves; the whole thing is a neurotic anxiety experience.

K. wondered about smoke and fire even as a very small child; "smoke" was a black, grey ghost that rose in an uncanny way from the uncanny fire; but mysteriously, wood, coal and other "beings" that held the fire-smoke magic changed themselves

into fire. Anxious, with a fearful heart, little K. saw fire-smoke in the stove, in the oven, in matches, in the cigars and pipes of the big people (men), and then in Satan's monster, the locomotive, etc. The fire burns in hell, e.g. in the pipe bowl and it smokes out of the mouth hell of the big boss. But fire also falls from heaven (sunlight, lightning), and can ignite and change itself into smoke that ascends again, and so on. He who rules fire-smoke is lord of life and death; so one "has to" ignite, steal matches, light them one after the other, let them burn a little, then stick them in the ground (fire in hell), and hold the burning match to the headman's long pipe, a sign of power over fire. So one has to stare at the sun, "stand up" to the lightning, etc. But it was very dangerous to play with fire and smoke; one could go blind (= die), suffocate (= die), but anxiety about fire-smoke was already the all-powerful protecting demon that banished the enemy demon; if the beating in the left breast came, the enemy demon was recognized and thus banished; it worked as magic on the heart, but this beat against it – with the result that "the (heart) attacks, and death, were beaten off"; and K. retained his "magic" life.

The first attempt to smoke (at age 12) was a terrible experience, but the hunger to be like the others was so strong that the hard battle with the fire-smoke demon lodging in the cigarette was repeated under thousands of anxieties about the magic effect, and of being found out; also after "sweat und tears", a certain satisfaction with the demonstrated heroism made it's appearance (one did something that was really only permitted to the big people). By then other anxieties were hypertrophied (of the dark, of being questioned, etc.), but the "internal quaking" was strongest with smoking, so this was the concentrated demonism, the greatest danger, and counted as the cause of the cardiac neurosis, as was later also confirmed (wrongly) by physicians.

In reality, the neurosis was, as always, latent (as a disposition), ab origine, and then manifest in early childhood, even if not yet diagnosed, long before trying tobacco; it then waxed further as smoking became actual as a sort of puberty ordeal. From the pure system-genetic aspect, according to the biological structure of the ailing reflex system the cigar is the main object perceived and conceived in association with cardiac reflex systems, including hypertrophied anxiety reflex systems. So smoking is not the cause of the cardiac neurosis; K. smokes neurotically. How could the smoke or even the unsmoked cigar "cause" a heart neurosis, or any other neurosis or illness? Without magic it would not happen. Nicotine, carbon monoxide, and other products of burning a cigar cannot cause a neurosis either; it is simply a matter of the existence of certain people who smoke neurotically (smoke or tobacco neurotics). The fiction of "causalitiy" is neither an "explanation" nor a "satisfying of the causal requirement" (one keeps on asking "why"); it is only a confirmation and strengthening of the demonistic thinking of the patient.

Horizontal therapy also belongs to this interpretative thinking:
1. Forbidding or avoiding the cigar as the probable cause of the cardiac cramps; giving up the fight; flight from the front; confirmation of the weakness. Fictitious proof of causality through the unreal; if K. were not to smoke, he would not get heart

cramps; in reality, if K. didn't smoke, then he wouldn't smoke, i.e. the "smoking" experience in connection with cardiac cramps does not take place.
2. The suggestion that smoking is really damaging and dangerous after all; it would be meritorious to give it up and be abstinent regarding tobacco (and, at the same time, best to do the same with alcohol, meat and love), thus giving recognition to the demonic nature of the "devil's weed" etc., and magically depriving it of its might in the form of negation; similar to the call for "self-discipline" as opposed to "temptation"; defamation of smoking as a "mental weakness"; training in compulsive thinking against the temptation; vows as distractions, and so forth.
3. The suggestion that the patient should calm down; smoking in moderation is for him harmless; the physician is there as the father demon whose permission "takes the danger out" of smoking for the child-patient (blameless and without sin).
4. The recommendation of denicotinized or other cigars impregnated with bad tasting substances (see 1).
5. Prescription of cardiac sedatives, etc.
6. Psychoanalytic information; the cigar is a penis symbol; smoking is a symbol of coitus; the smoke-heart anxiety is caused by the suppression of sexual wishes, and is really anxiety about tabooed sexuality, of castration (the penis burning down), etc. In fact, for the genotic smoker, smoking is a perverse-sensual process; not so with the trophotic smoker; furthermore, the perversion is a biologically false structure, not caused by a "psychic trauma" or "psychic manoeuvre" (forming of symbols, masking of "what's really meant", etc.), and cannot be reversed by psychological interpretations or auguries that are moreover wrong in their generalization and misunderstanding of the structural and behavioural analogy as "exclusively libidinous"; finally, the appropriate explanation for the genotic person about the perverse structural state of affairs is still diagnosis (for the trophotic person a false diagnosis), and not yet therapy; one may have to call it therapy so that the patient is brought to believe that the diagnosis is the therapy.

Vertical therapy (cognitive therapy) is the leading of the patient out of the demonistic way of thinking, so that fire-smoke-cigar, etc., are recognized as purely physical things, and therewith the magic and accordingly, the "excitement" (as a magical warning defence and as a wonder-magic), is removed.

Mrs. S., 34 years of age, complains of "an unbearable feeling of weakness in the legs" (among many other symptoms). They go "all wobbly" when she's standing at the stove cooking. She thinks she will have to sink down at any second. The weakness climbs up into her body and heart, and so on. Interpretation from her and her physicians; standing is the problem. "It doesn't suit her". So "sit down when cooking; let your maid cook", or "pull yourself together", etc. In reality, the stove, the fire the patient must deal with, the duty of cooking (examination by the husband), are experienced in a similar way to fire-smoke-cigar being experienced by the neurotic smoker. The stove-fire-food set, etc., of objects perceived by the senses is an actuality series of optic and other modal cells thar are partly functionally sick (infantilistic) and partly almost healthy; the expression of the sick reflex systems is cramp of the

associated skeletal muscles, in this case, especially the leg muscles, registered coordinatively as quaking, shaking, a feeling of weakness, sinking down and fading; system-genetically associated are sick autonomic reflex pathways, in this case especially the cardiovascular, with the anxiety and pain reflexes dominant; the expression is cramplike contractions of leg, abdominal and breast vessels going as far as painful cardiac cramps; also of cerebral vessels; this leads to ischemia, disturbance of cerebral nutrition, reduced clarity of consciouness as "things swimming", "fainting", etc. Interpretation: in the (black) stove, the cave-hell, lives the devil-death, the "black one", who gets fire from the coals and consumes his own children, like Satan-Saturn; he roasts, fries, cooks killed beings (potatoes, meat, etc.); he also conjures weakness onto the woman who deals with him; this is the death magic of death itself and at the same time the banishment of death, life magic; the patient is still alive – but as what? As a hell-devil being that knows the devil, or as a heaven-god being that the devil cannot touch? Even as a little child the kitchen, the stove, the mother who "killed" (sliced, cut up, etc.) and dealt with the fire were uncanny; full of anxiety, she saw the "witch" working in the "witches cauldron"; the stabbing and cutting "cut into her heart". Within this magical experience she learned cooking herself; the control of the demonic fire (the food must not burn; it must be ready in time) "inside the protection of her anxiety"; naturally, without knowing the personal view of the world meaning of her symptoms. It wasn't a matter of the physical preparation of the food; it was the banishing of the stove demon. Avoidance of the "battlefield" is, of course, not healing, and the order "pull yourself together" is an empty demonic phrase. The road to cure is the dedemonization of the stove and the person, and the world in general.

A woman patient has "unbearable anxiety" before and during train journeys, with palpitations, oppression, death anticipation, etc. The supposed "cause" was a sudden braking of the train on the Brenner with suitcases falling down in the compartment. In reality, even as a young child she was terribly anxious about the carriage monsters that consumed the people and took them away abroad into the unknown, the beyond. All forms of travel were uncannily dangerous. When about 18 months old she was driven to hospital by her mother and they wanted to keep her there; but she screamed so terribly that her mother took her home again; an early experience that confirmed her fear of the evil carriages. Later she "passionately loved to travel" (hunger challenge the "risk" and banish it), but always after the most detailed preparation ("everything in order, one never knows what can happen, train accidents do happen, don't they?"). The journey is the life-death journey. Death lurks in and around the carriage, etc. Then the anxieties proliferated; the demonism of death floods foreboding anxiety into her; but with this it (the demonism) reveals itself to the equal (the patient whose demonism has grown equally); thus the "anxiety" warns and protects her. So, the event on the Brenner was not a "cause"; it was an experience inside the framework of the neurosis that confirmed "special emphasis" of the demonic danger of travelling. In such anxiety many a patient cannot get into the train (crossing the threshold = the life and death decision; shutting the door = the clap of doom; there's not way back); cannot travel a long way (inescapably imprisoned; the disaster has to come sooner or later; now it's there... and now... and now); but the demonic anxiety

banishes the disaster. Nothing happens; everything's saved! Locomotive = black monster with fire in its belly-hell; black men = devils that make the fire and drive people off into infinity, etc.

In many other cases the system-genetic relationships are not so obvious. A woman patient has severe neuralgia as soon as she lies down in bed. "The pain prevents me from sleeping"; "don't know what it is"; "one has to believe directly in spirits of the night that make one anxious and torment one"; "it's real hell", and so on; Childish superstition; night = sleep = death demon (cf. Morpheus, Mors, nox-nex etc.); goodbye to the mother, to day, to the light demon, etc. The little child had already wept copiously for that reason, and had pains, as a sign that "the night" and the spirits were around it and wanted to draw in into death; the "child" protects itself against this painfully; so "pain", on the other hand, is a good demon; the purgatory fire of hell is also pain; magic from the Devil or God as atonement for the sins of the world (martyrdom of Christ and the descent into hell), and so forth. A tablet "brings sleep", it "sleeps for me", i.e. the drug magic scares off the messengers of death; in the protection of this magic one can quietly go to sleep; it isn't a real sleep; it's artificial; a fake sleep; death has no power; it is overcome (tablet = Host = sacred thing that banishes death and takes the power away from hell). In the sanatoriums the magician-doctor keeps watch, keeps the dangers of the night and nightmares at bay, but hopefully he's a powerful enough magician; better watch out and see if the pains come after all – there, now it really twinges in the neck, and then down the leg, and so on (pain cells actual). Vertical therapy: psychobiological clarification about day and night, waking and sleeping, pain, etc., so that all the demonism goes away.

A patient has a dry nose and throat catarrh for a long time, sometimes with closure of the Eustachian tube, tonsil swelling, disturbances of hearing, etc. Previously fluid catarrh for years; clipping the tonsils, mucosal excision, innumerable packings and so on; all in vain. The fluid catarrh changed to a dry catarrh that troubles the patient more than the other ("at least the stuff ran out before"). Medical advice; avoid smoking, dusty atmosphere, alcohol and so on. One looks for external "causes", their control has to heal the catarrh but "has no intention of improving it". In reality the catarrh is as old as the patient, was at first latent and only noticeable in a "tendency to catch colds"; then it became more and more manifest, at times as "diarrhoea" (hypersecretion = cramping contractions of the bodies of the glands), then as "constipation" (cramping closure of the gland openings, dryness of the mucosa), with, in addition muscle spasms in the throat, Eustachian tube, vessel spasms with swollen tonsils, etc. The associated perception of objects by the senses is "the air", interpreted as a demonic life and death force with mysterious effects as cold, dust, smoke, fog, bacteria, pollen (cf. hay fever, etc.), but also as spiritual forces. Reaction: flooding out of the death strains; on the other hand, closure of the exits; both magical saving of life; maintenance of the almighty power over life and death. Vertical therapy: clarification of the superstition as how he personally views the world and the abundantly proliferated early childhood interpretations.

Periodically, severe liver cramps appear in a patient (with constipation, jaundice, etc.). "What's the reason?" Numerous medical investigations, also from authorities in internal medicine. Prescription: diet, cholagogues, baths, clinic, etc. Nothing helps, "If the time is up, the attack is there again." Is there no cause? No, there is none; the sick reflex systems have their specific period of function, but of course in connection with certain external circumstances. Even as a very small child the patient was deeply sad about the trouble in the world (only child, father dies of progressive paralysis, mother melancholic), especially about the "constant dying", the world a "heap of rubble"; the child wept often, had to sacrifice himself, getting rid of "the rubble"; he "exterminated everything", especially, he ate up all the leftovers, "ate all carrion" and in this way "got it out of the world", freed the world from the dead, etc. But the consumed death pressed on the right side of his insides (liver area), and at an early stage sometimes an uncanny fuss was noticeable there. Later this was called "liver cramps" (a young child knows nothing about "internal organs", and even if he knows a name or two, can only "conceive" something demonic there. A battle in his inside between good and evil demons, and so on). The liver pressure was connected with "the eating", but was purely system-genetic in reality. There can be no question of effective causality in the sense of the magical interpretation of the patient, or the causal interpretation by the doctors. The case was a sorrow-anxiety trophosis (sorrow the main hypertrophy, and anxiety a secondary hypertrophy).

A woman patient aged 25 suffers for 11 years from frequent "attacks" of unstoppable vomiting, feels "sick to death", "completely worn out and dried out", "like a mummy". Repeated stays in hospital with gastric lavage, radiography, etc. "Normal findings", every type of cure and medication in vain. "Cause" unknown, a puzzle even for the doctors. A professor is supposed to have mentioned a disease in the midbrain. "Neither have annoyances in my job (clerk) nor with the family (lives with her mother), live a solid life, pleasures are too stale for me, I haven't any friends, I don't want anything to do with love, who'd marry a sick girl like me. I had my first period when I was fourteen. It was awful, and embarrassing, even uncanny. It didn't really hurt, but I'd have preferred it without the bleeding. Since then it comes regularly, and normally". On questioning: "I bleed very little; one or two days; I don't like to bother about it." Further questioning: "I've never been able to stand the sight of blood or red as a colour; it was always weird. I remember I had such an anxious feeling in my stomach when I was little; when I was five I saw a bloody sausage in the lavatory; it was a tampon; I had to vomit; it was awful. Later when somebody talked about blood and bleeding I got ringing in my ears, with dizziness and nausea. I can't look at my own blood either, but the vomiting doesn't always come with the period. It also comes at other times; but one sees blood, bloody things, and red often. I daren't think about it. I get a worried feeling in my stomach – it's only becoming clear to me now because you asked me", etc.

So there is a perverse genital-stomach reflex connection; the associated object perceived by the senses is something red, and especially blood; it is experienced genically; the associated concept corresponds to the object perceived by the senses.

> Vomiting begins as soon as the morbid reflex systems have their peak function, in accordance with their specific periodicity. Earlier, there was a "worried feeling in the stomach" and the beginnings of nausea. At five years old, she vomited once as menstruation began, that is, the development of the genitals in puberty with the accompanying spasms, oligomenia, more hypertrophy of the perverse reflexes, and especially anxiety reflexes with long-lasting peak functions; unstoppable vomiting (cf. diarrhoea, enuresis, menorrhagia, leukorrhea, salivation, tears, hyperhidrosis, etc., as well as hypersecretion in hay fever, etc. The expulsion-defence against "hostile demonism").
>
> Meaning taken by the patient: blood is the demon of life and death, magic, that works in my insides, presses the life out of my body, wants to kill me, wants to dry me out like a mummy, etc., but I overcome the haunting, my sacrifice saves me, the death-devil-god cannot take me; I vomit the death magic up, I'm still alive. Cognitive therapy, healing.

In the search for the "causes" of the internal disease, here the neurosis of feeling, one finds that not *one*, but *several*, even *many "causes"*, each with different, "cause quantities" are "responsible". In reality, all these "factors" are circumstances; in these, the neurosis is developing and thus these circumstances are part of its development, connected with others in time and space. The effect of the cause holds good on the principle in causality thinking, and everything is connected with everything causally. For the man in the street, all the causal interpretations are at hand that "can be thought of", according to the relatively small amount of precision of individual relationships in the association net, but the scientist also brings his differentiated causal series into further connections ("diminished causaltiy") and, finally, into the general causal connection. In the area of possibilities that are, in principle, unlimited, many false and mistaken associations also take place; the result is that the quantity or degree of causality of one or more "factors" is given too highly or too lowly: *cases of false causality.*

This leads to an insomniac being sent on holiday because he has overworked, and can be made well in this way, with the overcoming of the reason for his illness. In reality, the fact that somebody "overworks", i.e. works in a cramped way, is already a neurotic symptom, or the insomnia has nothing to do with the work and lies in the genic. The holiday is not the reason for his getting well; it is the, at most, functional interval of the sick reflex systems. The leukorrhea is supposed to be because of a cold bath, the appendix pains due to concrescence, to a piece of cherry cake, a swallowed cherry stone, to oxyuriasis, etc. Impotence is due to a bad experience with a girl, marital enmity to the "experience" that "all men are nothings", or that "more important matters have to be attended to" (which is why impotence or an unmarried state is not supposed to be abnormal among "heroes, saints and geniuses"). Neuralgia is supposed to be because of the birth of a third child, the lack of character to being brought up badly, the heart neurosis to scrofula, epilepsy or a poor memory to a fall on the head that the patient had as a child (as if children weren't always falling!), hysteria due to a robbery,

nervousness to masturbation, sterility in a woman to smoking, etc., etc. Fiction and error at the same time.

The effective causality in the "external factors" is associated with the effective causality in the "internal factors". Feelings are taken to be spiritual, the soul is divided into spirit and mind, working with and against each other in a mysterious way, as well as on the appendage of the body and the external world, and on the other hand are influenced from there. A trinity that is supposed to be certainly a trinity and yet one, etc. The reasons for the symptoms of the neuroses of feeling are supposed to be the organs where they are localized, or the unconscious, where the repressed desires are haunting, the Id that gives trouble to the Ego and the Superego, the good or evil demons that lodge in the organs or as cell spirits in the cells, or the spirits that live in the head and battle with the lower demons, etc.: furthermore, the hormones which have recently acquired a high position in the inner demonistic hierarchy; no matter how small or few – that is the evidence of their magic power – they have immense effects on the mind and spirit; they even keep or not the whole mental-spiritual-physical function in order or disorder; they are equipped with a demonistic power that hangs over everything! And the hormones are already competitors of the vitamins, but in the distance notice is given of the mysterious powers of "metabolism of life", existing beside the physical and the mental, and "causing", for example, old age.

It is clear that people with sick thinking accomplish something extraordinary in their primitivistic (raw demonistic) thinking, confused in itself, and wrongly associated with the more mature thought areas, with unclear causal assumptions, superstitious interpretations, "motivations" and subterfuges.

Therefore, the duty of real therapy is to clear up the unclear; it is not enough to correct false causal interpretations and thus let causal belief in it's place and recognize it; the causal problem itself, the metaphysical problem in its raw and diluted stages, the body-mind problem, must be cleared up in such a way that it no longer exists.

To understand the neuroses of feeling, it must be realized that the autonomic functions also take their course without the organs being specifically filled with material. Stomach pains can appear in an empty stomach, tenesmus in an empty intestine, genital cramps in the time between menstrual periods, etc. This is also evidence that the filling substance is not the cause of the complaints.

There is not something essentially different to be said about the connection between *concept* and *feeling* or about that between the object perceived by the senses and feeling. It is not unusual for feelings to become actual *after* the concepts to which they belong system-genetically with the proper sensory perception remaining non-actual. In this, someone says, "I daren't think about it, my heart grows heavy", etc. In feeling neurotics the feelings are hypertrophied in this case; with a memory that is not connected with a high level of feeling excitement in an analogous experience in a normal person his feelings are "stirred up", and this can be recognized as overplayed. On the other hand, he "remains internally untouched" with memories that are tied to a high level of feeling excitement in the analogous experience of a normal person. Once again, the concepts are not the magic-mystical reason for excitements of the feelings, with their organ and sense organ neurotic expressions; there is only a systemgenetic associative connection.

1.5 *The neuroses of sensory perception*

In the neuroses of sensory perception functional hypertrophy of the sensory part of the sick reflex system predominates. In the sick areas, the objects the senses perceive are mainly hypertrophied, and the feelings and concepts less so. There may be more or less intimate contact between the sensory pathways and the autonomic or idealic parts of the system (pp. 46, 47). The actions of expression are therefore more or less sympathogenic (impulsive, etc.) or ideogenic (prudent, considered, worked-out, etc.), but they are always constrained and compulsive.

A neurosis can start as a neurosis of the feelings and alter to one concerning the objects the senses perceive, or to a concept neurosis; the opposite can also take place, a neurosis of the objects perceived by the senses, or a concept neurosis can change to a feeling neurosis, and a neurosis of sensory perception can become a concept neurosis, depending on the specificity of the individual case. The predominating element is the determinant when deciding which neurosis is present.

A sportsman can, for example, be overambitious for many years, train doggedly, and later become rheumatic, "unable to move". A patient can work too hard at school, later work too hard at conceptual thinking, and then suffer more and more from headaches so that the mental work is limited. Addiction to drink sometimes changes to compulsive thinking against the "demon alcohol", and so forth. During involution, it is not unusual for hyperfunctions to become long lasting hypofunctions, this process seems to be "healing", but is really only a more or less lessening of the manifest complaints, also with symptom displacement. Fanatics, for example, become quieter in old age; many anxiety patients become able to do more; many cases of migraine, etc., disappear with the climacteric (involution of genital anxiety reflex systems and pain reflex systems), etc.; an increase in concept hypertrophy can be connected with this as, normally, conceptual ability broadens and rises with the wisdom of old age.

Looser contacts and interruptions between the sensing neurones and between the sensing and motor pathways also occur in the sensory areas; so do hypofunctions: a sinking down of the relevant objects perceived by the senses up to their "absence", with the corresponding disturbances of expression. Such dysfunctions of the senses are punctate or more extensive cloudings, shrinkages, failures in the visual, hearing and touch senses, etc. The patient is "insensitive" to heat and cold and can even burn himself. The patient does not "notice" whether he has legs any more and must first of all look (partial failure of coordinative registration; this is changeable; e.g., it is not long before the legs are "gone", the head separated from the trunk, the patient soon loses the ground under his feet "as if he's floating"; there is usually also anxiety); the patient "has lost the ability to smell", etc. The failure, etc. can remain at various degrees of intensity for a shorter or longer period of time; it can constrict, or even extend over an entire sense area (neurotic blindness, deafness, etc.). The contact can return gradually or suddenly. These dysfunctions have to be differentiated from other cloudings of consciousness and losses, e.g., those in fright and other anxiety states, in severe pain (with angiospasms in the brain, p. 21) etc., and, of course, in hadrotic brain processes.

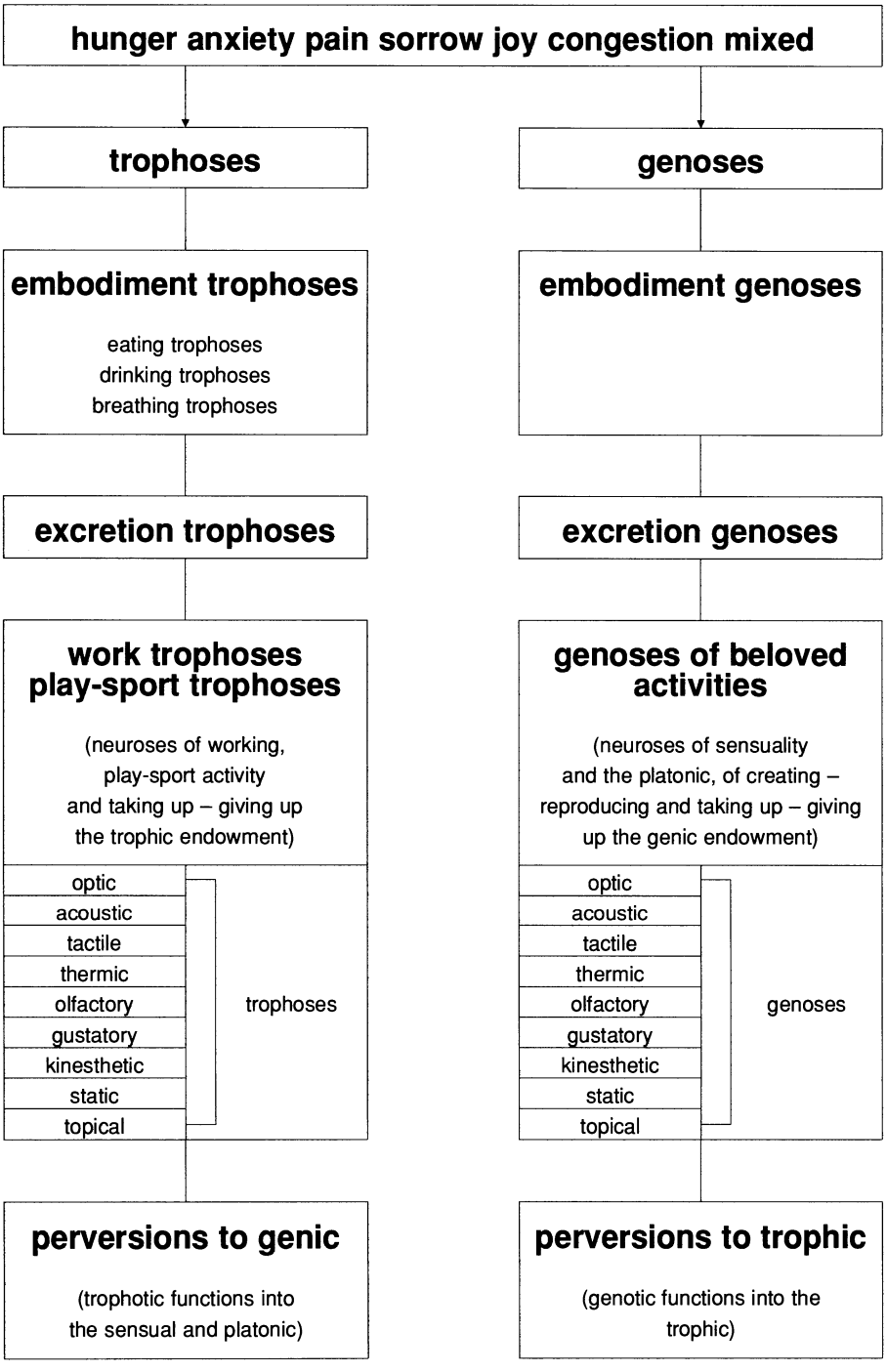


Figure 13. Scheme of the neuroses of sensory perception, classified according to the type of feeling, trophic and genic, intake-output, and sense organ systems.

The neuroses of sensory perception are the so-called *compulsion neuroses in the narrower sense of the word.* More precisely, we have to say: modal compulsion neuroses, as the conceptual neuroses are also labelled with "compulsion" (compulsive thinking). Precisely, all the neuroses are "compulsive". On this account the word "compulsion" is used pathographically. Normal events also take a "compulsive" course in the sense of biological determination (Textbook of Psychiobiology, Vol. 4, 3,1), of biological order, the fact that everything that happens within the normal range of variation comes to pass as it does, and never in any other way (the demonist understands this biological order as the effect of a metaphysical ordo ordinans; in reality, the order is a purely biological, namely, associative-coordinative fact). In this general sense, every pathological event is also "inevitable"; but here the sick order of things is false order. Within the general inevitability of the event, processes make their appearance that come to pass under compulsion, given certain limitations and constrictions.

In neurosis theory, "compulsion" processes characterise the sick experiences and behaviour as being fixed in an associative-coordinative way, machine-like, invariable, repeating themselves in rigid, "absolute" inflexibility, partly against the hunger (want) direction, partly against better insight ("I don't want do do it, but I must; it happens anyway; any idea that it's nonsense is pointless"). Many patients with compulsion illness have no insight into the illness; many have anxiety about the diagnosis; but they all interpret "the compulsion" as a secret, weird effect of demonic powers, the compulsion itself demonic, and even with insight into the illness, doubt is cast on "the disease" again and again, as demonic compulsion: if the compulsion is fate, and the inevitability a process of destiny, a magical ceremony, the only possible way of fighting against the hostile demonism, can "the illness" still be an illness? Can destiny (cf. necessitas) "deviate from its course on its own" to even the smallest extent? The hostile demonism is however trying to find a way to break trough the process of destiny, somewhere, somehow, and the tiniest attempts are precisely the most dangerous; every one of them contains the "entire demonism". In this way the neurotic "legitimises" his compulsion with a compulsive fictitious, vicious circle.

The sick, autonomic reflexes also take a compulsive course. The asthmatic "must" be short of breath; cough, retch, etc. The neurotic diarrhoea patient "must" go to the lavatory 20 or 30 times a day; he cannot do without it, even once. The frigid woman cannot conjure up the feeling of voluptuousness; she "must" watch out for what's happening "down there"; sometimes it starts to sneak in, but then it "naps off" and "the more she tries to force it to come, the more it disappears", and so forth. It is uncanny that this internal autonomous-demonic event that is itself compulsion, withstands every compulsion compulsively, although one requires "the Ego" to bring it under control! The sick feelings themselves are also compulsive in their periodicity, persistence, fierceness and obtrusiveness. However, feeling neuroses are not usually termed compulsion neuroses and, accordingly, we wish to use this term only for the neuroses of objects perceived by the senses, and also to retain the term "thought compulsion", or "compulsive thought".

Like normal movements, compulsive movements are innervated individually and at any given time over a sense centre (one of its cellgroups). The actualities

of the thought cells belonging to the hypertrophied reflex systems also appear compulsively; abnormally frequent, pressing, persistent, in rigidly false order, "as if conjured up, and full of magic", "banished-banishing". So, we speak of optic, acoustic, etc. compulsion processes. The individual compulsion experiences and behaviour are made up from associated parts of different sense areas; the association-coordination can vary more or less from the norm. These *cerebrogenic* compulsive movements have to be differentiated from those with their *origin* in *the cerebellum.* Each muscle action is supplied by a nerve stream with idiotonic and syntonic parts (Textbook of Psychobiology, Vol. 2); the one comes over the cerebral centre and the other over the cerebellar, the coordinative centre, by which the position, strength and direction centres are summarized (l.c. 30).

Thus, the syntonic parts are the coordinatives. If they are especially large in number, the muscle actions are termed "coordinative" movements (e.g., gymnastics). In cases of coordinative hyperfunction, the muscle actions are coordinative compulsive movements. They are also fed from a different sense centre (idiotonic), but this arrangement can often not be diagnosed without difficulty. A tic, for example, cannot be recognized readily as being connected with an optic, acoustic or tactile, etc. situation; it needs more precise exploration. A patient "twitches", for example, only against a person in authority (in this infantilistic way he is "rebelling"), or twitches more vehemently in this situation; on the other hand, he does so less vehemently in the absence of his intended opponent; this is nonactual functioning of the cells concerned that deal with objects perceived by the senses; in this connection the twitching can stop completely at times; it can recur on thinking about the opponent; asleep, the patient does not twitch (function intensity lowered; in other cases the twitching is especially increased when the patient is asleep).

Both types of compulsive association-coordination have the peculiarity that the properties of things that are experienced and dealt with under compulsion withdraw more or less in importance behind function – according to the functional hypertrophy and according to the early infantile chaotic-ghostly experience and way of behaviour, where the forming, shape and its alterations, their changes of place, the floating changeability of every "appearance", the blending of all forms, namely, the diffuse and beginning structural association-coordination, is more conspicuous than the properties of the schemes; that means that the functional is interpreted as the true effect of the animistic-magic powers.

In this way, for the patient with compulsion illness, only the technical, mechanical, formal is essential; the compulsion method holds true for the whole event; it is the only method; everything has to be subjected to it, and by following it he feels, sees, hears, etc., absolutely certainly-uncertainly, moves himself and the world, acts and thinks; it is the method ordained by destiny, the Almighty, the absolute will, etc. his own or other demonism, his own or other magic, to come to terms with the world, life and death; it is "this way and absolutely no other way of doing things", the rigidly automatic, the "don't relax at any price", the absolute code of conduct, regulation, law, duty, the "principle" (the only true faith, all-powerful, dogmatic), the universally valid guiding light for everything, the absolutely precise copying of the original, the sterotype, the scheme, the permanently identical repeating, the speaking

like a gramophone (declaring), absolutely correct behaviour, ceremonial, appearances, the display (tailor's dummy), subtile methods (the normal person is not cunning, he is prudent) the polished surface, etiquette, order, rhythm, the plan, the programme, the order of things as the universal magic, the absolutely vulnerable-invulnerable taboo. The "way things go" is essential; the things themselves are not so terribly essential. The properties of things can only be a measure against which the effect of the functional can be recognized; a series of reference points that can be used to feel one's way along (like a drunk feeling his way along the house walls; for him they are not dwellings as such), for training and drill, mnemonics of special validity for the general functioning process. Substance is only a material of the demonic power; the body is commanded by the mind, the spirit, led and directed like the coachman's horse; the properties of the material are only in the service of the effective demonism, and are at its disposal; they are worked by it to complete the magic conjuring methods that reach out from the inside to the outside, and the other way round; they make themselves felt in the internal and external compulsive processes; they do this with the reliability of pathological automatism, and even insight into the illness cannot stop this. The logic of the compulsion is also "enchanted" against the explanations of healthy logic. Even if it resembles madness, it does have method.

For the *schizoid* and *cycloid* forms of movement – the one type is stiff, rigid, springing, and the other soft, flowing, swinging – see Textbook of Psychobiology, (Vol. 5, 13, Vol 6, 4).

All movements, and all compulsive movements are *directed* at something, even if the purpose of the movement is not always visible at first. So are mimic and gesture compulsive movements, cramping of the facial muscles ("facial corset", "mask one is hidden behind", analogous to "abdominal armour", "the body has been conjured away", magically disembodied, frozen to stone or wood, etc.), pursing of the lips (lip pouting, analogous to sucking movements) and other tics, shoulder shrugging, raising the shoulders and keeping them raised = retracting the head (a cramped protective movement, quasi drawing the head down into the upper torso), hiding the head under a cap pulled well down over the face (magic veil), crooked walking, swaggering and giving himself "airs" ("What about the world?" "*I*'m the boss!"), slinking like a fox (the fox walks in the furrow with one paw in front of the other), "odd", bizarre (also pseudochoreatic) finger, hand and arm movements, and other mannerisms. For diagnosis and therapy it is essential to find out the "address" the movements are directed to.

Mimic and gestures are a speech supplement, and this is also always directed at someone, sometimes at the speaker himself. Not all movements are intended for contact; they are nevertheless directed, e.g., eye movements. One can consider all sensory movements as being directed at optically perceived objects; movements after a noise, a contact, a scent, etc., are directed towards the optic subject associated with the corresponding noise, etc. So far as the object perceived by the senses is non-actual, the movement appears to be "pointless", "undirected", but in reality this is not so. Movements in athetosis and chorea are also compulsive, and directed, but only in the early infantile type of the chaotic, erratic, unsure. A movement cannot, of

course, be directed at itself, and therefore not at the registering position-strength-direction reference points; since these coordinative points are all localized in the muscle and bone of the individual experiencing them, movement by the partner cannot be directly registered in one's own coordinative experience. It can only be registered in such a way that one can make a connection with the position, strength and direction of the partner's movement from one's own registering coordinative points in a movement of resistance, and also observe the movement optically. Checking all these points results in the infantilistic development step and the personal world-perceptive (chaotistic-magic) sense of the compulsive movements.

Every individual movement and group of movements takes place compulsively in the case of the neurosis. We speak, for example, of compulsive eye movements, and depending on the hypertrophic species of reflex system, of compulsive looking about, eye rolling, a shy look, squinting, winking, blinking, a piercing, penetrating look, lowering the eyes, opening the eyes wide, an ecstatic look, etc., of compulsive mimicking (face twitching, etc.), compulsive eating, drinking, smoking, talking, laughing, weeping, gesticulating, grasping, cleaning, washing, working, ordering, etc., and of compulsive taking of medicines, etc., of a compulsive ceremony when going to bed and getting up, in behaviour to (certain) things, plants, animals, people in trophic or genic intercourse, etc.

Compulsive movements have to be differentiated from the *compulsion* to *make a movement*, e.g., compulsive talking from compulsion to talk, compulsive laughing from compulsion to laugh, compulsive imitation from compulsion to imitate, etc. Here, according to demonistic interpretation, "compulsion" is used for the effect of the mental-spiritual reason (motive, etc.) behind the physical action, whose all-powerful magic power "explains" the irresistible, driving, uncanny compulsive movement. In reality, one can use the term compulsion for the pathologically invariable association of the sick feeling excitement with the sensory functions to which they belong system-genetically. However, the feeling does not compel the sensing muscles and it does not compel their action or their course of action.

Greed for alcohol is the hypertrophic hunger feeling directed towards alcohol and associated with the sensory movement of drinking; the patient suffers from a compulsion to drink; if he is a "boozer", i.e. the hypertrophic sensory functions become actual, he suffers from compulsive drinking, addictive drinking (abuse), but he is not "possessed by the alcohol devil who commands him to booze to excess", etc. The patient with alcohol anxiety (abstinence) has not only a sensory compulsion to avoid alcohol, he also avoids it as regards feeling, due to hypertrophic anxiety. Associated with hypertrophic, painful, sorrowful, joyful feeling excitation with alcohol and the corresponding sensory movements, there is compulsion to fight with the alcohol, compulsion to a sensory attitude of sorrow (beaten down, hangover, etc.), compulsion to a sensory attitude of joy (overemphasized exuberance, hypomania, etc.), in short, to a compulsive attitude to alcohol. Also in this connection, compulsion does not only signify the anxiety stage, it labels all the other stages as a pathologic invariable. "Urge", on the other hand, only describes hunger-anxiety states (cf. p. 17). Insofar as each neurosis of the objects perceived by the senses is tied to feeling

symptoms, the *clinical* difference between "compulsion to deal" and "compulsive dealing" may be insignificant.

The excitations of feeling accompanying a neurosis of the objects perceived by the senses can "win through", depending on the reflex movement, or they may run more "into themselves": with intimate autonomic-sensory contact many sympathogenic parts go over to the switched-in sensory refley pathways; the *inner compulsion* to deal finds its expression in the relevant dealing (e.g., the compulsion to touch in the corresponding compulsive touch); with loosening of contact the feeling excitation remains mainly in the autonomic areas; the inner compulsion then finds no external expression, or hardly any (e.g., the compulsion to touch is not followed by the corresponding touching movement, or the sensory expression is only suggested). The demonistic interpretation of these cases is "lacking" or "successful self control"; in reality, it is only a matter of variations in autonomic-sensory intimacy of contact, and this is a pure biological fact (specific function periodicity of the neuroses in question). The compulsive dealing can of course take place without intercurrent actual feelings. The "purely" sensory compulsive dealing also does not need to reach the target at which the hunger stage is directed; it can branch off at the anxiety stage and finish at the wrong target whether the course takes place actually or is trickling away and changes to non-actual intensity; here, antagonistic, autotherapeutic and allotherapeutic functions can make themselves felt. Accordingly (compulsively directed, running falsely, incomplete, etc.), the idealic functions belonging to the sick structure take their course, the actual concept series; they can be associated with concept series, deliberations, from higher differentiation stages with a diagnostic and incipient therapy character, insights into the abnormality of the compulsive thinking and actions, in the false sense of his attitude to the world; certainly, this does not have any significant success; success can only be achieved by means of allotherapy, namely cognitive therapy. With appropriate switching of the idealic pathways to the sensory the compulsive attitude is modified ideogenically (more recollected, considered, calculated); but it still remains compulsive behaviour (with "clinging on to consciousness and understanding" as the "spiritual power-omnipotence that rules the body", etc.) Here there is a changeover to the conceptual neuroses. The therapeutic functions are not causes of the variations in the diseased functions and their possible alterations; they are nothing more than peculiarities of a functional ensemble, as is the case with the sick, and only the sick.

Both horizontal autotherapy and allotherapy take place without the diseased functions reaching a higher level of differentiation; the vertical development can however start "on it's own" and be continued and completed with cognitive therapy, as ascertained from experience.

The compulsive behaviour is directed against the patient himself or his surroundings (certain objects perceived by the senses). The compulsive patient lives in compulsion ("in the straitjacket"), and can only exercise compulsion. All compulsion is spasmodic. Everything spasmodic is compulsion. The patient acts and behaves as if he is balanced on the edge of a knife, on a silk thread or even on an imagined line over infinity; the slightest false step or sway means a fall into the "bottomless" pit – and balancing is a question of continuous swaying! Thus the patient constantly

has to disempower the powers of the deep that want to pull him down; first of all, he also has to defend himself against everyone who wants to make it clear to him that he is really on the earth; such truths are a lie and betrayal from hell; such rational explanations are only a form of the hostile demonistic attempts; they would lead the chosen-cursed one astray, thus "destroy" him and the world; in his "uncanny sureness", his "only possible" methods to keep the upper hand against all hostile demonism, to ban the spirits of darkness, death, hell, and thus redeem the world; his singular and unique "mission".

This is how the neurotic behaves, without being able to say how this "destruction" is possible, or how it would "look", without recognizing at all the only world view interpretation (namely, raw demonistic) appropriate to his experience and conduct, or beyond a foggy lack of clarity, without "knowing what he is doing", no matter how extensively he gives reports on his complaints, and demonstrates *his* logic. He "must" therefore exercise his compulsion on his surroundings, "on the world", and force the world into *his* line. But he fails when he has to face the facts; "the world" does not let itself be compelled; only other compulsive patients can attach themselves to the compulsive patient; healthy people act in a healthy way also to the patient; they refuse the compulsion, segregate the strange one, if necessary, with methods that one also calls compulsion (e.g., locking him up), although this is not diseased compulsive behaviour; it is a manner of healthy attitude to the patient.

Many neurotics have no insight into their illness, but even the ones with this insight (it is often only a very general insight, that "illness" exists), cannot make the diagnosis exactly, and fancy that the compulsion comes from the environment; their own behaviour is caused by "external compulsion" (as A. Adler assumed in his basic error); "the normal reaction of the mind to the sick environment." The division of "community" into layers, classes, ranks, with vertically different abilities and needs is the "culture disease" that makes humanity ill, and that can and must be healed by flattening out the pyramid of society and making "everyone the same"; the drive to higher stages of differentiation has to be broken down so that "I" can perform everything (individualism), and so can everyone else (collectivism). Learning, posessions, ambition, all count as asocial, contrary to the public interest, and must be rooted out, or at least despised. In reality, the rich variations of the social pyramid are the mark of a highly differentiated culture. The neurotic likes to make the environment responsible for his "suffering" and takes himself out (as an exceptional person to whom the rules for others do not apply). "My father made a mess of me" were the first words from a physician patient as he sat down in my armchair. "My upbringing is to blame for my becoming so ill; if you had experienced these crazy methods you'd have become neurotic too". "I desperately wanted to be an artist like my brother, a well-known painter, but my father made me go into technology and then become a railwayman; he wanted me to be sure of my daily bread, but I'll never forget that he destroyed the happiness of my life". "Until my marriage I was perfectly healthy; I mean to say, since I've been married: my sufferings began with the wedding; I've a wife who can make life bitter". "Yes, if I was rich I'd have no trouble with my nerves". And so on. Nonsense upon nonsense.

That external factors can force a human being to become something different to what he "might have been" due to his biological makeup, and that a healthy person can be turned into a compulsively ill person by external forces, is fiction and error at the same time. The human being is "complete" with the formation of his germ cell; his development is genetically determined in its entirety and detail, is autogenous; it is the series of cell division that begins with the division of the germ cell. The person who grows into the sickness is a descendant of sick parents; sick parents are bad at rearing children; as neurotics, they also apply compulsive methods to the children; but these methods are not the causes of the children also becoming compulsively ill; they become compulsively ill as an inheritance in the course of their development; their perception of the world becomes more and more manifestly pathological, and the compulsive rearing methods, the external forcing are all part of the already pathological perception of the world, like every other experience; apart from interpreting the cause, they are considered to be confirmation of their own rightness. The healthy person can neither become compulsively ill nor ill in any other way. Neurosis, like every other illness, is a biological characteristic. Neither external nor internal factors force "compulsion" on the healthy person; it is a peculiarity of the pathobiologic structure. The compulsively ill person cannot be "thought up" without compulsion, and cannot "live" without compulsion (apart from in the case of convalescence); he not only compels, he also "lets himself" be compelled, compelling his surroundings to compel him; he sets compulsion against compulsion; he "turns" compulsion into "a voluntary action". The father who compels his son to enter a certain profession is just as compulsively ill as the son who lets himself be compelled and, in fact, has to be compelled. The healthy person makes his way without compulsion; no compulsion can divert him from his path. A person who lets himself be "diverted from his chosen path" is compulsively ill; he follows the path he has been compelled to follow; it is a conceited fiction and error for him to believe that his "real path" would have been completely different, that he can or must blame his parents or other external factors for his not being able to follow his "own" way, and that his "life happiness" has been destroyed in this way. The chosen lover is also a characteristic of the biological state of the partner. The compulsively ill person chooses under compulsion; the compulsive marriage is mutual compulsion; nobody ever becomes compulsively ill or ill in any other way owing to marriage; a sick marriage can only be made by sick partners; but their illness can become especially manifest at the marriage stage of development. Rich people also "have nerves"; the percentage of neurotics among them is even higher than among the poor, but neither wealth nor poverty "make" a person nervous, and with the unreal condition clause, everything and nothing can be "proven". And so forth.

The objects perceived by the senses to which the compulsive act is directed belong, naturally, to the compulsive experience; they are as infantilistic as the compulsive act. For the dipsomanic, alcohol, milk, or water (such dipsomaniacs also exist) is not the drink adults know; it is a magic drink, a bearer of destiny, life and death, a gift of God or the devil. For the compulsive worker,

the materials he works with are demonic toys, and it is not a case of doing human work; the demon-foe work has to be exorcized, and this is only the "work" of the compulsive worker. Hence, he experiences the material and equipment he works with completely differently from healthy people, but that is only to be diagnosed by the compulsive act and its description; the material and machines are "outwardly" the same for the healthy worker and the sick worker, and have the same names. Genetic differences and experience of the objects perceived by the senses have to be considered; the little girl who helps her mother in the kitchen experiences sensory perceptions differently from her mother, she grinds coffee differently from the older girl or her mother, but these differences of "outwardly similar" action can only be understood from the developmental biology point of view. The objects perceived by the senses are actualities of thought cells of collocatively or dislocatively constructed reflex systems, e.g., compulsive masturbation can be carried out with the genitals or another part of the body (such as compulsive leg stroking, tickling the nasal mucosa with the tip of the tongue, fumbling with the lips, habitual rubbing of the eyes and nose, scratching the skin, etc.), or of extracorporal objects (e.g., rubbing, squeezing, pressing a hard, stretched object, playing with the handbag catch, etc.). The neurotic behaviour is often very similar to its normal analogue; compulsive behaviour can only be determined by more precise exploration. The healthy person also crosses a busy street carefully, makes notes, keeps his study in order, and so on; some neurotics do these things in such a way that only more detailed investigation brings out the compulsion (it has to be like this, embarrassment, pedantry, etc.) that does not know or recognize the normal range of variation. For pretended legitimization of his neurosis the sick person likes to refer to analogous normal behaviour that he cannot differentiate from his own.

As is known, we also label the neuroses of objects perceived by the senses and neuroses of concept according to the feeling belonging to the system, and speak of sensory or modal or idealic hunger, anxiety, etc., neuroses, respectively. We specify them further according to the sense area, then according to the function group, and finally according to the objects perceived by the senses to which the compulsive movements are directed, and also in the manner of avoiding them. Terms like reading, writing, talking, work, etc. hunger; anxiety, pain, etc. neurosis, or alcoholism as alcohol hunger, anxiety, etc. neurosis; possession hunger, anxiety, etc. neurosis, also hold true for the appropriate neuroses of feeling that are specified according to the sensory functions or the relevant objects perceived by the senses; for differentiation, the terms autonomic or sensory are added. For some neuroses there are also additional special names, such as addiction, abstinence, insomnia, squinting, vegetarianism, sado-masochism, homosexuality, exhibitionism, etc. Terms to do with character and temperament are also applied, such as pusher, fanatic, coward, pighead, pedant, nagger, grumbler, phlegmatic, unlucky fellow, lucky fellow, windbag, etc., and finally, terms to do with how the world is perceived, such as nihilist, negativist, severist, pessimist, optimist (Textbook of Psychobiology, Vol. 6) as the names summarizing the appropriate neuroses of feeling, objects perceived by the senses and concept (cf. fig. 3).

Examples:
Patient C., 46 years old, "drank heavily in the past but has stopped the boozing" and can only occasionally "not avoid it for business reasons" (he came for the treatment of another complaint). Even as a little child he had a strong interest in the bottle from which his father often took a drink, greeted guests, etc. "The secret had to be got to the bottom of". It was the demon of the paternal, the magic substance, the elixir of life, as it were, the mothers milk of the great godhead. At five years old, on the occasion of a billeting, the first attempt to get the better of the demony of the bottle, the alcohol. C. took a bottle of brandy, drank, and was later found in deep narcosis. His father laughed. Later, there were several similar attempts. He became a travelling businessman and in this job he "had to booze with the others", it was "part of the business". "I was forced to take part, and that's how I became a drinker" (the patient fancied!). In reality, he was a hereditary alcoholic, first of all latently; in early childhood it had already been manifest periodically, and the addiction also made its progress at each development at thrust; it was closely connected with his business (grocery). "One day" this neurosis of sensory perception developed into a neurosis of feeling; a strongly hypertrophying fear about alcohol attached itself to the hunger for alcohol, and then the painful feeling of denial, sorrow about the hardship of being, the joy about "steadfastness" against the "temptation". By this time, he had overcome the "demon alcohol" (god or devil?) in the form of a sort of abstinence, i.e. the series of feelings tied up with the alcohol system genetically took its course "within itself", without actual sensory functions; the thirst only came to a head now and then, with the sensory function "boozing" regaining peak function. "There is an internal compulsion at work, but there is also external compulsion from my boozing pals" ("seduction"). (See quarterly drinkers.) C. had, of course, thought about his "change", and he was proud of it: "I said to myself, it can't go on like this, you must get yourself under control", etc. But he only described the rampant fear about alcohol that became stronger than the hunger, and already gave the hunger a strong fear content. There was only a shift of symptom, a "sensible thinking" was not the reason for the "improvement", it was only concomitant circumstances to the symptom shift (C., by the way, had had such thoughts often enough before – "without success"). In some cases, the addiction to drink becomes an alcohol concept neurosis: the drinking is replaced more and more by the compulsive thought, as a cramped, repeated vow and training: "alcohol has no more power over me; I don't care a bit; I am freed from its temptation". Cramped demonism of the "spirit" against the demony of the "wine spirit", alcohol. The patient does not have the same experiences with alcohol as a healthy person. It bears the magic that must be banished. All these people are alcoholics, the abstinent person just as much as the abuser of alcohol, although it is certainly better to be abstinent than an abuser.

Patient P., aged 42, a controller in a major bank, was also an alcoholic. He always had a small baby's bottle in his waistcoat pocket – the sort of bottle bought at fairs, filled with red lemonade. Formerly, he had yearned for these fair bottles. His wife filled it with half a glass of red wine every morning. Before he entered a room on his control visits, he had to take a secret drop of red wine through the rubber nipple; then

he could "surmount the threshold", then "he was full of his god", insurmountable, infallible, all-knowing: no mistakes = no devilry could escape him. Without the holy bottle he was helpless and unable to do his job. He was a suckling, a baby, a large-scale infant. The first "bottle" is the mother's breast, her milk is the blessing that "soothes" every need, the "milk magic" changes to "alcohol magic", under whose protective influence every trial and its demonic dangers can be withstood, etc. (See p. 126).

Addiction to drink is a sensory hunger neurosis; compulsion to "consume" alcohol combined with fear about not being able to pass the big drinking bout test, of being "shamed to death", and with the overambitious struggle with his boon companions for "the first prize". The contrary: compulsion against alcohol, abstinence as an addiction (fanaticism, antialcoholism), nervousness, lashing out at the "enemy of mankind" in word and deed. (See pp. 134, 135.) The sensory alcohol sorrow neurosis is lazy, phlegmatic drinking, chewing the drink, the woebegone expression used to "look the enemy of mankind in the eye", the procedure used to assume to take on the unavoidable and evil, the "utter misery", the pathologic hangover with the vow "never to do it again". Sensory alcohol joy neurosis is the overcheerful, silly-to-hypomanic fuss about alcohol, praising and adoring it as the fortune of the world that one has under control, as shown by the fact that one consumes it. Naturally, pathologic feelings (moods) and concepts are connected with these neuroses of compulsion. In many cases addiction to drink is a secondary symptom associated with fear about real or imagined major tasks in work and love, anticipated events, strokes of destiny, the challenges and tests of the day, etc.; shortly preceding the enemy-demony in the many "embodiments" of alcohol, in these cases alcohol is the friend-demonism, the lifesaver, the problem solver, the god who banishes the devil. Or is it, on the contrary, really the evil foe that distracts and seduces a person away from the task desired by God? (flight to alcohol, etc., "to the mother"). Treatment has to be adjusted to the structure of the neurosis. It has, for example, to be aimed at the persecution fear in patients who run to the pub, the "altar of God" (or the Devil?), full of persecution fear and rescue themselves with alcoholic narcosis.

Patient K., 27 years old, "destroyed everything" as a small child. Destruction was the method he used to control "everything that approached him". It didn't matter what the object was; it wasn't the object, it was the banishment of the enemy demony, the maintenance of omnipotence. Later, the destruction mania "specialized" in glass, windows, eyes "that had seen and therefore had to be destroyed" (see Wotan, Oedipus), in the mirrors that "told the truth", and plucked the soul out of the body", then it turned to people who remonstrated with him or resisted him in some way, including his mother (father had a cataract operation when the patient was four years old and died when he was 11, Mother, the witch (or goddess?) was to blame for everything. The patient had to deal with her or she would destroy him, too). Knives and scissors were suitable for destruction, the terrible magic instruments that overcame death with death, extinguished the enemy-demony, althought naturally the facade they hid behind, the body, had to be stabbed. As a boy and teenager he attacked

his mother several times with a knife or scissors. Then, the sensory pain neurosis accompanied by hypertrophic hunger changed to a feeling neurosis with mainly hypertrophic fear and intercurrent compulsive thinking ("attacking someone with a knife; that's awful; I must punish myself by stabbing out my eyes, kill myself", etc.). The sensory course did not take place. The patient had "become outwardly well behaved". Mother had no more fear about him. "How it looks inside has nothing to do with anyone else."

Patient G., aged 23, "has to grasp everything that had made a noise" (see p. 128); as a result she gets no work done (she is a typist). She has more important things to do, the only important thing, to ban the demonism, ruling things that "speak", and compel her to grasp and thus neutralize itself (see grasping as a gesture of possessive gripping, primum capiens = princeps, handshake, etc., also laying on of hands as a magical healing method). In this way, the patient was the ruler over life and death, the saviour – what's all this ridiculous work and daily bread? She herself could not be touched, for then her taboo, her demonism, would be extinguished. This meant that in the morning she had to lie absolutely still in bed, because even the tiniest movement would be a change in the "resting exchange of contact" and thus the unchaining of the demonic struggle between her own and foreign contact powers, with the permanent doubt "who, whom?", namely, whether the other would unload and banish her demonism or she that of the other. About noon her mother "had" to chase "the lazy thing" out of bed. Then she had taken over the contact magic (the daughter compelled her to) and carried the responsibility in the service of her godly daughter, who now went on with her "duty to the world" outside her bed. Knocking noises then also announced the contact magic; she then had to knock back in the same way and thus annex the knocking spirit. As is known, small children grasp everything they can reach actually or magically (e.g., the moon); the all-oneness world is the all-wealth of the child and anything that escapes from the child's omnipotence and also cannot be grasped or held is "inconceivable" or "incomprehensible" and only destroys his omnipotence; by maintaining omnipotence the patient, to the extent that he is sick, is "always" busy; everthing else is unimportant.

1.6 The neuroses of concept

In the concept neuroses, functional hypertrophy of the idealic part of the diseased reflex systems predominates. Thus, in the diseased area the concepts are predominantly hypertrophied, and the objects perceived by the senses and the feelings less so. The less the autonomic-idealic contact, the "soberer" and "colder" the conceptual thinking. The closer the contact, the more "feeling content" in the conceptual thinking, and the more mixed with feeling excitation and actual feelings. The less the sensory-idealic contact, the more "detached from the world" the conceptual thinking, i.e. the less it has to do with objects perceived by the senses, and the less the ideogenic part of the sensory movements, but hypertrophic conceptual thinking, being hypertrophied, is always unconnected in a pathologic

way, and closed-in on itself, wrapped up in itself, and thus detached from the world.

The movements of expression belonging to the diseased area are also here all cramped; with a high ideogenic content, they are compulsive in the way of an overemphasized intention and calculation. There can be contact loosening within the concept sphere, with impediments and interruptions in the course of concept and thinking also connected with a falling off of the sick functions also to a non-actual degree; this can be via limited or extensive areas (narrowing of thought, poor memory, loss of memory, partial amnesia, inability to be aware of optic, acoustic, etc. sensations). False memories point to sensory-idealic and also interconceptual false associations. The conceptual neurosis is often mixed with strong feeling symptoms; depending on the function periodicity, the feeling excitations remain for shorter or longer periods of time at low intensity, and then rise to a higher and high degree, including switching over to the sensory pathways, so that outbreaks of sensory feelings take place; one also speaks of a "nervous breakdown" as a special type of "failure of self control", of "self discipline", also thus interpreting these changes in function demonistically.

The neurotic with a neurosis of feeling, to the extent that he is ill, mainly lives in the world of feelings; for him, the sensory perceptions and the concepts are structures of lesser order, only important according to emotion. The neurotic with a neurosis of sensory perception only lives in the world of sensory perception, to the extent that he is ill; for him the feelings and concepts are structures of lesser order, only important according to sensory perception. The concept neurotic, to the extent that he is ill, lives mainly in the world of concept; for him the feelings and the sensory perceptions are structures of lesser order, only significant according to the standards of concepts, only "patterns" for the ideas fixed in hypertrophy (imaginings, ideas), for the "world of the spirits", the "spiritual world", the demonic quintessence, and thus for the essence of "earthly" events. In the beginning was the Spirit; it created all things (see God is Spirit, God created the world from nothing, and man in His own image; He is the Spirit that builds the body; ideocraty, etc.); all things are His incarnation; He works in them and from them; and He can leave them, destroy them and become a pure Spirit again, when and how He wishes. At the end of everything He liberates himself from earthly bonds. Ideas are everlasting; earthly things are only passing shadows of them; the kingdom of the Spirit is not of this (material, earthly) world. Reversed, the concepts are "pictures" of this world, and as such are otherworldly and metaphysical. Thoughts are "inspirations" of the great spirit, and thus completely spiritual themselves, godly – or also of the devil? Good and evil thoughts? "Descended" from above (holy) – or rising from below (unholy) – in a permanent struggle with one another? The (demonic) "Me" – or the (demonic) "It" thinks inside "me"! In this way the good-evil spirit, the all-knowing, the all-thinking, is within me and makes "me" lord over heaven and hell, life and death, "I" am the all-knowing. Everything depends (causally) on the train of thought! The spirit is the creation of the soul. The soul is life, but now also it's "adversary", etc. In this way the concept neurotic takes the lesser part in the "worldly" the more the conceptuality hypertrophies; he lives a pretend-life "in the pure sphere of the supernatural and transcenden-

tal" in contrast to "mortals" tied to their flesh, He is the chosen-accursed one who has overcome the world.

"I am the all-knowing"

An expert is someone
who knows more and more
about less and less
until finally he knows
all about nothing

Victor Weisskopf
Austrian-American Physicist (born 1908)

Figure 14. Example of a concept neurosis for a cognitive therapist (job disease).

In this way the pathologic concept quality is a hypertrophic replacement for (each specific) sensorial experience and its description: they are still only the narrow starting point for hypertrophied ideas and thoughts that have, so to speak, become independent and document the central importance with the frequency of their appearance and their compulsiveness. The pathological concept series is infantilistic, and as abnormal as the corresponding feeling and sensory perception series.

One may spend many hours each day thinking about how a square can change to a point (p. 130). In a square, a smaller one is thought of across the corner, and in this another smaller one, etc., until only the point in the middle remains – "a miracle, the effect of my magic, making a point out of a square; but is the point really a point – or really still a tiny square?".

One may hear a name, and now there are "mile-long" conceptual word mixtures, "variations on the main theme", with wild deviations into comparisons, familiar connections, birthdays and birthplaces, dates, etc., a sort of infantilistic genealogy. One may want to smoke a cigar, but beforehand he has to imagine painstakingly how he will take it out of the box, cut it, light it, etc.; he "bans" the tobacco magic in this way, and could now smoke "without any worry", but "now it hasn't any more point". One may have trained himself against alcohol with compulsive thinking; he drinks in thought "as intemperately as he wants"; in fact, not a drop of alcohol passes his lips; another "compels himself to reason" when he's at the bar, i.e. the compulsive thinking "stop, don't go on" is intercurrent with the sensory series "drinking", but sometimes "the seductive voice wins", and the patient drinks himself stinking full once again; the sensory and idealic functions vary in this way. One may tell the boss "the truth", with all the pride of manhood – but "in thought" (see "fist in the pocket"). One may "write" his enemy long letters for hours – but only in his head and at night. One may imagine love scenes, "eats his heart out thinking of the loved-one", but behaves towards her as though she has nothing to do with him; one may wallow in perverse sexual fantasies, but is outwardly an apostle of morality. One

"cannot get rid of a melody". "Now you must swear – swear – swear" whispers the devil into the priest's ear during the sermon. "Now you'll dry up – now – now" murmurs the fatal inner voice to the public speaker. One may attach complete systems of thinking to a few objects perceived by the senses – "ideologies" – that are more or less far from normal, depending on the circumstances, and therefore do not agree with the facts; the one cloisters himself in his senses, the other proclaims it verbally, the third tries "to make it come true" (sensory functions), but sooner or later they are all "shipwrecked" on the normal.

Unlike the normal person, learning by the concept neurotic is not a true, organic, productive structuring of vertically differentiating conceptuality, but a mechanical storing of "dead knowledge" subject to the development of false associations, with details appearing and disappearing like will-o'-the-wisps in the fog of knowledge; the patient is only concerned with de-individualizing the details, banning their magic power, and levelling them into his knowledge chaos. Hypertrophied knowledge (as with the swot, who crams, learns fanatically, "consumes" all knowledge, "digests" unceasingly every sort of book, is a "walking dictionary" and "knows everything") is a type of wrongly arranged museum collection, "cabbage and beet", "undigested material", "wanton growth", beside more mature areas. Knowledge is death (see Schiller, Lessing and others). Details are the deadly enemies of totality, they have to be deprived of their power – only that has to be learned, and one learns only for that purpose. One is proud of his intelligence – but he's still only an intellectualist. Intellectualism is concept hypertrophy near the normal, but one should not confuse a normally high level of intelligence and education with intellectualism – "intelligent stupidity" – as the intellectualist likes to do, and defame the high intelligence.

Hypertrophic excitation of the feelings often precedes, mixes with or follows the pathologic concept series. One dreams up unheard of aims and feels the urge to attain them. While thinking about a cigar, about walking in the street, about sitting in the theatre, about school homework, about a lecture, about a meeting, one starts to sweat, gets palpitations, feels oppressed, gets stomach anxiety, etc. One remembers a painful experience and gets actual pain. One cannot stop thinking about a loss, and sinks into deep sorrow. While "thinking of success" (joy neurotic planning), one winds up in a state of overemphasized joyful excitation ("best feeling in my whole body"). An impotent person indulges in sensual fantasies and gets an erection that, in practice, fails to appear or diasappears prematurely. On the street, one gets an irrestistible urge to urinate during compulsive thinking on "examination of the sexes" (imagining the sexual organs of passers-by, with transvestial experiments), and has a "lavatory sketch" in his head that he seeks out immediately (victim of the urine devil tempter, so that it is kept content and thus banned). One theorizes about love and tears it apart and thus becomes convinced of its lack of sense and value, of the need to keep a cool head and his wits about him, even in coitus, so as "not to lose himself", but every now and then "all reason goes to the devil" "and every devilment is good enough to overpower it". The "mortifying of the flesh by the spirit" is always connected with genital and filial gastric, cardiovascular and pulmonary symptoms, etc. The symptoms in the individual case indicate the biological structure and function

of the diseased organism, but possibly not the effects of mental-spiritual factors or other metaphysical powers. Whoever "settles" his sexuality conceptually should not glorify in this as a "victory over himself" or let himself be praised by others, he isn't to be honored for it, he is neither hero nor saint, only a poor sick person.

The concepts are the memories of their respective sensory perceptions. The *scheme of the concept neuroses* is thus the same as that for the neuroses of objects perceived by the senses (sensory perceptions) (p. 61).

Pathologic compulsion is the inevitability of the abnormal event. Here, the "train of thought" is considered to be substantial, and the thoughts themselves are considered as secondary: mechanistic thinking (p. 62). Thus, the diseased conceptuality is compulsive, too; one speaks of *compulsive thinking* and *compulsive thoughts*, but without labelling the concept neurosis especially as compulsion neuroses. Here, too, the compulsion is interpreted as being demonistic; as an effect of metaphysical power and, after all, the ideas and thoughts themselves count (according to their biologic nature, namely, the relative uncertainty and variability of their coordination etc.) as spirit, spirits, spiritual, as good and evil spectres that come and go when they want and nevertheless, can or will be cited, bound, mastered and banished by the "I". This is how *thought compulsion*, the compulsion to compulsive thinking is interpreted, whether one means the feelings that precede the concepts or the objects perceived by the senses to which the concepts are bound; the sensory perceptions should have the power to conjure up thoughts, to leave them out of themselves and retract into themselves if the thoughts do not carry on their burdensome, crafty, rollicking, impish game on their own, etc. In reality, this is also a pathobiologic function.

The system genetic connections between the concepts and "their" sensory perceptions and feelings are easily seen in many cases. This is because the individual concepts always join themselves genetically to "their" sensory perceptions, but can then also be actual without the objects perceived by the senses and belonging to each individual concept becoming previously actual again. This is especially true for collective concepts, the sphere of comprehension and reason. These connections have been made clear as being purely biologic by psychobiology; in demonistic thinking at all levels they are a puzzle, especially in neurotics; there, the feelings and thoughts are interpreted as being mental-spiritual, consequently, they are polarly opposed to "the world" as "the physical". Then, all kinds of theories are thought out about how the mutual influence (the transition of the mental-spiritual to the physical and the reverse, consequently, also the consciousness "of" the physical) might be possible, or whether it might be a matter of "parallel appearances", no less puzzling than those "causal effects", or whether the spirit, mind, and body might be a trinity, with the conjuring trick of "three beings in one", or "soul = the internal aspect of the identical physical" have to be taken into account. So, if the hypertrophic ideas and thoughts join themselves to certain feelings or external events, the connection is precisely specifiable, even if it is mysterious in demonistic thinking. In other cases the hypertrophic concepts seen to be completely autochthonous and closed in on themselves, completely metaphysical.

The concept neuroses are also named according to the feeling belonging to the system, according to the species of feeling: conceptual or idealic hunger, anxiety, etc. neuroses. A further specification can be taken from the name of the belonging remembered object perceived by the senses, but one cannot create monster terms like "alcohol concept hunger neurosis". Instead, the neurosis of sensory perception in question is indicated, and the terms "idealic" or "notional" placed before it, e.g., idealic alcohol hunger neurosis = idealic addiction to alcohol, idealic sadism, notional masturbation, etc., or the remembered sensory perception is given separately, e.g. brooding about something. If the diseased conceptual thinking takes its course in higher conceptual zones, it is then labelled according to the concept-typical comprehended scope there, e.g., one speaks of religious, moral, judical, aesthetic, political, social, economic, philosophic, etc. concept neuroses, and especially defines more precisely the deeply wrapped-up systems as nihilistic, negativistic, etc. ideologies (see fig. 3, p. 12).

Examples:

Patient S., aged 44 reports: "Years ago I happened to see M. He struck me as odd. I had the impression he was giving me a special look, like a concealed threat; I can still see him quite clearly standing in front of me, and ever since then I have had to keep on asking myself, what did the fellow want from me? But then I noticed that other people also gave me looks like that, and the thought tortures me night and day: what do they want from me? That M. is the cause of my illness. It's really weird how a person can destroy a whole life like that with a single look, and how he can torment me invisibly for so many years; that's certainly got nothing to do with normal things".

The system relationship is clear, even if not yet cleared up up to now; it emerges that even as a very small child the patient studied the expressions of the big demons, first of her mother, then of her father, and had thought a great deal about them. Many people visited the parent's guesthouse, and there were many miens (the patient's mother was called Wilhelmina, and she herself was also called Mina or little Mien, so person = miens, see "mask, person", etc.). The mien is the good-evil, godly-devilish demonism; it is the life and death magic; the "fatal mien" comes from those childhood studies of the "mien changes", that presumably caused the brooding.

Patient H., aged 32, married believes: "my upbringing brought me to brooding; I was treated very strictly, almost closed off, and wasn't even allowed to leave the house alone; for instance, when I was already a big girl, I was given an awful beating when I went to the cake shop with a girlfriend when I was seventeen years old. I've always asked myself if I'm something so special in the good or bad sense, a saint who lives in sanctuary or a whore who has to be guarded".

Mother was a "home bird", the child had fear about crossing the threshold from the very beginning. "Outside" the demonic dangers, life and death, doom, threaten; a

great impression was made over the caveat "see; sin rests before the door, but do not grant it your will, rule over it" – namely, by avoiding the outside. So the "compulsion of her upbringing" was only confirmation of the personal view the child had of the world.

"Life", says a severely schizoid theologist, "showed itself to me at an early stage as a work of the devil, everything picked on me, I bore all the wrongs, my childhood, and really my entire life was a round of wrongs and injustice. But life is the creation of God, I always have to think about God and the devil; God leaves me no peace to think against the devil, so the devil brings me the consciousness that God works in me and in my spirit, that I am of God, and godly, called to overpower the devil and the worldly and redeem mankind". The patient was singular even as a toddler, without playmates, without friends, he had "nobody and nothing apart from his thoughts", and he played with these as though they were angels visiting him from heaven and confirming his "origin in heaven"; this led to countless whys and entangled and enmeshed him in thousands and thousands of complex questions.

Patient S., aged 33, married, was an intractable tyrant as a child, enforced her will on all, was called "witch", had "always liked thinking", had to know everything and collect all thoughts together, nothing might escape her, she was an "exellent schoolgirl", always knew everything, ruled over everything with the omnipotence of her spirit (in which every concept neurotic believes). In addition, fear that something might be forgotten, and thus the omnipotence, the omniscience, might be lost. No time for love, had to "think". With great fear, married a thinker (insomnia, "chaos of thoughts") – he might make a general attack on her omniscience. She "succeeded" in subjugating his thinking; he had to think like her; she "let" him think, but in constant doubt whether he would start "independent thinking", and think differently from her, deprive her of her own thoughts, etc. So she always had to think that he thought precisely, to a "T", what she thought. Her main predicament was that a stranger might think something she didn't know: so she had to think her thoughts into the stranger, transfer them, read thoughts, and guard her uniqueness. Whatever approached her had to be executed by thought, including appointments, meetings, the next day, the future; later, there was compulsion to write notes, "reminders", had to think about the impossibility of the possibility of forgetting something, then the forgotten was not just forgotten, but only thought away, and remained in her omniscience. But she could also "dismiss" thoughts (thinking pause), or feelings of anxiety replaced the thought gap, chased after the fleeing thoughts and caught them: "I must always be complete".

Patient L., aged 49, had "insomnia" for a long time. "I'm not yet in bed when the thoughts come over me and buzz in my head like a swarm of bees; they give me no peace. Certainly, there are memories of concrete events there, but many more expanded meditative trains of thought that are completely unearthly in their independence, and spontaneity; they are plans, intentions, inspirations, so to speak, (the Holy Ghost effuses), and with these I visualize the future, but not a happy one, I

always have to "think in disasters"; a sort of Cassandra, and she didn't exactly feel well either.

"I have the thought I may be able to ban what is coming in this way, that it now won't be so bad, or will even be good. All the trouble I take to scare off the thoughts is useless. For example, I think of numbered sheep jumping over a hurdle, but once I've begun, they never stop; real defiance. The thoughts do what they want with me."

There are no "external causes", and no "internal causes", so the thought spectre is all the more puzzling.

Patient R., aged 20, law student, reports; "When I'm working I'm constantly disturbed by sensual thoughts – they force themselves up as a medley of pictures and voices that compel my attention. My work is a constant battle between good studying thoughts and evil sensual thoughts, so I'm not really studying. The disturbing thoughts are vague scenes of masturbation and coitus, but I only know that the scenes themselves are unclear, whirling and spectral. Sensuality tortures me in other ways too; I have a terrible desire for sensual-satisfaction, but even more anxiety". Had previously masturbated a few times but "had repressed masturbation from anxiety about the consequences"; the thoughts about sensual scenes have taken the place of genital masturbation. Even as a child, major anxiety about the mysterious being called mother that appeared later in many transformations. At age six discovered the vagina of his four-year-old sister, and then supposed, but more imagined its presence in other girls; sometimes surprised mother in her bath; all black down there; witch! Frightful secret, etc. Causative connection of compulsive thinking with longing for love and love anxiety assumed in this case; in reality a pure biologic, flourishing arrangement of the diseased functions.

Patient K., aged 33, married, lying beside his wife, always has to imagine two fighting housemaids before he gets an erection. As a toddler he believed he was a girl without knowing what that was. The love struggle – a fight between two girls; first seen between two housemaids, and also in hunting pictures à la Watteau, etc., simply imagined "in such a way". So, the thoughts have a mysterious power over the feeling, and the imaginary fighting scenes erect the penis".

Patient E., aged 30, married, reports: "I wake up with migraine every morning; the pain also moves out of the nape of my neck into my back – I don't know what it is. Since nobody could help me, I arrived at the idea of using my thoughts against the pain – according to Coué. It won't hurt any more; I have no more pains; I can stand up now, I spend half an hour with exercises of this sort, then I have the pain so far under control that I get out of bed, but during the day I must, nevertheless, always keep thinking about my pains so that I can think them away, otherwise the migraine gets the upper hand. Improvement only towards evening." Mother says that, as a baby and a toddler, the patient could not hold up her head properly; "you could see how much trouble she had to take". Interpretation later: the head must be held fast in order

to "hold one's own". The head can easily fall off or be knocked off (she had often been struck on the back of her head by her father and teacher; so this was mortally dangerous). Increasing hypertrophying anxiety, and especially pain reflexes with cramping expression in the muscles of the back of the head, nape of the neck and back. Relative peace at night, but "one has to be on one's guard". On waking, the daily battle with the pain begins, and only ebbs with the coming of evening. The thoughts force the pain to be still, and thus have "power over the pain", in reality, compulsive thinking alternating with anxiety and pain feelings.

Mrs. O., age 36, before getting married (at age 29) to a teacher, seeks help because of flights of ideas, poor memory, insomnia, general exhaustion, etc. "Ever since I could think, I've only thought and ruled the world with the omnipotence of my knowledge-consciousness; I've looked at the earthly sphere from the unearthly, as God regards earthly events, and guides and leads them without himself taking part. The ideas and thought were spiritual beings for me that I could deal with with confidence; I myself was a spirit banished to the flesh (incarnation); especially at night "the relationship" visited me from the beyond, angels from heaven, but also the devil from hell, to talk to each other and to me, and the angels always chased the devils away, or I took charge of the whole affair – it is also possible that I visited the "relationship" in the beyond. The world was a dark riddle; people, especially my parents were weird beings about whose "being" I was already brooding as a little child, and who I resisted in this way; worldly things were only magic trouble makers in my supernatural existence, trails and temptations to drag me back to earth and thus spoil me forever; but my Think-I, a Christ on the pinnacle of the temple, repulsed the evil powers. For a long time, I fancied that I alone could think, and it was a great shock when I heard that the "others" also think, but I thought to myself, these are also only my thoughts; I also think in the others; I think for everyone and in everyone; everyone else thinks in me and through me. Learning at school, etc., was the omnipotent way for me to keep the ever reappearing spirits in my power, to banish them, so I worked very hard; it was my calling; no thought was allowed to escape me, but while I was chasing one, others were there that threatened to run away from me, and so I, a hunted hunter, am always running to and fro after the teasing thoughts – always with the anxiety that I might be deprived of me – for instance by the teacher or other tempters. I always had to "take stock" – rather like a librarian or a bookseller with his books. You could say my knowledge was outside me, external, only collected and piled up like the books on a shelf. Like this, I was a "knowledge store", a dictionary, I used myself relentlessly – always with anxiety that an article might be missing and make the whole dictionary useless. As the omniscient, I naturally had to become a teacher, a philosopher even from the very beginning, but now I see that even with all my pedantic conscientiousness (with anxiety for the slightest supposed or real mistake), I was a bad teacher; I always only had to confirm my own omniscience (an endeavour as constant as it was useless); I only used (misused) my knowledge to rear my pupils – and other people – in and to my enchantment. "Far above the lowly life on earth.....", that was my motto. My body was also only a necessary evil; I, the God-like, was only banished to the flesh like Christ to overcome

> the earthly temptations of the flesh. So, I tried to forget the functions of the body, to shut myself off against abdominal sensations (stool, urine sensuality) by clinging onto the only true method of negation, by thought; I took a vast amount of trouble to never lose my reason, that means "me", that means my (eternal) life, not to lose "my head", to deny myself and leave the world, to lead a pure life, to disenchant, nevertheless, the necessary fleshly and earthly functions with the omnipotence of my spirit. In this way, one could say without my own true participation (see Christ in hell), also my marriage has taken it's course up to now and my child has been born. I was an ascete, not a human being". Diagnosis: idealic hunger-anxiety-trophogenosis.

In many patients the neurosis develops in such a way that two mistakes cancel one another out "externally", e.g. an initial hunger neurosis later becomes an anxiety neurosis with hypertrophic hunger as a side issue, "anxiety about one's own courage", fanatical storming free in inhibition so that an "inhibited" fanaticism emerges; if this is directed to the normal, it can outwardly resemble normal behaviour and its results. But two errors remain two errors. This also applies to the "replacement" of symptoms concerning feelings and, vice versa, sensory perceptions by concept symptoms.

2. The structure of the neurotic experience

Every experience is a hunger-anxiety-pain-sorrow-joy series and is composed of a (its) hunger, an anxiety stage, etc. The stages follow one another in the order named. Each actuality belonging to an experience is in coordinative proportionality to the preceding and succeeding ones, i.e. in kinesthetic (position), static (strength) and topic (direction) proportionality; as a result, the individual successive stages of each experience are related to one another and, in addition, the start and end stages of each experience to the end stage of the previous one or the start stage of the next one in a coordinative way, specific to each. Like the total actuality, their coordinative symbol components are specific (corresponding to the coordinative adjustments of the actual thought cell); so the structure of each experience is also specific; it corresponds to the associative series of the actual thought cells (to the structure) and thus to the constitution of the experiencing individual, which can also be called its structure. The hunger actualities are arranged in a wide circle and the anxiety actualities in a narrower one; pain actualities are in twists, sorrow actualities are in short straight lines and joy actualities in long ones. Each experience consists of round and straight series, and the change from round to straight is the threshold.

The norm is the most frequent under analogues. This is also true for the structures. The analogue experiences are compared here, and one thus finds out the normal structure for them with the normal range of variation. In this connection, only actions that belong to a certain category are comparable; in diagnosis, one should not compare childlike behaviour with corresponding behaviour by adults, but rather with analogue behaviour by individuals of the same age or condition or profession or the same level of education, etc. According to the development stage now diagnosed, the pathologic is, of course, infantilistic, hence the normal analogue is to be looked for and to be found in childhood and mainly in early childhood.

The abnormal structures lie outside the normal and within the abnormal range of variation. The healthy person experiences in a healthy way, so his experiences and behaviour are also normal in structure. The sick person experiences abnormally; his experiences and behaviour are structured falsely; his healthier and almost healthy experiences are near-normal to almost normal, but they are never normal. The abnormal structure is abnormal formation of the round, twisted, straight arrangements as such (*false structures*) and abnormal arrangements together (associations) of actualities, so that, more or less, many actualities occur in the sick experience that (analogously) do not occur at all in comparable normal experience, or in other connections (*false construction*). The hadrotic actualities (the actualities of the hadrotic experience) differ in this way from the normal anatomically, and the leptotic only functionally. The purely functional abnormal is connected with the primitivistic lack of clarity (vagueness) of the actuality, but this whole property is not an anatomic characteristic, and can only be understood biologically. The qualitative characteristic of leptotic experiences can only be recognized from the abnormal function, and is determined by this.

The further the experience from the normal, the further its structure from normal. In this connection the false structure is often less noticeable than the false construction. The intensity and extent of the symptoms is not the indicator for the direction of the experience. Serious and extensive symptoms can also occur in directions that are near the normal. The intensity and extent vary periodically, and the direction can also change. For example, one is sometimes unable to work and sometimes passably able to work. In their course, structure errors of previous stages (errors in structure parts) can more or less balance out in each of the following stages, but the "errors" cannot be "made" to appear as though they "had not happened", or be "rubbed out" in this way. The approach to the normal is the greater the more near the normal the sick experience, or the more almost healthy parts it has. The sick experience, or the pathologic in the experience, take its course on the level of the infantilistic development stage and is also falsely associated with the healthier and almost healthy experiences or experience parts of the individual, so that there are structural particularities in these connections, too. The hypertrophy of singular experience stages also marks the direction of the other stages and, thus, the total experience, e.g., if the hunger stage is hypertrophic in a hunger neurotic experience, the following stages also have a strong nuance towards hunger – with a relatively strong hunger content. The structure of the experience is also specifically abnormal in hypotrophy. According to the reflex action, the experiences also agree in structure with the movements of own action expression (statements, behaviour) to which they belong: from these the observer gets to know the experience of the observed person, or makes conclusions about them. The diagnosis is often only possible for the specialist trained in psychobiology, especially in near normal or compensated cases.

The structure and, consequently, its alterations, the function, has to be described according to position, strength and direction. The sick actualities have a more or less abnormal, far from normal or near normal relationship to one another as regards position, strength and direction. This is the *structure of the disease*. The structure of a neurosis is, for example, the configuration of the functionally sick arrangement and formation of the symptoms. Hunger neurosis, for example, shows a wrong arrangement according to the hypertrophy of the hunger functions, and either a predominance of the sick feelings (feeling neurosis) or diseased perception of objects by the senses (neurosis of sensory perception) or the sick concepts (concept neurosis). The sick also has an abnormal coordinative relationship to the environment. These *false relationships* are labelled according to *position* with words like "wrongly placed, in the false place, inside out, too far, too narrow, distorted, too short, too long," etc., according to *strength* with words like "too much, too little, abundant, undersized, cramped, lame," etc., and according to *direction* with "inverted, divergent, wandered, gone wrong", etc., to the course of the function altogether with words like "wrong, false, queer, perverse, exagerrated, minimized, unsure, stuck there like a machine, petrified, compulsive", etc. The sciences of constitution, character and temperament are special ways of describing healthy or sick individuals according to structure and function, as well as the specific characteristic for individual cases and their groups. And more major experiences are also described in this way, consisting of individuals and their interpersonal behaviour and behaviour to the environment,

according to structure, function and characteristics, namely, every type of hunger-anxiety-pain-joy-sorrow series according to position, strength and direction. With indication of the position, the strength and direction corresponding to the position is always also meant; the reverse is also true.

Here, we wish to consider the neurotic experience according to *direction* and, furthermore, as a *task*, and the therapeutic experience as a *recovery task*.

2.1 The neurotic direction

Every healthy and every sick experience has its own beginning and end, its hunger and joy stages reached via the anxiety, pain and sorrow stages. The beginning follows on from the preceding stage and the end precedes the succeeding experience. One usually describes the pain stage (the threshold) especially as the stage of fighting, danger, obstacle, trouble, working, executing, examining, resolving, decision, and as a problem that has to be solved, with the joy stage as the aim. In the hunger stage the direction is the wider circle, and in the anxiety stage it is the narrower; in the pain stage it is twisting; in the sorrow stage it is the short straight line, and in the joy stage it is the long straight line (completing itself). Every experience is also specific in this, and the specificity includes normal and, respectively, abnormal ranges of variation, and the predominance of one stage or the other inside or outside the normal variation range. We wish to call the total direction hunger – joy of the experience the *experience axis*. It connects the mid-points of the hunger and anxiety circles and the pain twisting, and goes over to the sorrow and joy straight lines. In this diagrammatic line the circle and the twisting are represented by the mid-points; the complete direction is a matter of importance to us; beginning – end: startpoint – aim. Figure 15 gives an example of the pain structure in the course of experience.

The succeeding figures may help visualize the total direction. They are diagrams, and diagrams taken from experience should not be expected to always correspond directly to conscious sequences in every individual stage. Moreover, for didactic reasons the "incomplete" experiences are not considered here; neither are the mixed and congested feelings (e.g., hope, hate, envy, anger, rage, solace, loathing, etc.). (See Section 1.4 for the nature of the feelings and the course of reflexes.)

The ordinate is the experience axis and the abscissa the threshold, the pain stage (the task). The letters are the first letters of the names of the individual stages. The sizes of the dots show the hypertrophy.

Figure 16 shows the direction of normal experience; the other figures are samples of neurotic directions. Comparable experiences have comparable start points.

The healthy experience is also topically healthy, i.e. has a healthy direction. The healthy person can only arrive at the healthy destination from a healthy beginning via a healthy route (with healthy methods), and can arrive nowhere else. The normal course lies inside the normal range of variation; normal errors belong to it. It is impossible for the healthy person to lose the way. He always follows the right and correct way (neglecting the normal circling-twisting) that is also called the "straight"

Figure 15. The pain or threshold stage; the fight with the task. The face is painfully distorted, the eyes are slitted, the torso and limbs are tensed maximally around the longitudinal axis. The creases in the shirt and shorts configure to the almost grotesque, unnatural, oblique, elastically taut posture. Real pain feelings are not necessarily present; this is a case of predominantly sensory processes. However, the effect on the oblique parts of the striated muscle reflects the painfight experience.

Tennis star Boris Becker in action. After getting rid of the ball, the answer to the tension is at hand: sorrow stage → contraction of the short, longitudinal muscles → relaxation, sinking together of the body; then the joy stage after a successful ball exchange → contraction of the long longitudinal muscles→ straightening and stretching of the body; waiting for the return ball, the move to the hunger stage → contraction of the long, circular muscles → hollow-round, bentforward posture; then the anxiety stage → contraction of short, circular muscles → careful, hesitant to lurking, expectant contraction of the body; hopping from one foot to the other, waiting for the opponent's stratagem; and a new pain stage → contraction of the oblique muscle bundles → twisting, struggling and writhing for the outcome of the conflict. This is the hunger-anxiety-pain-sorrow-joy scheme in action.

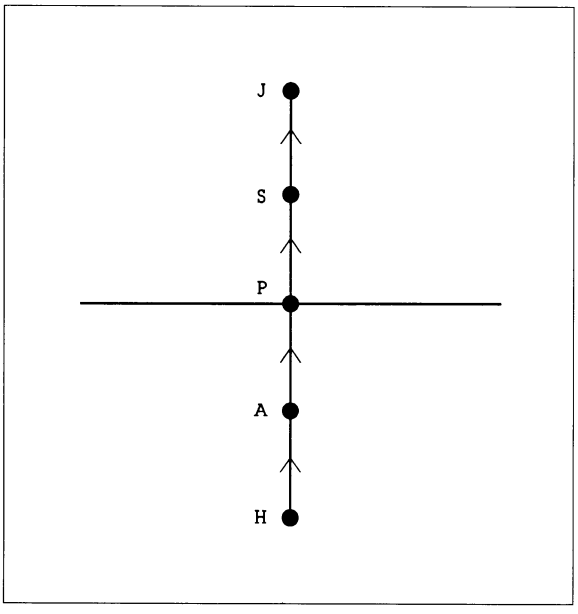
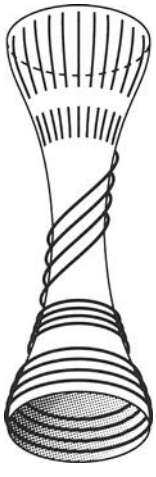


Figure 16. The normal scheme of hunger-anxiety-pain-sorrow-joy (H–J).

way – in contrast to the "crooked" way (unjust, concealed, etc.). The way of the healthy person can be more or less correct, it is always correct and never false. The healthy person is the measure for everything. He himself is the rule, the norm. The experience of the healthy person is the only norm that we have. A metaphysical, transcendental norm that orders the earthly according to its inscrutable decrees, to which the earthly has to adjust itself, only "exists" in the interpretation of the demonists. The rules are not the causes for human experience and behaviour; they are their description, summarized in abstract formulas. The healthy person does not need to know the rules, nevertheless, he acts true (uncompelled), according to the rules; he cannot behave in any other way; his reflex organization is healthy, and he cannot do anything about it; it does not have to do with merit. He is the "straight character", the honest and upright person. He has no final failure; he always succeeds (sooner or later); he has no aims in view that exceed that framework of his personality; constitutionally, he cannot act in any other way. Of course, he does not "choose" his tasks, targets, and directions, they show up as functions of his reflex systems and "fit" his personality. The conceptual thinking of the healthy person is also correct, as is the description, and ends in the really positive target.

Normal experience is summarized in figure 17.

Topically, the *sick experience* can also only be sick, and can only have a sick direction. With all the to and fro in the component parts of the structures the experience axis can be near normal, and can have a normal ending; the neurotic pupil passes his exams, etc.; the directional errors are mainly in the major and accessory hypertrophic stages with nuances in the other stages; they can be so minimal that only a specialist can diagnose them. The aim reached in this way can coincide with the normal, outwardly, and be counted as normal mechanistically

Conscious Manifestation	Type of Feeling	Success Organ	Contraction	Expression	Experience Axis
Feeling of fullfilment, satiation, completion, etc.	Joy		Long longitudinal fibres	Extent of joy	J
Feeling of patchiness, smallness, having crossed the threshold, etc.	Sorrow		Short longitudinal fibres	Extent of sorrow	S
Feeling of being on the brink, being cornered, of the critical moment, of crossing the threshold, etc.	Pain		Oblique fibres	Twisting in pain	P
Feeling of hemmed-in opening, of a task urgently waiting to be done, danger, etc.	Anxiety		Short circular	Narrowed in anxiety	A
Feeling of hollowness, emptiness, of the beginning, of not yet having reached, etc.	Hunger		Long circular fibres	Extent of hunger	H

Cerebral cortex ⟶ efferent reflex pathway ⟶ smooth muscle, glands, connective tissue of striated muscle, tendons, bones

Figure 17. Schematic synopsis of experience according to the five basic feelings. The smooth muscle fibres of a correspondingly innervated tube, like the gut, belonging to every feeling; contraction leads to narrowing → twisting → widening of the lumen (peristaltic wave). In reality, the muscle fibres that differ according to their innervation and coordination are crossed, mixed, bundled, or fused together in layers, as in the stomach (fig. 4, p. 14). With subcortical reflexes, the conscious manifestations that describe the expression are absent. Most autonomic functions are normally unconscious. The feeling belonging to them does not always appear.

and statistically, while *biologically* it is only near-normal, pseudonormal, and thus different from the normal. The neurotic experience takes its course in the infantile development sphere where it has grown old, so that the near-normal direction and aim are also infantilistic and different from the comparable normal in this biologic way; even if there are almost normal elements in the neurotic experience that attach themselves, for instance, in an associative way to sick actions, these actions are only almost normal, and nuanced to the pathological. Some neurotics even reach targets that impress as being excellent, wonderful and genial at first (at first for a while – until the unavoidable breakdown). *Abnormal* is confused with *enormous*, and overshooting the target with the healthy peak achievement; it may even be glorified as "incomparable"; the ways and means used are not taken into consideration; they may even be approved and admired because of the pretended magnificent target ("it doesn't matter how he gained his ends, the main thing is that he gained them", "the end justifies the means", etc.). Only too few people

are aware that the use of neurotic ways and means only leads to gaining neurotic ends. Diagnosis of the ways and means and the person using them also characterizes the end attained or attainable with them; conversely, diagnosis of the end (success, etc.) characterizes the ways and means that led to the aim.

The near-normal experience axis can be shown as a diagram that resembles figure 16; only certain stages are hypertrophic, and the experience takes its course in the infantile development sphere; it is therefore biologically different from the comparable normal experience. This biologic difference is also found in the layered experiences that consist of infantilistic and more highly differentiated, or even possibly almost healthy parts, and also when these are compared with healthy experiences. The near-normal axis does not take its course within the normal range of variation, but is approximately parallel to the normal axis and lies in the aberrant at a different level of development. The "coincidence" of the near-normal and comparable normal targets is also only an outward appearance, and never a genuine biologic coincidence. The *importance of recognizing this* makes it clear that everything pathologic, including the fictitiously normal has a false value and is damaging for the individual and society; at best, it can be useful mechanically, it is never really useful. Of course the sick person cannot help being sick. He has a biologic inheritance and constitution, but he must also taken responsibility for the damage he produces.

The joy-neurotic axis (figure 22) also resembles figure 16. The stages preceding the joy stage are topically nuanced towards the straight. The joy-neurotic experience also takes its course at the infantile development level, and is therefore biologically different from the comparable normal experience. The hypertrophy of the joy stage (excess of – unearned success, fortune's favourite, etc.) should not be allowed to camouflage the biologic difference between sick (untrue, fictitiously true) and healthy (true) success. If a preceding stage is far-from-normal-hypertrophic alongside the direction of the axis changes there to the far-from-normal, and a false hypertrophic target is reached if there is no further change of direction to the near-normal in a succeeding stage. In mixed neuroses of every type, the direction can, however, be near-normal.

Figures 18-21 and 23-25 show aberrant axes. Figure 18 shows, for example, some hunger neurotic experience axes. The straight axis H-J is near normal. In the axis H-P'-J" the aberrant direction is taken in by H (hypertrophic hunger: fanaticism, greed, etc.) and the other stages are accordingly topically displaced. In the axis H-P'-J'" the direction in P' moves even further from the norm. In the axis H-P'-J the (far-from-normal) threshold P' is not crossed, and there is a move in the backwards direction. In the last three cases a false target is reached via false intermediate stages. In the axis H-P'-J the false direction H-P' changes in P' towards the J, the normal target in a comparable normal experience, that is to say, it reaches the near-normal target after a wide diversion. Analogously, in figure 19 the straight axis is the near-normal. The neurotic anxiety patient may thus arrive at the near-normal target via the near-normal threshold (that "coincides" with the normal) and the near-normal sorrow stage (with too much anxiety and inhibition). Other neurotic anxiety patients are structured in such a way that they evade at the anxiety stage, arrive at an aberrant threshold, divert and sneak around the comparable normal threshold in a shorter arc,

Figure 18. Hunger-neurotic experiences (examples): H–J, H–J'–J, H–P'–J'', H–P–J'''-, H–P'–J^x, etc.

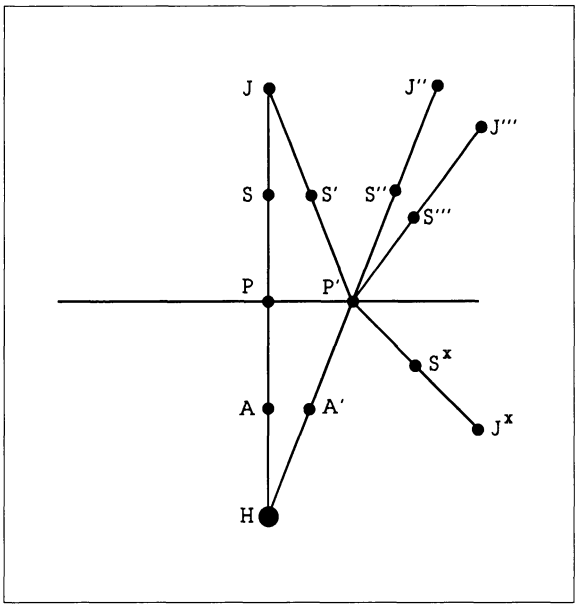
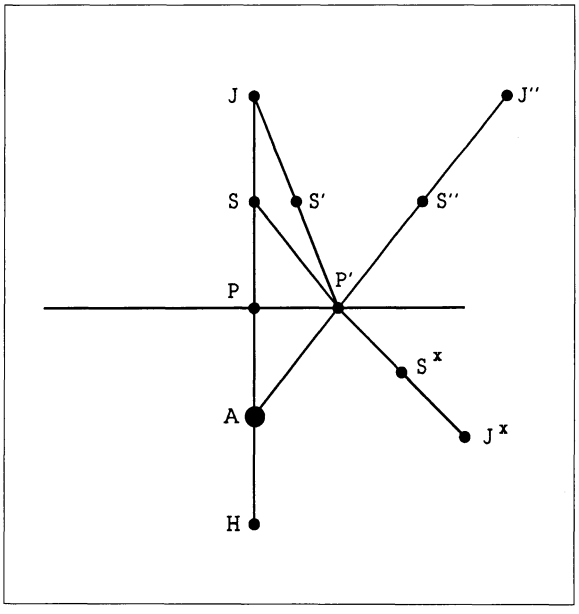


Figure 19. Anxiety-neurotic experiences (examples): H–J, H–P'–J, H–P'–J'', H–P'–J^x, etc.



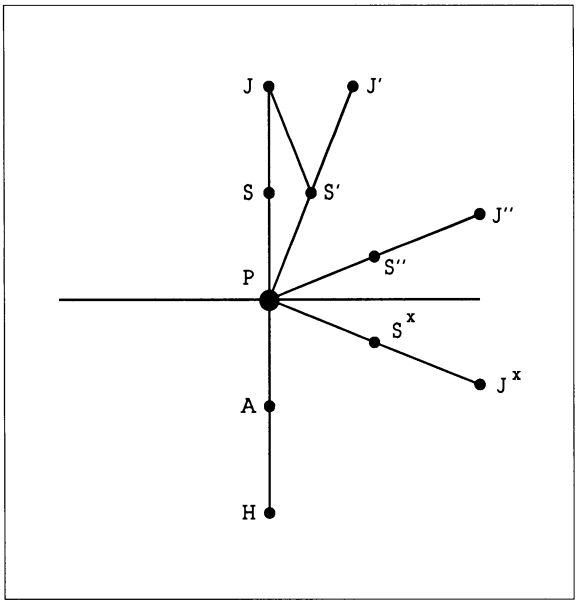


Figure 20. Pain-neurotic experiences (examples): H–J, H–P–J', H–P–S'–J, H–P–J^x, etc.

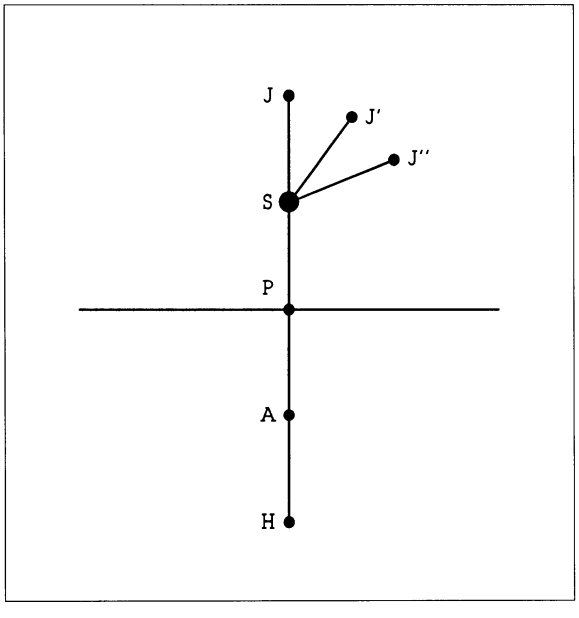
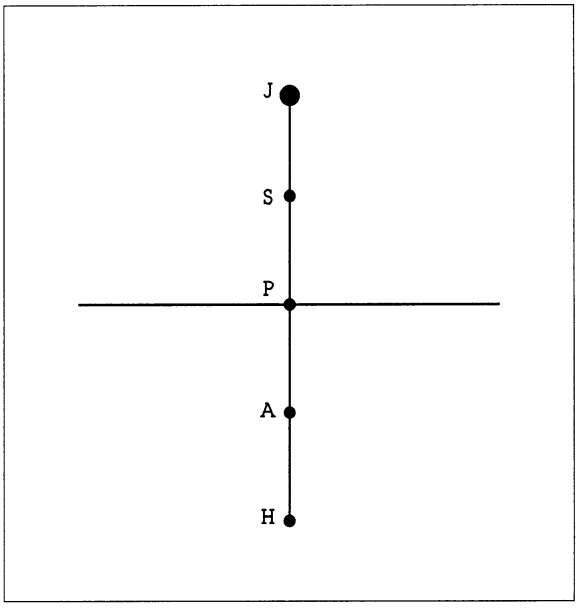


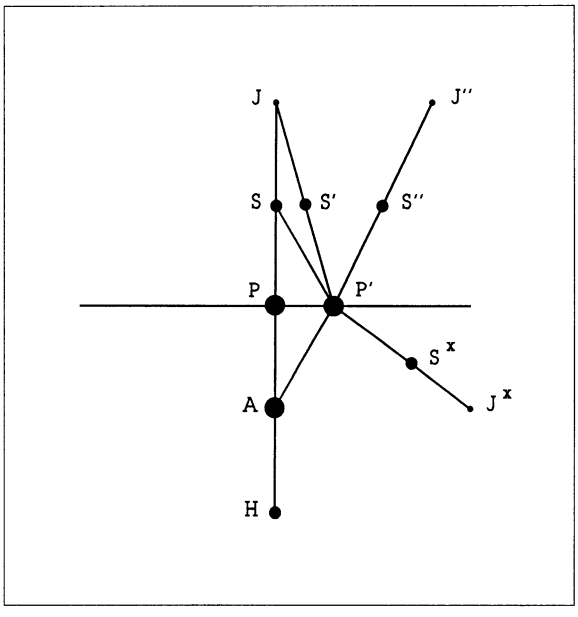
Figure 21. Sorrow-neurotic experiences (examples): H–J, H–S–J', H–S–J'', etc.

Figure 22. The joy-neurotic experience H–J.



Figures 23-25: Examples of combined neuroses.

Figure 23. Anxiety-pain-neurotic experiences with major hunger and sorrow components.



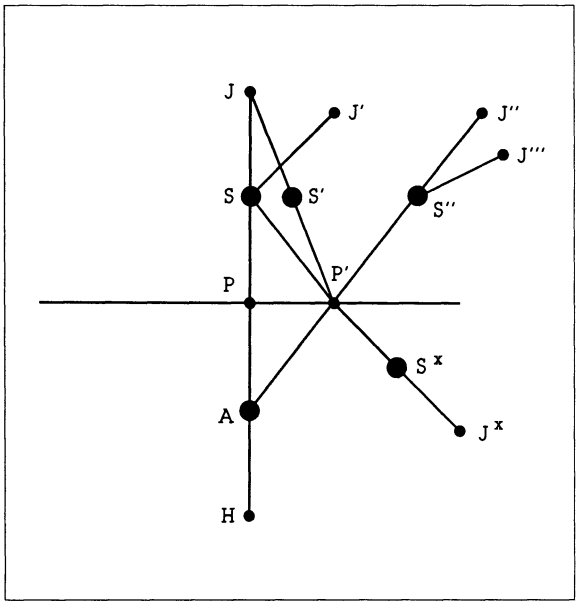


Figure 24. Anxiety-sorrow neurotic experiences.

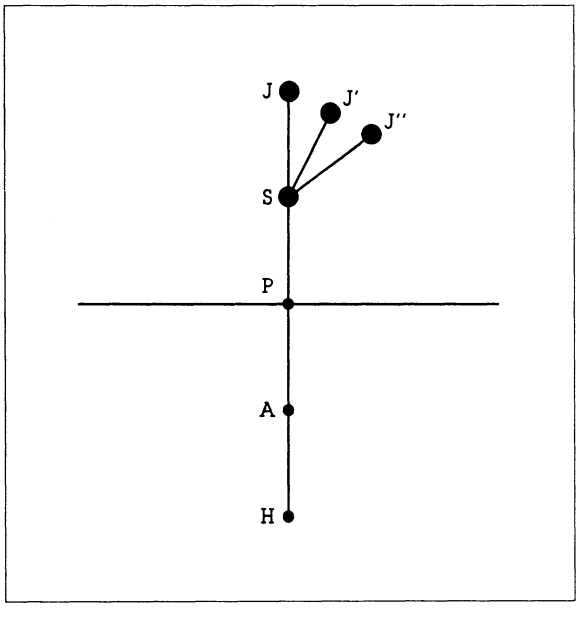


Figure 25. Sorrow-joy neurotic experiences.

and via a sorrow stage that is near to or distant from the normal, arrive one way or the other at a near to normal target. Others tack to the distant S" and J" via the far-from-normal threshold P'; yet others divert back at P', etc. In figure 20 the straight axis is the near-normal once again; the pain neurotic with this structure approaches the near-normal P threshold (in a comparable experience the normal), crosses it in neurotic style (cramped, with too much pain effort, too much bother, work, zeal, is "always" in the struggle, etc.) and arrives at the near-normal target via the near-normal sorrow stage, which is, of course, soured for him by a relatively large pain content. Other fellow-sufferers tack from the threshold to S'-J. S'-J', S"-J" or S^x-J^x, respectively, (slip back, are beaten back, fail, etc.). The sorrow neurotic lives through a hypertrophic sorrow stage; the preceding stages (figure 21) are also nuanced with topic sorrow; the direction is near-normal and can stay so from the sorrow stage to the joy stage; otherwise, a far-from-normal joy stage (J', J", etc.) is reached. Figure 22, see above.

Figures 23-25 show the axes of a variety of mixed neuroses. The course of the neurotic experiences is dislocative to a greater extent as far-from-normal than near-normal; in the latter case, the dislocation can remain within the collocative range.

With worsening (proliferation of the neurosis) near-normal cases can become far-from-normal; targets that had been reached up to now are not reached any more; higher targets that the healthy person achieves and reaches owing to increasing differentiation can be unattainable for the neurotic, even in the near-normal abnormality, provided he tries for them at all (e.g., marriage).

In a nervous breakdown, previously practicable neurotic experiences become non-actual, and the direction becomes retrograde, at the latest, at the threshold. Of course, the sick aims are also aims, something human that also occurs in the normal experience, with appropriate differences. Whether someone tries for and attains an aim that is near or distant from the normal can only be diagnosed from a comparison with the analogue, the comparable normal process. The task of going to school, or, at another time, of going swimming, is presented to the healthy pupil and the sick pupil; but anyone who "solves" the task of going to school by playing truant and going to the swimming pool has attained an aim that is distant from the normal. Even the most false directions can only lead to targets that are also (well understood as normal and accordingly "different") in the direction of normal experiences. The direction someone takes, the ways and means in his progress, and the targets he reaches are never to be judged on their own, but in comparison to the norm. Even the "greatest success" can be reached via crooked pathways and is then nothing more than a pseudo success, wrong target, reprehensible, and many a "great one", glorified and given memorials, is only a cork on the wave or a shimmering soap bubble; one dare not touch or the shine is gone.

Naturally, the sick person cannot control, select, etc., his experience and, accordingly, its direction by means of "his own might", with the "power of his heart", with the energy of his will, his *Ego*, his soul, his mind, or any other demonism, but also his experiences take their course according to their biologic structure and function, only show his biologic structure. One cannot reasonably demand of the sick person that he should not be sick, and should adopt a healthy

direction against his sick structure and function. It is silly to make such suggestions to him, to encourage him to do this or even "oblige" him "to be healthy". With the order "pull yourself together", the appeal to "self discipline", to "mental energy", etc., there is as little change of "making" a sick structure become normal as with the suggestion that the disease is only "fancied" and is "really" not present, or other magic phrases of so-called psychotherapy that "heal" the "soul". The cramped efforts of the sick person to act as if he were healthy are themselves a symptom, and only a Münchhausen could tell the tale that he had pulled himself out of the swamp by his own pigtail.

2.2 The neurotic task

2.2.1 *Main task and secondary tasks*

If we label the pain or threshold stage of the experience a task (p. 85), and the functions at this stage as wrestling, struggling with the task (normally for the productive solution), the hunger stage is to be described as hunger for the task, preparation in the broader sense, introduction, preliminaries, the anxiety stage as anxiety about the task, preparation in the narrower sense, careful approach, the sorrow stage as sorrow after the struggle, exhaustion after the trouble taken, a sort of testing, the joy stage as joy about the achieved aim, mastering the task, completion. The development of the individual is also the development of his tasks. Compared to the separate development stages, the tasks are *lower* (simpler, smaller) and *higher* (manifold, of more importance); the difference in biologic level is given in this way. The homogeneous development front of the healthy person is consistent with normal ranges of variation, so that there are lower and higher tasks at each development stage that are also called *easier* and *harder*, more difficult. The lower tasks can be achieved by a larger number of people than the higher; those (tasks) are more general, usual, and these are more differentiated, specialized, and can therefore only be achieved by correspondingly differentiated, educated people ("specialists"). But the educated person also performs easy tasks, the day to day affairs in his development level, but to that extent differently from the uneducated person. The educated person can, for example, not bring primitive muscles into operation (he has none of this type); his brain functions are not primitive; the learned person eats and drinks differently from the primitive; he lifts a weight differently; his daily conversation is different too, e.g., when buying something, etc. He cannot leave his education level. The primitive person, on the other hand, carries out higher tasks in his field in his primitive way. The "bone and muscle man" is not a "brain man", the "cerebellar person" is not a "cerebral person". The basic person is not middle class and not a top person in the pyramid of society. The unskilled worker is not a general manager, and should one "take over" such a post, he is a parvenu – or the position is "degraded", levelled out, collectivised. The servant is not a master (see "how he clears his throat, how he coughs", Schiller, Wallenstein's Camp, 6th scene), and the would-be great man only

acts the great man, poses and plays a role, is a giant dwarf, etc. These are all biologic facts that cannot be altered by closing ones eyes or by attempts at levelling.

Many tasks are *uniform* throughout life, e.g., human females may cook potatoes from about age 8 or age 10 and for their whole lives, but the task is experienced differently each time and it's accomplishment is *biologically different*, even if the technique is the same. The boy experiences and reads the newspaper differently from the man; the news is understood according to the stage of development, *Terentium aliter legunt pueri, aliter Grotius*, etc. This also applies to description, similar words at various stage of development are biologically as different as the experiences they describe. Owing to phonation, meaning and association change, it is not always easy for people at different differentiation levels (e.g., the naive and the learned) to understand one another and make themselves understood. Understanding between the sick and the healthy is especially difficult, and between healthy people and neurotics with their stepped development front.

Many tasks thus belong to a complete series of development stages, but are biologically-genetically different at each. The tasks are "*suited*" to each stage, "appropriate", and accordingly at each stage the tasks are suited to each individual and are appropriate to each performance capacity of those who experience them as their own; they can, purely biologically, (i.e., according to the reflex structure,) never lie outside the individual's boundaries. Certainly, everyone experiences tasks that are performed by others, that fit other people, and the healthy person knows one man's meat is another man's poison, that he can differentiate his own and foreign tasks, and refuses tasks that do not suit him, but also pushes no unsuitable tasks onto others. Not uncommonly, the task is to recognize the unsuitable task as unsuitable, and to refuse it. The healthy person also cannot carry out sick tasks, he does not have the sick reflex systems. Apart from his sick tasks the sick person can carry out healthier and, at best, almost healthy tasks, but he can never carry out healthy tasks. The symptomatic tasks of the sick person and his behaviour are also described by comparison to the analogous healthy ones as unsuitable, unseemly, etc. But these are just suitable for the sick person. It is completely off the track to press the carrying out of normal tasks on the sick person, to "encourage" him, even therapeutically (!), to do them, to advise him to do them, rather like "prescribing" the practice of proper breathing for the asthmatic, or the prescription that he should simply help himself for the eating neurotic, or telling the impotent that he should really pursue the girls, and, best of all, get married! It is nonsense to expect something of a person for which he is not equipped according to his biological structure, or to expect something of a sick person that he cannot manage in his sickness. The sick person has to develop himself out of the illness (in the course of cognitive therapy); then he thinks and does the right thing possible for him "all on his own", purely reflexly.

The *development of how a healthy person views the world* is given in the fifth volume of the Textbook of Psychobiology and recapitulated in the sixth volume. The little child lives initially in the chaotic all-oneness of the world with which it is identical, where there are no contradictions, distinctions or differences. He matures against his "world catastrophe", the all-oneness of the world changes to the world of plurality, individuation begins, the contrasts with their differences and distinctions;

the individuals and details appear primitively, the formerly vague shapes and forms take on more and more shape and form, and are given an animist-magic *interpretation*, still spectrally. The appearance of individuality (the I and You) is the end of the all-oneness (omnipotence, omniscience, etc., solitariness, absoluteness, godliness, (old German) god, i.e., the general, chaos, etc.). Furthermore, the world of the child differentiates itself in a constantly critical advancing front, the mythical, and then the mystic way of thinking connects itself to the raw demonistic, and the further dilution grades of demonism follow this. All the seeking of the child is directed towards what's "behind" things, which is interpreted metaphysically, but is also "simply" always physical.

The *neurotic*, so far as he is sick, has mainly not lived through the early childhood world catastrophe, and is stuck in that early period, with its interpretations. With his growth, the left-behind reflex systems with their thought cells and actualities have proliferated functionally, and aged. Other reflex systems have reached higher infantile differentation stages and are functionally hypertrophied on these. The almost healthy reflex systems of the adult neurotic have developed over the puberty threshold and have reached the normal grade of maturity in a pathologically nuanced way, as almost normal. The task series is equally graduated and disharmonic as the development and the relevant development front. The neurotic task has its genetically normal analogue in the corresponding infantile task (lower, less), but it is hypertrophied and grown old, so it is no longer the real infantile task; in this, it differs from the comparable normal task biologically, and is a sort of caricature of it.

It is therefore understandable that from the point of view of how the world is perceived the neurotic task is the protection and defence of early childhood all-oneness (godhead, absoluteness, all-demonism) against the foe demonism of the You, the "others", especially the big-old-gods-devils, and that the task becomes the more difficult the more the child partially matures, rises on life's ladder on one of it's own feet – the other remains "below"; consequently, more and more difficult "demands-challenges-attempts" are to be overcome, with inextricable doubts increasing as to whether the child is "up to" the adventure of (magic) life and death in all its transmutations, and whether it would be or not, and what would happen in the one case or the other. So, every neurotic (not only the anxiety neurotic, although the most serious) has anxiety that he will be found out, not as little but big, as big and nevertheless still little, as young and nevertheless old, as old and nevertheless still young, as low and yet high, as high and yet low, as the sprite who plays and imitates the grown-up, as giant dwarf, as dwarf giant, as "big nothing", as large size baby, as pseudo-big, as boaster, as would-be big man, as swindler, as braggart, etc., in short, as an as-if-being, and seen through, recognized, banned, banished, rejected, thrown out, laughed out, extinguished, robbed of his godly all-demonism, and thus destroyed. The anxiety says that the child has no place in the kingdom of the adults with their tremendous secrets, but the child rebelled against the adults (rebel, cf. Prometheus), or has let himself be drawn in, brought up, and is urged now to satisfy the bigger and big demands of (demonic) life with demonism, to life or death. The neurotic fancies that it would have been far better if he had remained totally in the all-oneness of early

childhood, better if he had been spared the (cerebral) birth of the I and the You and then the climb to adulthood ("Suffer the little children to come unto me, for such is the kingdom of heaven."), but, unfortunately, he has been conjured to adulthood *nolens volens*, or has conjured himself up to it, and must now bear and suffer the wearisomeness and extremes of the world (see the words of the harpist in Goethe's "Wilhelm Meisters Lehrjahre" 2, 13: "who never ate his bread with tears", etc.) – but on the other hand, he has to thank his neurosis for his being able to do this (so he fancies); it shows him the demonic dangers (so he deludes himself), warns him and thus protects him already from destruction. These are the (knowing or unknowing) interpretations of all neurotics.

Figure 26. Caricature by Chaval.

It has also to be considered that the neurotic experience is a *remnant from early childhood*, but hypertrophied and grown old, a *relic* with many parts of the corresponding childhood experience left out genetically, such as mother, father, etc., living now in a different place, or dead; the environment having changed a great deal; in brief, the sick person has grown into his healthier and almost healthy parts; the

residual parts (a pars pro toto) are associated into the more mature parts (and, similarly, not necessarily recognizable in this way as remnants and representatives of the childhood experience). To understand the sick experience "completely", it has to be "completed" according to the corresponding early childhood experience of the patient. At first, he also lived alone, in all-oneness with the mother; then mother and *I* separated, disunited; then father appeared, the brothers and sisters and other beings; trophic and genic transmutations-separations-representatives of the nearest relatives, strange beings with human, animal, etc., form attached themselves, and, moreover, with the primitive social order of the grouping all other "things" around the person began to take shape and become more and more obvious. So, the presence of these beings and reference to them has to be considered in every neurotic experience, in which those archetypes and prototypes, or their chaotic-magical transmutations no longer occur directly, and are only still remenbered, and have "turned" moreover, into superiors or other persons experienced authoritatively (possibly including underlings, as well as children as "watchers") and, in addition, into friends, lovers, etc. Only in this way can such experiences be completely understood. If the neurotic does not recover, he carries his early childhood with him in his illness to the end of his life.

Examples:

The power-greedy still wants to extinguish the demony of the mother, the father, the "old ones", and protect his omnipotence and all-oneness against all succeeding transmutations of the old gods-devils.

The person with street anxiety has not yet separated himself from the protection of the parent's "castle", from his mother's hand, from her apron strings; the street, the strange, is just as mysterious as when he was a little child.

The constipated person is still in early life with anxiety about the pain of defecation; the bodily function "defecation" was accomplished unnoticed, or hardly noticed in the all-oneness and then this was threatened by the mysterious outgoings, conjured up by the puzzling mother being that also protected and served, and then by the terrible "mouth" (the lavatory bowl), and-or by inner powers that wanted to drive out the demonistic downwards – and to lose something means to lose everything, to lose "ones self", etc.; so, "nothing" can be passed over, or only that which has been disempowered (the material is unimportant), whether it is under the control of the "higher being" that rules the "lower being", or a voluntarily compelled "donation" to the inferiors (devil = god of the stool), thus deriving them of power, namely, satisfying them, or with a mandate to the laxative, whose magic is put into the service of the alldemonism and is responsible for what appears; the chamber pot was already mysterious, and the lavatory all the more mysterious, and some constipated people have not yet been able to stop using the chamber pot (an elegant lady took her chamber pot with her in her suitcase when travelling – for "reasons" of hygiene).

The pain of the pain neurotic is still in magic connection with the mother-father-demon that harmed him, that subjected him to the terrible test, and he is thus a demon himself, his own demon against "death the reaper", and with anxiety his approach is already announced.

The engineer buried in his laboratory wrestling with his "problems" still lives in his childhood playroom; the parent's house arched over this room just as the factory arches over the laboratory, and nobody dare disturb him at his magic (like the little child); he is using it to "master the powers of nature" (the intruder would be the evil foe sent by the enemy powers of nature to spoil him); father has become the factory manager; in practical life "outside" the patient is completely helpless, but he has a wife-mother who "takes care of everything", and "mothers" him.

The migraine patient X "is", during an "attack", "mother"; that is her mother suffered from migraine and often had to lie down; for the little child (who never knows what a "mother", "father" or a "child" are genealogically, and only experiences and uses certain primitive distinctive features like voice, clothing, size, habits, illness) was the "maternal", the "mother magic", the "being" of the mother, just the migraine (mother complained, "Oh, I've got my migraine again", etc.), an evil demon that afflicted mother – perhaps ordered up by father? – the deadly attack that made her lie down – dying; the room darkened, groaning in pain to survive the "attack", rising again, returning to life victorious over death, the "migraine" that she nevertheless has to fight again and again; thus growing up – to get migraine; then "one is mother" (so is does not need children!) with other interpretations in addition; headache = labour pains, that is head birth, birth of a "spirit being" (see Zeus = Athena), even perhaps godly (mother groaned, "Oh my God, Oh my God"), or a devilish affliction as a spiritual wedding, etc.

The bachelor still lives like a little child in his family environment; he has not left its "ban ring"; against its magic all the trials and temptations of the love demon come to nothing. But the married person, so far as he is sick, also experiences the spouse as maternal or paternal or both (in childlike confusion), as presentations of the eternal maternal and eternal paternal, and his or her children as brother and sister playmates, as large and small puzzle-beings that are all the more puzzling because the spouse is also loved sensually anyway (in the more mature parts), and the children say father and mother and are obviously not "created", but are the issue of each of them.

In early childhood experience, all changes to all, but the anthropomorphism of the demonistic is already germinating in animistic interpretation; so every task is given by "someone"; the neurotic task by the demonic "grownups", with their demonism changing into the task. The competence of raw demonistic interpretation of the neurotic symptoms comes from the fact that neurosis is infantilism of how the world is perceived, a functional persistence in the early childhood development sphere and even its hypertrophy. *The neurotic suffers from the demonism. The nucleus of every neurosis is*

the doubt, i.e. the primitivistic being-doubt, mixed up with doubt about perception of the world in maturer thinking stages, and with all individual doubts.

These facts need to be thoroughly understood for the interpretations by the patients and for therapeutic clarification of the sense-nonsense of the symptoms. This is complicated by the way that sick experiences or sick parts of the experience are associated with the healthier and almost healthy, and that higher tasks, and even very high tasks, appear beside the sick ones (according to the individual degree of differentation of the almost healthy reflex systems), connected with those or interspersed with them in a false or almost normal way.

Examples:

A 20-year-old typist does "very precise" work, but she has not yet learned to eat properly, i.e. adult food is as mysterious as formerly; as she watched the grownups at table and then ought to eat new food herself, but with the "best will in the world" she could not eat; she takes children's food in hypertrophic, fully grown form (lactovegetable food, raw food); the "precision" in her work is the neurotic nuance, the compulsive-mechanical, reminiscent of pedantry.

Many stutterers can speak tolerably smoothly in a quiet room; their speech anxiety (i.e. the function of the phonetic anxiety reflex systems) intensifies in conversation with others, especially with people experienced as being in authority; it is most intensive if they are questioned, before a talk, at the beginning of a speech (lectures, etc.); it gradually goes away and finally becomes non-actual, so that the speech runs more freely; to the extent that they are sick, these neurotics have not mastered the early childhood task to speak, especially with and before grownups (examiners as "judges over life and death"); they have remained in undisturbed play-babble (talking to themselves), and in anxiety about higher tasks (making mistakes, shamed to death, etc.), and hypertrophied and aged there; this infantilism is mixed into the lectures by the stuttering professor or the speech made by the stuttering director to his colleagues; in the sick parts these tasks are experienced in the same way as a little child, but now they are hypertrophied and fully grown.

Many neurotics behave quasi coldbloodedly in really major critical situations, even more cooly than healthy people involved; this is a matter of a switching off of the autonomic reflex pathways, and of feeling excitation from the sensory (p. 46), and with curtailment of the clarity of conceptual and sensory perception experience. A person cannot light a match without trembling, but when a house is burning he behaves "heroically", Somebody cannot look at blood without shuddering, but on the battlefield he "shuts off his crazy anxiety internally" and thus "is" one of the bravest ("it was like a dream"). Somebody spends a sleepless night because he painfully regrets spending ten pence too much on a tin of plums, but accepts a major loss of wealth with equanimity. Interpretation: details are a specially dangerous hideout for enemy demonism and accordingly have to be given the appropriate attention, etc.

> Often, at first the sick parts of a task take their course, and then the healthy and almost healthy parts attach themselves, e.g., a student always has to spend hours cleaning his desk before he can start the task of studying, but this is also done in a slightly perfunctory manner.
>
> As nuanced towards illness, all the higher tasks of the neurotic also have compulsion and cramping features. In a fully developed neurosis the tasks take their course in stereotype, in a sort of monotony series; moreover, the neurotic learns nothing (without cognitive therapy); he refuses everything new by means of his neurosis (fanatic, hateful, with all the signs of digust, with twisting away, with gloomy inertia, careless momentum and jokes, in any case, radicalistic, with extremism); he removes its newness, disempowers the magic of the new thing that makes something old to something new, conjures it into his indiscriminate omnipotence-omnisciense. He is the person with spoiled and missed (real) opportunities, but for him, his methods are just his "only chance".

The sick task takes up a too broad area, according to the hypertrophy; for the neurotic it is the most important, the most essential, the *main task*, even the unique one that "really" exists, the world task, in the face of it, all other tasks take a secondary place; they are *secondary tasks*, unimportant, even invalid; they are only important so far as they have sick nuances.

Even in the higher tasks the minor or major infantilistic component (content) is the essential – depending on the extent of the neurosis; in this way they are also "really" only a demonstration of the unique task of all-oneness, that can even change itself into so-called higher forms. These higher tasks are the coming tasks, the ever more difficult and severe ones that appear in the course of differentiation, opening into the examinations of puberty, then becoming even more difficult and harder in youth until a completion peak is reached with the master's examination. This complete series of tasks in work and love is experienced by the neurotic as a magic transformation of the basic, original task, the task of giving up all-oneness, during which the enemy demonism, effective in the old-grown-up-examiners and the tasks given by them, becomes more and more concentrated to keep the striving little one little, to remove his all-oneness, his all-demonism, his all-magic, and thus to destroy him at last in the final battle. The neurotic is not aware of human tasks; he only knows the struggle of the demons for omnipotence, and for him the "material" tasks are only opportunities for this battle of the demons, who strangely enough have to use the material, the physical, the earthly for their eternal struggle, as God and the devil use the "worldly", the "flesh", as the soul the body.

The secondary tasks, especially the higher ones, disturb the neurotic basically in the fulfilment of his sick, i.e. only, unique and solitary task that, of course, appears in many different transmutations (all sorts of symptoms), but without changing its nature. For him, other tasks are demonistic attempts (and temptors) to divert him from the main task and its fulfilment on which is supposed to depend "to be or not to be", eternal life or eternal death, the preservation of the world or the end of the world, all or nothing, the salvation of the world: one has to be on guard for such

devilments all the time; all these "demands" must be refused and disempowered, and it is quite the impudence to do something human, to behave like a human being must be abolished as a general attack on the superhuman, on the unique "*mission*", the (godly-devilish) omnipotence itself.

One could say that the neurotic looks out on the world from a monastic retreat through a child's telescope; his central position is his early childhood all-oneness. He melts "all future things" (the higher differentiation stages) into this, magically; he removes the details from every detail, levels them all to "generalities", and thus rules them, safeguards his "world dominion" – and beside all his hunger for development, i.e. hunger for recovery, has exaggerated anxiety about leaving his standpoint, on which he stands in cramped balance, for him that means falling into the bottomless pit.

Thus the task field of the neurotic is biologically completely different from that of the healthy person; it lies outside the normal range, and in the abnormal range. The neurotic can do absolutely nothing normally, only abnormally; at best, he can experience, describe, think and act almost normally. So, he also cannot differentiate normally between "normal" and "abnormal", only in his abnormal way. He can only differentiate between lower and higher, easier and harder, important and unimportant tasks in childlike unclarity, and this overshadows the more mature insight also, and his differentiations (value judgement, etc.) lie in a different scale from those of the healthy person; at the most, there is overlapping where sick and healthy tasks and judgements cover themselves outwardly. "Human standards do not apply to me" (the godhead-devil). The fact that comparable tasks have the same name, and that the sick judgements are words also used by the healthy, should not camouflage the biologic difference, but only too many persons are deceived in this.

Most neurotics know that their neurotic experience and behaviour is false, wrong, nonsense, idiocy, stupid, but this *insight into the illness*, a naive diagnosis, is not a means of clearly separating the abnormal from the almost normal in one's own tasks as regards experience and behaviour and "making it right"; it is also not a means of differentiating clearly the tasks of the neurotic from those of the healthy person according to normality. The self-diagnostic characterization that takes its course in the more mature, or, at best, the almost healthy judgement areas, and is therefore itself pathologically nuanced, does not unveil the puzzling nature of the symptoms; it cannot be justified as a cognitive description of the "nonsense", namely, as a clarification of the sense of the nonsense, with which the "world task" can be dethroned. The symptoms persist in their full glory, and can even proliferate and become worse. Diagnosis is not treatment. Precisely, this independence of the symptoms in the face of better insight, this compulsiveness, seems to the neurotic to be evidence that the "nonsense" is actually something special and unique; a demonism where the word nonsense (etc.) in the usual sense could not be applied. "The demonism of nonsense is certainly not yet nonsense".

In this way, the insight of the neurotic into his illness is unreal; according to it, the illness is "really" not an illness (as is confirmed by incompetent speculating doctors, clergy, etc., who are frequently themselves neurotic or at least in psychological doubt). The illness is imagined to be only the special form of spiritual life, the

exception from the merely human, the elect (saints, martyrs, monks, nuns, etc.), which is, of course, a curse, too, the obsession with God or the devil, or both the "omnipotent ones" (ecstasies, prophecying, rapturous trances, out-of-body-experiences, etc.), carrying out their eternal struggle in the chosen-accursed and through him, revealing and hiding themselves in mystery so that the neurotic himself is the all-one, the almighty power, destiny, the lord over everlasting (magical) life and everlasting (magical) death. The illness counts as the "only chance", as the "capacity for the superhuman achievement", as "welcome suffering" that gives the first class passport to eternal bliss; therefore, it cannot be difficult enough; it has to be borne without complaint, and with proud satisfaction about the role that has been assigned to the individual by providence – what indeed can a doctor, a human being, do against the might of destiny?

The neurotic believes in himself in this doubting way, in his neurosis, and in the repeatedly reconfirmed "absolute" rightness of what he experiences and describes, thinks and acts (structurally, in a compulsive course) – and he "must" compel "everybody" else to believe in His absoluteness also. The neurotic knows and recognizes (in a doubting way) only *one* godhead, himself. Every neurotic worships himself, even when he worships the "other god"; he compels the other god, de-deifies him, identifies himself with him, disempowers him in his omnipotence.

In this way, the "nonsense" "confirms" him as the first and the last, unique, all-one sense of his being, the neurotic task as the only, unique, as the *world task*: the banishing of the enemy demonism that intends to bring about the world catastrophe by every means, to prepare the end of allness though even in the form of secondary "earthly" more difficult or so-called higher tasks. Every neurotic considers himself to be a "saviour", and every "saviour" is at the very least a neurotic. That "other people" are thus able to carry out their human tasks is thanks to the all-one, who has banished the enemy of the world, constantly and everywhere, owing to his mission, or endures his ban, whether he be called destiny, life or death, heaven or hell, god or devil, etc. In this way the neurotic carries out the superhuman, eternal and infinite task of the world.

Because *I* (the neurotic) resist the temptation to eat meat and, consequently, ban the demonism of death, of killing and the dead, the others can eat without any trouble, they even must eat, because their eating shows the effectiveness of my omnipotence. Because *I* exorcize the street demon the others can carry on crossing the street untroubled. The others are only able to do their work at all because *I* "work" all the time (also when I'm asleep, etc., 25 hours a day) shoulder and ban the work demon and the demonism of work onto me. For this they have to work as ceaselessly as *Me*, to "the last gasp", to "the ultimate sacrifice", till they collapse, because *I* the omnipotent and thus its ban can never be inactive. *Me*, who first of all "makes" the task and the work, *I* "keep the world at work", and only so long as *I* order or allow it may the slaves rest. Because *I* constantly work restlessly at doing nothing, to avoid every sort of work and thus overcome the demon work, the others can work, *I* "let" them work. Because I abstain from love (impotent), and consequently with my omnipotence (i.e. impotence) overcome the love demon, the others can, even must

(in my allpower) love and beget without becoming "guilty" and taking on eternal ruin. Because *I* avoid and ban the satanism of marriage and, consequently the definitive sacrifice to "Eve", the seductress, incarnate sin, the death bringer (celibacy, bachelorhood), the profane can marry; it would certainly be better if they did not, depraved mankind would die out (see Paul's First Epistle to the Corinthians, Chapter 7, Verse 38, and many other misanthropes and despisers of the world). Other neurotics marry to look for the sensuality devil in the marriage hell and overcome him with "chastity" or busily sweep him out. In this way virtue is "made" out of necessity, and there are still many, many stupid people who do not see through the falsification of humanity, see a *morbus sacer* in the neurosis, believe the pious or malicious cheat, and believe the miserable and blown-up drip to be a saint and hero, and take his cramped activities as miracles. *It is really shattering to see the mischief a neurosis can produce.*

The doubts of demonistic thinking in general are reported in the 5th volume of the Textbook of Psychobiology, and about the proliferated doubts of the neurotic especially in the 6th volume. Indication is also given there that the patient does not know these primitive interpretations *in extenso*; he likes to say, "*I didn't think that*", or "I don't think like that at all" – certainly he does not do so in his more mature thought areas, but he has to admit, of course, that he once lived in the *fairytale age*, and believed in ghosts, etc., as he has to admit that he was born, althought he cannot remember the event. He is shown that his maturer thinking, where it is proper in any case to have belief in the soul, the spirit, in the metaphysical, wonder about the creation of the world and the future destruction of the world by Almighty God, etc.; in brief the body-soul problem has developed from the primitive (raw demonistic) way of thinking, that in the symptoms he has not left the early childhood type of experience and behaviour, that this can consequently only be described primitive-demonistically, and that it is to be understood in this way more than before. In addition, words are easier to forget than experiences, and thoughts are memories themselves, one cannot remember them at all; they can only just become actual again to the exent that the concept cells from childhood have been maintained and are still capable of actual function. Moreover, the science of how the world is perceived (*Weltanschauung*), although everyone has his own way of perceiving the world, and describes it as he perceives it, is still almost unknown. And in addition, every hyperfunction and hypofunction is interpreted (by the neurotic) as "superhuman or subhuman, in any case beyond the human", accordingly, these functions have to be described demonistically, in fact pathobiologically.

The *formulation of fairy tales* is unimportant in detail; it is only important that, so far as he is sick, the patient recognizes that he is living in early childhood age. However, many patients know that their symptoms "are" superstition, magic, possession by good or bad demons, that as such rule over the body, the earthly, that wrestle with one another and with external enemy demons; they believe themselves to be demonic beings, chosen or condemned by destiny, etc., and they also know that magic and demonism do not exist. This knowledge either belongs to the sick thinking itself and is then only negation sorcery that teases, bans, rules the enemy demonism by its no or none, or it belongs to more mature thinking and is then autotherapeutic

in the form of autosuggestion, as self-tranquilizing-diverting (also as self irony, laughing at the demons, which of course means their recognition, otherwise they cannot be laughed at and thus banned, etc.); so it is still only a magic, too, against the symptoms that now simply have to give way to the omnipotence of the magic phrase, and often "regress" temporarily. This "denial" of the demonistic, also when occurring (compulsively) in determined forms, is still nevertheless more of a game, not yet real and clear; by all means, it "dare" not have any real value in doubt thinking or it could not be used as a counter magic, and even in therapy a more or less serious anxiety is actual against raising this knowledge to a true one, because with giving up the personal magic the cross magic is pretended to triumph and the destiny of the magician would be sealed (in an unimaginable way). Nevertheless, the maturer insight of the patient that the demons do not exist in the primitive sense is the germination of the beginning of true world perceptive knowledge. It has to be achieved by work in a definite way and must fully mature; in vertical therapy (cognitive therapy). It has to become an experience. If the demonism is really recognized as an interpretation and fiction it falls off and so do the neurotic symptoms. In therapy strict attention has to be paid to the patient not putting the cognitive insight into the service of the neurosis and thus continuing to conjure, experiencing the doctor by all means as the great master magician who can teach him real conjuring for the first time.

The *ontic* development stages with their respective interpretations are analogous to the *phylic* development stages with their interpretations; the latter are to be brought forward in cognitive therapy, with advantages for the explanation of the neurotic thinking; they are listed in the ethnologic books, e.g., Buschan, Frazer, Stoll, Frobenius and others. Infantilism is also always archaicism.

In the way described, during the growing up of the still latently or already manifestly neurotic child and later of the youth-adult, multiplying and ever higher tasks are also *levelled* into primitive tasks that the child experiences as his *world catastrophe*, as giving up all-oneness, as the changeover to the individualized world, as the start of wrestling with demonic powers that have their effect in the contradictions mysteriously brought about and transmuted by them, in the differences and variations of the physical, which is as such inessential. This world task remains the nucleus (centre) of the neurosis and hypertrophies more and more; the genetically attached tasks count as constantly new disguises of the raw demonistic that appears absolutely hostile in ever more mixed-up and complicated forms, and is thus more and more dangerous for the totality, the omnipotence, the demonic integrity, the taboo, the magic, godly-devilish completeness of the neurotic. Thus, the growth is a demonic drive towards the "final battle" (*"Götterdämmerung"*), but the self-demonism of the neurotic bans all, the coarsest and the finest efforts of the enemy demon to destroy the totality, so that in the differentiation processes the puberty threshold and all succeeding tasks (examination, demands, achievements) are overcome with the ways and means of total demonism. This "survival" cannot be measured by "human" standards; it cannot (simply) be a completion of the tasks, a passing of the examinations in the "usual", "normal" way; it has nothing to do with the physical (earthly-human) occurrences, for the physical is only the facade of effective de-

monism, its organ or instrument, its "embodiment", "incarnation", its lair and means of manifestation, and so the "essential" is only the metaphysical, the task is to ban the enemy demonism, and this banning, namely, the overcoming of the teacher and other testers and the tasks set by them, can also take place in the form of avoidance, flight, failing an exam, outwitting, false pretences, etc. Only *I* (the neurotic) can afford this demon fight; "the others", as normal mortals, are only midgets, trifling beings, living and dying only through my mercy, in my omnipotence, and whoever segregates himself from me to the smallest extent, already turns against me, is my deadly enemy and has to be destroyed "in one way or the other". But there is still doubt as to whether my demonism bans the enemy demonism or vice versa, whether the enemy demonism just exists in my totality, omnipotence, absoluteness, and only tries to wrestle itself free, and thus destroy *Me*, the totality – an attempt that "must be nipped in the bud."

The neurotic experiences and behaves in this way; it must be emphasized once again that he does not recognize this world perception sense (his nonsense) of his symptoms, at least not *in extenso*. Naturally, the tasks and the ways and means are different in every patient, but every patient is deluded within his own symptoms, to be the godhead, the totality, the oneness, the absolute, and also in the way that he takes all illness on himself and thus may be the all-sick and also the all-healthy, the Redeemer, who certainly alone has to ban "the disease", and be the Saviour of the world from (the) evil.

In all-oneness there is not yet an individual, there is no I and no You, no individual experiences, no single experiences, no differentiated hunger-anxiety-pain-sorrow-joy series, no completed function, uptake or giving up, no contrasts, differences or variations, no tasks. The first task of the little child is the giving up of absoluteness; the primary-primitive appearance of the "others", different, new, strange, of the You (in the broadest sense; see duo; two); opposite the I is the end of the all. The individual is formed from the all-oneness, the general, the unseparated, the chaos, lifts itself up, disengages itself and comes to: now the all-oneness has ceased, the world is "broken asunder", "torn apart", but at first the little child still experiences in a ghostly way (vague, unclear, etc.); the "spectres" are animistic-magical changes and thus only "spectrally" different. Whatever the child takes-in (food, drink, air, etc.) and what he gives away (breath, words, tears, sweat, urine, stool, hair, nails, pieces of skin, occasionally also blood, etc.), whatever he sees, hears, touches, etc., the feelings, the objects the senses perceive and the concepts of all sensory areas, internal and external movement are physically (materially) irrelevant, and are animistically-magically identical.

While the healthy child develops (differentiates) vertically beyond this evolution stage, the neurotic, to the extent that he is ill, remains for the most part in this primitive evolution stage, while the other reflex systems differentiate to higher evolution stages in accordance with their specificity in the framework of the biological structure of the organism. This means that he "principally" must maintain the all-oneness-omnipotent-all-demonism-absoluteness from his central ideological position; he dare not give up, give away, have removed, have torn away, etc. even the tiniest thing, and dare not accept, take up, allow, cause, add, etc., the tiniest thing

either; otherwise his oneness (in an unimaginable, demonistic way) would break up, with the principle doubt whether the oneness still exists at all if "another" exists (see Latin, secus, secundus, related to sequi = to follow), and how the oneness, the godhead can give itself up as a consequence in whole or in part. Every change has to be deprived of power by magic, so that when happening it does not happen. And oneness is also concerned with the two general demons "to be" and "not to be", "(eternal) life": "(eternal) death", "day":"night", "god":"devil", "white soul":"black soul", "good spirit":"evil spirit", etc., as well as the many individual demons as subdivisions of both the general demons, that are as numerous as the physical things, altogether omnipotent, or nevertheless by omnipotence(?) and in eternal struggle for omnipotence, that however cannot be there any more as soon as there are two partners who quarrel about them! The enemy demons stand opposite one another in the inside of the I, and this is thus the cosmos, the universe, where the eternal struggle take place, or they work from inside to outside and vice versa (whereby "inside" and "outside" are still unclearly separated), or appear in the "spirit" as "spirits" (as concepts) that want to give the death blow to omniscience, but have to be tracked into the omnisciense. The banishment, removal of magic and power from the enemy powers is of course only the primitivist interpretation of really pure biologic functions that are outgrowths in the neurotic, and thus take a compulsive course. The general terminology for the functions is uptake and output; no intake or output of even the smallest thing – for that would be losing "everything" (magic: the part is the whole) – is the principle of the neurotic, i.e. whatever is taken up or given away by him in the course of the biologic functions, no matter how much or how little, has to be deprived of power by magic, and thus remains in the all-oneness-all-demonism; as mentioned, it does not concern the physical (material, materials, earthly, etc.,), but the demonistic only, the metaphysical, that has its effect in and from all "things", no matter how different they are.

The discovery of taking up food is, for example, like everything that is "other", the end of all-oneness inside of which nourishment occurred up to now. "Something" comes in addition; the "eating" task has to be mastered. Then the quantitiy and quality of the food increase. In the various types of food the eating neurotic only experiences magical changes of "what can be taken into the mouth", the material does not matter in itself, the demonism is essential, it wants to remove the all-oneness-all-demonism, as an enemy, and "one way or the other" (with abstinence or abuse) has to be deprived of its power. The little child does not yet eat meat; the vegetarian experiences "meat" as an altered form of "what the mouth can take in at all", and, as especially dangerous, because it is something from killed animals, containing, so to speak, a concentrated amount of death, a "poison" that is only taken in by the "big beings", who can deprive it of its magic, but the "child in the neurotic" cannot do this, and this resists its trial magic and thus deprives it of power, and only while *He* recognizes and exorcizes the demonism of meat are the others able to carry on eating meat.

The discovery of passing a stool is also the end of all-oneness for the little child; something is given up that had been in the all-oneness up to then. The constipated person is defending his all-oneness by keeping the stool back for a long

time, and only passes it in such a way that he "really" does not pass it, e.g. the laxative, enema magic, etc., working for him; in addition the interpretations; if the stool is evil, devilish, then I dare not let it "come out" that I am evil, devilish, or I have to send the "evil poison" "completely" (100%) into the lavatory hell in order to be absolutely clean, good, godly inside, and also to give the devil what he needs to keep him content, to sacrifice the devils kitchen to him from the belly hell (he only eats putrefaction, stools, urine, etc.) = and in spite of this, to remain absolutely pure, to protect the intactness-all-oneness, and deprive the devil of power.

The little child does not yet menstruate and knows nothing about it, but experiences everything that is excreted – with differences in the material – as threatening removal of his all-oneness, and later as its removal in fact. The patient with dysmenorrhea, so far as she is sick, does not experience the "period" as a sign of sexual maturity, but as bleeding, that is loss of a mysterious red fluid (somewhat instead of urine – yellow fluid, etc.), namely, "only" as a magical change in what can be excreted at all; the material plays no role, only the demonism of blood that makes an end of the all-oneness-absoluteness from outside or inside and therefore has to be deprived of power, e.g., by erecting a barrier at the door (hypertrophy of genital anxiety and pain reflexes), an embarrassing control that retains the discharge in the all-demonism, the all-will of the person giving it away, just as the mean person with his magical ceremony "turning three times" deludes himself that he can keep the magic of the penny, i.e. of money at all, of Mammon, in his all-possession, etc.

The little child cannot yet marry – the genital neurotic woman experiences her lover as an especially dangerous magical phenomenon of the "paternal-masculine" without being aware of it, as she experienced it as a little child; the penis is a magical transmutation of something "forcing in" in general, as deadly, as death (the physical does not matter); further, the birth of a child is a single case of "excretion" in general, and this – in whatever substantial type and form – would mean the loss of everything, (eternal) death, if not deprived of its power; so the birth happening does not occur magically; but the child is also only a single case of excretion in general, magically identical with every other excretion and like this dark-puzzling-demonistic with power over life or death, a godly or devilish ghost that threatens to escape from the "maternal" oneness-all-demonism and to destroy it, and therefore has to be deprived of magic and has to be retained in the oneness (cramping pains, etc., then magical dissolution of the existence of the child).

Analogously, every word, every look, etc., every movement, is a deadly dangerous giving away that has to be magically denied. Every strange word (and especially foreign word) threatens oneness; every strange look is the magic stuff to discover and recognize the neurotic and thus destroy his all-oneness-omnipotence-unapproachability; every contact is a "magical discharge", damage-removal of the "absolute uncontactability", of the taboo, etc. – and all that has to be deprived of magic, in whatever physical form the enemy magic may set itself in opposition. Briefly, everything to be taken up (conferable), no matter what it is, is a "mistake", something missing in the oneness, and means the removal of the all-oneness-all-demonism, the world catastrophe, the end of the (early childhood neurotic) world – and this "end" (as something demonistically unthinkable, unimaginable) has to be con-

jured away, and the eternity-immortality, the absoluteness-omnipotence, etc., has to be maintained; the neurotic attributes the fact that he continues to live to the effect of his demonism, which is at all events imperishable. In this way, all higher tasks, including those at the highest possible differentiation stage that the individual neurotic reaches according to his biologic structure in his almost healthy reflex systems, are also levelled out to the general original of primitiveness.

Thus, in this way, the neurotic lives (quasi) in his all-oneness-absoluteness-exclusiveness-seclusion, etc., in the magic circle, in the ring of banishment (like Faust and countless other "sorcerers"), in a personal prison, invisible, inaudible, unapproachable, untouchable, etc., like god and the devil and other demons, and is also unrecognizable to himself. The hunger neurotic, however he endeavours to get out of all-oneness, nevertheless remains in the midst of the wide-empty magic circle and hardly approaches the opening threshold that leads to the "beyond". The anxiety neurotic sticks in the opening, i.e. in the narrower magic circle, and protects himself absolutely from the threshold and the "beyond". The pain neurotic tarries, cramped in the threshold, and protects himself principally against giving up his all-oneness. The sorrow neurotic has just crossed the threshold bit by bit, but he mourns away what has taken place, makes it to not have happened, and thus protects his all-oneness. The joy neurotic finally radiates away what has taken place with joy, and also does not yet live in the I-You world in this way, but in eternal-all-oneness happiness, in all-happiness, in all-joy, that conjures everything that has happened into itself, and thus makes the separation from all-oneness not happen. Every mixed and congested neurotic, every trophic and every genotic also protect their all-oneness, their "existence", in this way. It is superfluous to say that the all-oneness-all-demonism is the as-if of the primitive-primitivist experience, rawdemonistic interpretation (fiction), which proves to be untenable by the real facts.

Tasks can also be called *problems*, to the extent that one interprets them demonistically. The tasks of the neurotic are problems of a special type; the higher differentiation grade problems attach themselves to the central, chaotistic, raw demonistic problems, but these are nuanced towards the primitive problems in accordance with the sickness content; they (presumably) only just have their "real" significance here, and are valid only as copies of the essential problems that are only attempts by the enemy demonism to distract the neurotic wrestling for his omnipotence from this, his main task. All degrees of concentration and dilution of the demonism (up to the dilution grade fitting the differentiation grade reached by the neurotic) are mixed up together. The chaotic, the primitivist confusion and lack of clarity, thus outweigh according to the hypertrophy; the main problem is (still) the demonistic problem in it's raw originality, the question of the cosmic to be or not to be, which is first experienced with the beginning of individuation, the animistic-magic interpretation according to which destiny, then life and death as archetypal demonistic powers, then individual demons also, work as "divisions" of those omnipotences in and out of the spectrally experienced basic shapes. By this, all the more mature stages of demonistic thinking, the problems of gods and devils, of God and the devil, the body-mind problem, scientifically the causal problem, are shadowed

and dimmed, drawn into the level of the primitive problem and are only important to that extent, "essential", but "otherwise" secondary affairs, even without meaning.

The problem as a "problem" is however insoluble, and the (presumably) superhuman struggle for the solution only produces sham solutions that are only perfunctory change of position of the enemy demon, teasing dangerous disguises to a denser physicism-materialism, pretenses of scientific comprehensibility (one can, in fact, only grow out of the problem thinking, and overcome the problem genetically). The neurotic keeps on meeting the basic problem, banning-banned, perpetually attached to Him, the worthy-alone, compelling him and being compelled by him, demanding and offering "every price". He lives in boundless immeasurability; every measure and boundary is a deadly enemy and must be extirpated, expanded and taken over into the measureless and boundless whereas "the substance" (the earthly, physical, material, worldly, natural) is only an appearance (facade, bearer, instrument of manifestation, organ, means of battle, etc.) in accordance with the hazy-spectral experience of the demonistic (the unearthly, underground, metaphysical, immaterial, the beyond, the supernatural, life-death, godly-devilish, mental-spiritual), and thus "really" not interested in at all. He, the all-one in his delusion, is all and nothing, has everything and nothing to lose, and everything and nothing to win (the healthy person is something, has something to win and something to lose). He lives in the world problem; he is the world problem itself, containing all problems in itself and thus "solving" them (= dissolving them into the general); in eternal insolubility, the problem and solution are the same. The beginning, the way (task) and aim vanish into the unseparated; the all-one is always at the beginning and the end at the same time, without a beginning or end, from eternity to eternity; chaos, the godhead.

Everything is mixed up and confused in this way, also the compulsively numbed mechanical invariable, and thus presumably "taut", "certain" and "clear" directed actions are only cramped uncertainty that can impress the non-specialist as excellent certainty (awareness of the aim, iron will, etc.). He who fights with destiny (according to his delusion) and is thus himself destiny, has to make everything chaotic and demonistic from his central standpoint of this, and proceed according to the "theory of the only chance". He overdoes everything upwards and downwards, always puts everything into play – and always doubts whether victory is defeat or defeat victory. He fancies himself – knowingly or unknowingly – as the almighty, the lord of the world, god-devil – and is only a childlike malformation, an evil clown and pest, even if he manages something mechanically useful in his almost healthy parts. In his "omnipotence" he cannot carry out even the simplest functions of his body respectably and properly. He fancies himself (at least) a superman – and cannot even complete human tasks as they should be done. He fancies himself as saviour – and needs "salvation" himself, namely cognitive therapy and freeing from his illness, his saviour delusion. The "world problem" is found in the areas of individual hypertrophy, in asthmatics it is in the pulmonary, in stomach illnesses in the gastric, in people with kidney disease in the renal, in the lovesick in the love areas, in work neurotics in the work areas, in concept neurotics in eccentricity of thought. As a result the "omnipotent" cannot even breathe, eat, drink, digest, love, work, see, hear, or think properly – and the fact that he cannot, that he (quite simply) is sick, he "turns

into" confirmation of his superhuman condition, his unique message, even his godliness, that is perhaps also devilishness – and he even finds believers! He deals with powers that actually do not exist, acting as the omnipotence himself, and thus has to fail when faced with the facts.

Differentiation is *separation*, the evolution of *individuals* and *details* from the basic-unitary. Each individual, every task, every problem, is a single one; every difference and variety is a detail. Primarily, the detail appears with the beginning of individuation, and the details are increasing; their increase-elevation is genetically immeasureable. The implicit develops to manifoldness and multiplicity. It is clear that *detail* is the deadly enemy for the neurotic; it is the *end of all-oneness*; as a result he "must" conjure it into the all-oneness, make it non-detailed and non-damaging, "remove" its demonism, "melt" it into the all-demonism, and magically generalize it despite all physical differences. In principle, the detail "wants" to withdraw itself from the allness, or penetrate it, in any case to remove the allness, absoluteness and completeness; so the following applies: do not give up even the smallest thing, do not leave anything out, do not let anything escape, be wrenched away, and do not take up even the smallest thing, or allow it, or let itself be offered or brought, i.e. cancel all changes by magic, always let everything remain as it is, remain complete, defend the originality.

In his parts that remain in the infantile the neurotic still lives in the chaotic, raw demonistic stage of perception of the world (*Weltanschauung*). To this extent, he is not yet an *I*, or just a germinating *I*, and there is not yet a *Thou* or only a germinating *Thou*; the forms and then shapes are still connoted in the general, beginning sections in and out of the chaotic-magic all-oneness, and then removing it. The neurotic should really not be addressed with *Thou* or *You* (so far as he is ill); he really should not refer to himself as *I*; he is the unseparated all-oneness, and in the beginning of the I-You separation, which is still being experienced as an animistic all-oneness. It is therefore understandable that he experiences-recognizes-accepts neither "himself" as I, namely as singular human being with a personal life, as an independent individual with certain characteristics, certain properties and functions – nor "the others" as *Thous*, as singular beings, and consequently does not allow the *Thous* to experience-recognize-accept him as *I*, and with all the hunger to step out of his chaotic-magical all-oneness, he has neurotic anxiety about the "world catastrophe", and defends himself (in a cramped way) by means of the neurosis against the danger of being "recognized", i.e. of being deprived of the all-oneness demonistically: of being banished, disempowered, i.e. having his omnipotence removed.

From the observer's point of view, the birth of the child is certainly the most critical event in the early infancy period; however, the child itself experiences the *genital birth* with much less consciousness than the "*cerebral birth*" from the all-one to the multiple (individuated) world, to the *I-Thou* world, the end of the world and (new) creation of the world; this takes place about the third year of life, and the naive observer of the child hardly notices anything about this, or nothing at all. In substance, the neurotic has not lived through this world catastrophe in his parts that have remained infantile (sick), and he sees his world task as avoidance of giving up his world, and consequently retaining his sole form of existence, identity with the world,

omnipotence-impotence, all-demonism against the enemy magical powers that want to remove all that. But the neurotic experience and behaviour can also be made "visible" at the birth process, the more so as certain reflex systems have remained functionally at the fetal-natal evolution stage, and are only aged and hypertrophied. All the genetically appearing differentiations after the early infancy evolution space, that is, the "future" evolution of details-problems in nutrition, job and love, are experienced from the primitive central "standpoint", interpreted as enemy and powers that want to destroy the all-oneness, and omnipotently deprived of magic and extinguished, levelled into the general – the growing, still latently or already manifestly neurotic child only learns "for this purpose" in the house, environment and school; he only learns to get to know "the world" in this unreal way, and to "finish off" all his tasks and problems, as well as those who pose them – and the neurotic youth and adult also acts in this way. He collects bricks, but does not build a house. For him, details are fleas he must squash, and they get bigger and bigger, become bugs and beetles, etc., and even elephants – and he has to deprive them all of power.

The neurotic can therefore neither experience nor recognize real details; he is incapable of real deepening, real learning or real research. The details that also come to him genetically are only detachments, moulds for him from the all-one-totality; they are still that and recurrently that; each of them is "the" detail, magically identical, only transformations without alteration of their essence. For the pedant who is keen on the minimum, the faultfinder who looks for the smallest mistake with anxious-painful perplexity, the fine-sighted who "sees the grass growing", the acute hearer who "hears the fleas coughing", the neuralgic who painfully registers the "fine draught" even in a closed room, the brooder who slices up "his problem" incessantly and bores it to pieces, etc., "the detail" is not a part and mark of differentiation as with the healthy person; it is "the only thing", that "everything depends on", the primitive totality, the absolutely demonic, that can make itself both very large or very small, and only the one-unique, the alone worthy, ("You are the same as the spirit that you grasp"), can find it in the smallest hiding place, "recognize" it and thus banish it already and make it harmless. All around his magic circle the neurotic feels, sees, hears, etc., thinks the enemy power-forms; they want to breach the magic circle, damage the taboo, and thus remove it. The neurotic can distinguish between friend and foe no more than an infant can do so. Friends are only masked foes, possible enemies, and the slightest possibility is held by him to be reality. For, so he deludes himself, if the possible enemy were not really there I would not be aware of him (circulus fictionalis), so I have to behave to the possible enemy in the same way as to a real one. He even decrees the possibility of impossibility. Anyone who is absolutely distrustful can never be otherwise.

So the slightest (probable or real) mistake, the "tiniest mistake", for instance, is the downright mistake (ethically: "the lack", the blame, sin, the evil, etc.), and with the detection of the slightest mistake the downright mistake, the mistaken at all, is detected (magic: the part = the whole) and thus banned, "made fast", fixed. His omnipotence the pedant, his holiness the scrupulant, etc., can thus save the world from "downright mistakes", as he detects their finest nuances and thus removes their mistakenness; for the detected, fixed, ascertained mistake is magically deprived of

power, and the "material form" is only interesting as a "matter for the mistake devil". Is it God's work that bans the effect of the devil, or does the devil only know his way around in "his" untertaking? Or does the devil ban the god "in me"? Have *I* been selected, a Christ, to save the world, or damned to find mistakes every where, even the most subtle one? Does he who hears, sees, etc. all mistakes not have every mistake? Doesn't he have to be the evil one, for if he were not, he would not be able to see the evil in all respects? Or does only God, the Godhead, see all mistakes, and has to see them to ban (assume-forgive) them? Or does the whole array of mistakes not belong to faultlessness (no mistake can be missing in faultlessness and in true infallibility), as omnipotence unites God and the devil, life and death in itself? However, these "powers" are the eternal enemies, each of which is omnipotent and has to be so like "every" demonism? And so forth – absurdum in infinitum.

Is there then victory and defeat in the demonistic? The neurotic has to keep testing his omnipotence-demonism-magic incessantly, but he is unable to perform "*the test by example*".

Firstly, omnipotence cannot be deprived of power, demonism cannot be made non-demonistic, magic cannot have its magic removed; eternal life as well as eternal death cannot be extinguished. How should it proceed, then, and what should become of the omnipotence deprived of power? What is banned magic like? Is it "nothing"? But can it escape the banishment, become free of it, return "there" again and work as freshly as ever? And who of the two magicians bans whom? Do omnipotence, demonism, magic not have to be eternal, timeless, deathless? Well, the neurotic functions keep taking their course over and over, so the omnipotence etc. confirms itself repeatedly with each fresh "trial"; of course the doubt about whether it (the omnipotence) opposing the enemy demonism is omnipotence at all, about whether it will work next time also confirms itself, etc., but there is never a decision in the demonistic vis a vis (God cannot get rid of the devil and vice versa; both are "omnipotences"!).

Secondly, omnipotence, demonism, magic, etc., is only interpretation, fiction; the metaphysical, whatever it may be called, in reality does not exist – so how can it be "put to the test", and somehow "confirm" itself?

So the neurotic is in a bad position; he truly suffers from the demonism, his doubts are hypertrophied; (structurally) to reach any certainty at all he can only apply the doubt methods, see his "certainty" in eternal uncertainty, direct his eternal questions at the nothing, which, of course, also can give no answer. For the neurotic, only his existence – no matter how doubtful it may principally be – is "proof" of the world-supporting effectiveness of his demonism. In reality this "demonic effectiveness" is only an interpretation, namely, misinterpretation of the biologic facts to which also belong the existence of the neurotic. In the levelling of the details the neurotic is an *individualist* (large size baby) and *collectivist* (large size child), his details are chaotic-magic identities, vague-fleeting productions-creations of the magmatic mass and thus still mass themselves. The neurotic is in no way able to experience the normally higher differentiated individuals. He experiences them pathologically or, at best, in an almost healthy way; for him the individuals and details are only objects of his levelling art; with his specific compulsion methods he brings them theoretically or practically to eveness, to the uniform and uniformity; he "sees

everything through *his own* glasses", but how the world really is, what the facts really are, he, the peculiar person apart, can neither see nor even foresee. The individualist can put up with no god other than himself, and the collectivist with no mature personalities, no true owner, no really free person – only with slaves and creatures, to whom he, of course, can give orders – to contradict, to mime a pseudoindependence – and to whom he, the tyrant, has to be slavishly obedient, so that they remain slaves! The neurotic has neither the sense nor the understanding for real greatness.

The *description* also corresponds to the levelled removal of individuality from the details, to the "living in general"; it is just as layered as the experience; to the extent that it is sick it is a childlike-general tell-tale (all-language-babble-language, fairytales) in an fully-grown form, and to the extent that it is higher differentiated it is afflicted with the tone of generalizing the details, the removal of individuality from the details. So, here, too, the detail floats into the general; it has something only pretended = likely in it; it is "there", but, like the detail, experienced only as a transmuted form of the all-oneness; and there can be numerous details, even overnumerous (e.g., in the precision fanatic, the overexact, the panhistoric, the know-all and the know-better, the word pedant, the fusspot, the word twisters and word changers at all levels of education), they are nevertheless all "the same". In his thought illness the neurotic is just as incapable of really differentiated description as of really differentiated experience. At best, he can spout carefully learned things at a higher differentiated stage that he has picked up from others. In description, the detail is also the deadly enemy of the oneness. Individual knowledge destroys omniscience, which is knowing nothing at the same time ("knowledge is death"). The neurotic expresses himself in general terms, even if he is quoting details; they are only waves in the chaos of knowledge and words, or islands that are flooded over by the sea again and again.

The therapist asks the patient; "Where's the problem?".

Patient: "Oh, everywhere".

Therapist: "That helps neither you nor me. You have to be more precise".

Patient: "I can't say it as exactly as you probably want".

Therapist: "But complaints you do have".

Patient: "You really ought to know that; after all you're the therapist".

Therapist: "But you probably feel ill".

Patient: "Sometimes I feel perfectly well, but then everything's all mixed up again".

Therapist: "What – everything! Give me an example".

Patient: "I get excited about everything. Or about nothing, I don't know either".

Many patients are niggardly with words, many are verbose in uncertainty, and speak words from hundreds to thousands. One gets to know troublesome situations, but also the statement of individual symptoms, e.g., migraine, palpitations, diarrhea, insomnia, crazy ideas, etc., but these are more naive descriptions of being sick, and not medical diagnoses.

"I have suffered for a long time; I sleep very badly – and so much else – look, it's no wonder if someone's gone through as much as me – if I was to tell you

all that, we'd need a year – it was already bad enough with my parents – unfortunately, unfortunately – you want to know that don't you, or not? – always such a theatre and spectacle; that doesn't make a child ill-mooded; I don't want my children – thank God they're completely well – to have such an example..." The patient talks like a big child; even if he shows off by using medical terms, he does not understand them (even if he is a doctor) in their precise professional sense. One cannot expect him to speak in any other way than he speaks, according to his structure.

The neurotic experiences and completes the task of describing individual things separately, of stating "something" ("concrete", "more exactly", "substantive", etc.) as with the phenomenal task; as a challenge of the enemy demonism that has to be banned, but not as a purely human task that has to be solved in a purely human way. He has no idea that all tasks are purely human ones, and cannot be something else; for him they are, even if he calls them "human", uncanny, fateful, fatal, godly-devilish, over-underearthly, super-subhuman, mental-spiritual, briefly, demonistic, and the demonism can embody itself in the word, in the word task. So, the out-grown little child wisdom dominates the general way of speaking, the commonplace, the wishy-washy way of speaking, that, also peaked in a cramped way, or subtilized, says all and nothing, but does not say something, and makes no obligations to anything. And though the higher differentiated statements, attached or mixed up with these in a queer way, are single statements, they are overshadowed with uncertainty in accordance with the pathological nuances; "substantial" only as carriers and attachments of the original-allness, in whose vicinity they lie; they are not true, matured details, precisely discerned and well arranged with one another, with just not having a chaotistic-magic central point, but belonging to a homogeneous evolution front.

The neurotic "likes to flee into the general". He says, that means they all say, one says. A misfortune has happened; that means there are only misfortunes in the world; even so-called fortune is only veiled misfortune. The teacher, the boss, has given a reprimand; that means they're all incompetent; the whole system has to be changed, the elders brought down and one should take their place. He doesn't find the right girl; that means all women are valueless. He has anxiety about marriage; that means marriage is an unnatural compulsion and should be abolished – at least for His all-oneness, the bachelor and his "task force". He has a poor marriage; that means that all marriages are bad. He has a supposedly good marriage; that means that all marriages are basically good, the marriage heaven always clear, the clouds do not count, and are not to be taken seriously, etc.

As soon as detail appears the neurotic disappears into the mass, "makes himself invisible", and thus conjures the task away. His statements have more or less clearly the mark of the automatic-mechanical, compulsive stereotype, drilled, learned by rote, repeated parrot-fashion, nonparticipant, nonindependent, not binding, "just having said so". He speaks a sort of gibberish, with childlike nonsense and "completely reasonable" – more this or more that – mixed in together; this confusion and mixing shows itself the more clearly the more he takes the trouble to conceal his insecurity from himself and others, e.g., with phrases, rhetoric, floods of words, dialectics, irony, inflated being right, crafty and tricky twisting, pseudoconsidered

"insight" into the "great affairs", boastful exaggeration, pseudoscientific ideology, the whole witticism. Even phrenotics can speak "quite reasonably" at times and for periods, and are possibly not all detected by the layman.

The humbug is found especially in the *quarter* and *half educated* neurotics who consider their concept hypertrophy plus what they have learned to be a "unique" grade of intelligence, and behave as omniscientists and wiseacres, as the top man everywhere (with the doubt that they might actually know nothing). From this "unique watchtower" they "look over" the details as God overlooks his creatures – who, of course, can turn against the creator, and therefore always have to be kept in the allness and have to radiate omnipotence themselves. For this reason they do and speak "in major lines", in double and many-meaning oracles, in "world ideas", but these "all-embracing considerations" are suspended centrally in the evolution sphere of the little child, who also experiences and describes everything "all-embracingly" in the sense of the chaotic-magic. These banal, trivial generalizations lie *before* differentation, and things that have set themselves genetically into the differentiation are only "bubbles from the unformed" (term used by a patient). Multiplicity, however it is experienced and completed (depending on the neurosis species), is only a film running as pictures with unreal figures before the spectator. Just as everything for the little child is "da" and "dada", all neurotics are "dadaists", each in his own way (nihilist, negativist, etc.), a confused "world philosopher", whether he proceeds with unsystematic general views and judgements, or spins together and tries to bring about bizarre doctrines about the world and humanity, about the social, political, economic etc., situation, about religion, ethics and law, about art and science, etc., from plain truisms and half digested maturer insights.

However, the highly educated neurotic, so far as he is ill, is also only broadly educated, and his description shows the immature nuances, also in the almost normal areas (at least to the specialist). The neurotic *scientist*, who is thoroughly trained and highly differentiated in his almost healthy parts, can describe and carry out the science to a large extent only from his chaotic-magic centre; he has only carried the battle especially far against the demon science; for him, too, the detail of science is something that has to be removed of its power magically, that has to be levelled into the general; only in this compulsive way can he take knowledge from it; according to his biologic structure he is not able to recognize the details as real constituents of the science, to seek them out and place them in the comprehension and reason spheres, in reviewed thinking. He learns outwardly, not from insight. Accordingly, his description also contains something "general", no matter how minute; it deindividualizes the details to the primitive-general, to the stiff-formal, to the tedious-schematic, has the tendency to slip away into the dogmatic, doctrinaire, speculative-unsubstantiated, is theory and theory casting, and removes the science with scientific methods – depending on the type of neurosis as nihilistic (hunger), negativistic (anxiety), severistic (pain), pessimistic (sorrow) or optimistic (joy). At the same time, it is in no way clear to the neurotic that he is fighting *against* science and not *for* it, nor is his behaviour in the sense of how he perceives the world (*Weltanschauung*). Even many of those who know they are neurotic delude themselves that the neurosis has nothing to do with their scientific activities – or their method has just helped them

to their position; they could only manage "the great task" in their own special way, and so they refuse enlightenment in their neurotic manner, also by quoting numerous examples, although with every word they avow that they are immersed in Faustian doubt, and "attach the words to the (mechanistic) formula" and thus "tame" them.

They also cannot readily see the difference between the mature insight that develops *during* and *after* differentiation, with deepening into details and mastering them, including the details experienced, and the immature generalization that lies *prior* to differentiation and so far as this differentation inserts genetically, "draws it into its interdict". They cannot differentiate between a really great idea, a high level of insight, final knowledge, fully mature wisdom - that "also" summarizes - and the generalities of childlike naivety and childish simplicity - and many healthy people cannot do that either; the nearer to normal the neurotic description, the more numerous the almost normal parts, and the further the described discipline from the hearer-reader's mind, the less they can do it.

In addition, in every language most (everyday) words exist and sound the same at the infantile and adult evolution stages. *From the point of view of evolutional biology they are different*, and also have differing evolutional biology meanings. "Concept determination" differentiates itself out of primitive unclarity into increasing clarity. Everyone can only speak and hear (write and read) at his or her evolution stage and understand words. The word "man", for example, is used by children and adults, but in early childhood it means a spectral, and later a soul-possessing being; only in cognitive thinking is it understood as an exclusively biologic being, and the world-perceptive sense of the word "man" also changes from a primitive mystery to realic recognition that the word "also only" is a pure biologic fact, namely, an acoustic actuality series. In general, the sick person does not use different words than those used by the healthy person (apart from various word garblings and word games, etc.), and it cannot always be seen readily in which niveau of the layered evolution front his words lie, and in what sense they are meant. To the extent that he is sick, his speech is grown-out infant speech; it is associated with maturer kinds of expression in a queer way, and mixed in with them. The neurotic makes a fuss about his "energy", but he labels his added weaknesses in this way; he says "struggle" and means "cramp"; he says "courage" and means wantonness or the courage to be a coward; he says "forebearance" and means anxiety-inhibited impatience or indecisiveness; he says "performance" and means overperformance or avoidance of performance; he says "work" and means empty busyness (idling); he say "self control" and means inability to act; he says "virtue" and means necessity; he says "faith" and means superstition, etc.

"Community" is the term for all evolution stages of association, but the neurotic "understands" community as the chaotic-collectivist into which all the higher social stages "have" to be levelled, and deludes himself that his concept of "community" is the highest, even the only possible, and its realization the final solution of the "social question" and true happiness for mankind. "Property, possession" he recognizes, but in the sense of "all-mine" and "everything for all"; "to each his own?" – of course, naturally, he says, but "only within the framework of collective all-possession" (see "Dead Hand" of the Church, State capitalism), everything belongs to everyone, and in the end *I* am the all-possessor, who consequently

possesses nothing (of his own). "A personality" is only the person who becomes merged into the collectivist community and proclaims its ideology. He says "freedom" and means compulsion; he says "obedience" and means subservience; he says "firmness" and means brutality; he says "tightness" and means rigidity, he says "generosity" and means superficiality; he says "inspiration" and means fanaticism; he says "justice" and means violence; he says "endeavour" and means bragging; he says "power" and means his own omnipotence; he says "great" and means inflatedness; he says "construction" and means destruction; he says "culture" and means barbarism, etc. – and sometimes the words even glitter onto a higher level. He translates words into other words and imagines to "explain" with renaming. He considers his more or less extensive symptom description (description of the neurotic situation) to be "motivation"; he believes in its rightness, so that the symptoms seem to have a causal explanantion and thus seen to be justified; in this way the neurosis confirms itself; normal experiences and descriptions are also taken as "evidence", as the patient experiences them; the symptoms are more mature insights, and defended "without compromise" in this way. He uses the fact that many words are homonyms for the sick and the healthy (e.g., the names of the feelings, many ways of behaviour, external situations, many thought processes) to de-symptomize his symptoms, to turn them into the norm and justify them; for example, he says; "You don't just cross the street recklessly" and in this way wishes to legitimize his compulsive standing still at the kerb. In accordance with his false associations, he indulges in dodging the issue, excuses, evasion, subterfuge, prejudgement, lies, pathologic mistakes, misunderstandings, falsification, distortion, hair splitting, self-extenuating, self-accusation, indolent perseverance, reckless wantonness, etc., always in pseudologic, which is always a defence of the all-oneness. The confused person can only describe in a confused way, and the doubt about the sense-nonsense of his own speech ("I don't understand me myself") also belongs to the confusion.

The naive hearer-reader, who can neither establish the diagnosis nor knows the evolutionary biological differences of the words and the sense of the words, or only guesses at them, takes the words of the other, at least at first, in his (the hearer-reader's) own sense, and agrees or disagrees according to this, but perhaps the speaker-writer meant something else entirely. The danger of this talking past one another is especially large if the neurotic, who really moves freely about, holds a high position, and is a "recognized authority". One possibly finds out then that there is a (but only seeming) gap between theory and practice, speech and action, and there is doubt then about the "authority". But then it is too late and much damage has already been done. The only good thing is that from the sick orders, etc., the sick elements are filtered off to a greater or lesser extent on the way through subordinated instances, if these are healthy. But the specialist can diagnose the fact as well as the speech; he does not let himself be preached at and be fooled; he knows that the speech fits the fact, also where there are lies, pretence and contradiction, and that the neurotic deals just as confusedly as he talks. In view of the broad spread of neurosis and the sheer immeasurability of the damage that neurotics bring about, it is urgently necessary to know the language of the neurotic and learn to see through it.

2.2.2 *All-responsibility*

Responsibility is: to be answerable, being tested. Accountablility is: the ability to take the test at any time. Everyone has the responsibility appropriate to his evolution stage. Every healthy person is conscious of his responsibility. Every healthy person thinks and acts (purely appropriately to his biologic structure) in such a way that he can be called to account at any time and passes the test. If the healthy person is called to account by a sick person he can initially suffer from injustice, but he passes the test in such a way that he and others recognize the injustice, and sooner or later he will be justified (law of inherent justice - Textbook of Psychobiology, Volume 4). Accountability is not one-sided; it is not only the accountability of the lower to the higher, or the younger to the older; everyone is accountable to everyone else within the limits of competence (ethically: respectability). The employee tests the employer in his own way; the child tests the grown-ups (parents, etc.); the healthy person recognizes this tight and claims it for himself. The "leader principle" is a designation of the differentiation of the social pyramid and normally includes the accountability of the led to the leader and that of the leader to the led (pathologic misunderstanding is the identification of this "principle" with tyranny).

The sick person is also accountable: testing his behaviour results in the naive or specialist (medical, legal, etc.) diagnosis and therapy; i.e. how the damage possibly done is made good and the sick person taught, improved or healed. Certain forms of disease are so far from the normal that the sick person is recognized as being incapable of guilt when his accountability is tested; one says he is not accountable for his actions. In general speech the diseased thinking and acting are labelled briefly as irresponsible – in the sense that when tested, the accountability cannot be justified, distinct, in contrast to healthy thoughts and deeds. Responsibility and accountability are really terms for purely biologic matters of fact, by any chance, not for the "psychic". A person cannot be made accountable for the way he is.

The neurotic deludes himself that he has only *one* task to fulfil in his experience, the only task existing, his world task; defence of absoluteness, godhead, against the demon foe; it is true that he experiences the (his) main task and secondary tasks, but these are only offshoots of that, *essentially* identical with it, and only relevant to that extent; "otherwise" they are bagatelles. The tasks of all other beings are also found, like the being themselves, in his all-oneness, absoluteness. And thus he is also responsible for all and everything. But just as the allness is all and nothing, all-nothing, absolute accountability is identical with absolute irresponsibility. The person who is responsible for all and everything cannot be called to account by anyone and for nothing – just as the little child carries all (future) responsibility unseparated and implicitly, and thus lives outside all responsibility. The insoluble doubt of the neurotic as to whether he is responsible for everything or nothing, and how the one or the other or both together might be possible.

How is it, if *I* am all-responsible is anyone else in my circle at that time, in the world, in the least accountable – to another or to *Me*, whose all-responsibility releases individual responsibility? If someone other than me were responsible that

would be the end of my all-responsibility, my absoluteness, the end of the world. The accountability of the individual can only lie in my all-accountability; individuals and their accountabilities are thus only phantoms in the ban of my all-oneness. So every "authority" is missing, to which *I*, the all-responsible could be accountable. To omnipotence? But that is *Me* – or it works in *Me* – is god or devil – or both in one? Or, am *I* "only responsible to *Me* (my conscience)", how should this accountability look? Can the absolute be responsible to itself, call itself to account? Absurd idea! A human being can test himself on how he has to answer the questions of others, but the godhead cannot do that – and neither can satanity – and if it were possible for the godhead to call the devil to account and vice versa, one demonism the other, both all-powerful "omnipotences" themselves? – and perhaps mutually responsible? Am *I* a double-I, two Egos, where one (perhaps the good one) calls the other (perhaps the bad one – or the other way round?) to account? Perhaps the mental-spiritual I, the physical? But the physical I (what is that, by the way?) is under the rule of the mental-spiritual I (what is that, by the way?), is its organ, etc. – so how can it be responsible? – or can both Egos separate? How can "I" call "*me*" to account? And how can *I*, the all-responsible, call others to account, for one individual responsibility would be the end of my all-responsibility? I push everyone's responsibility onto him like a position, a fief, I "make" everyone responsible, then *I*, the all-responsible, am the Lord of all responsibility, free of every responsibility? *I*, the omnipotence or at least its bearer, am taboo, can do and leave alone what I want, everything good and everything bad, am outside the law that *I* permit, outside all criticism, which is only due to *Me*, outside society, which *I* rule absolutely – absolute, i.e. without any thinkable contact with it – and yet its lord, its peak, its nucleus? And if my all-will, absolutely mysterious, works in everybody, is not every person then absolute, and the society, even the world, blown up "inside" which the absolute will just works nevertheless? Cannot and must not everyone do or leave alone what he wants in my all-responsibility, good and evil? And dare I call someone to account when everything that happens, every blame, every devilment, happens in my will and is thus justified already! Everyone simultaneously responsible and irresponsible – responsible perhaps only for the irresponsibility? He who subjects himself one hundred percent to the all-will, who lives under the compulsion of the all-mighty rules, has he not dethroned the all-will, the omnipotence, has he not become these himself? They cannot hurt him; he follows the law in blind obedience, he is not at all independent; without the all-mighty rule, the external or the internal and both magically identical, he is "lost", "sunk into nothing" in an unimaginable (that is: impossible) way. But he who rebels, does he not also do that in the all-will – or is he the foe-demon that wants to break the all-will and thus has to be destroyed for the defence of the all-will? Is he acting outside my all-responsibility – and how could that be possible? – or is he actually with my all-responsibility and thus also justified as a sinner? (compare with Brunnhilde's crime in Wagner's Valkyrie, Adam's defence of the so-called Fall of Man, Christ's salvation of the world, and the innumerable "world salvation" dogmas of innumerable neurotics). The neurotic thus gives no recognition to the social structure of accountability, as with the social pyramid (even if he claims he does); as an individualist-collectivist he absolutely levels out the accountability of everyone

into all-accountability, and puzzles about it in his confused way just as much as about the all-oneness, whose attribute or identity it wants to be.

Sometimes there are neurotic *organizations*, each with a founder as the nucleus-peak, religious (including anti-religious), philanthropic, social, political, popular philosophical, scientific, etc. sects, each with a "teaching" that is a dogmatic system of "prudent and foolish" (Joh. Bresler), "a dizzy, rocking construction on a small base". They are all individualist-collectivist communities, head and limbs are "one", the head holds himself to be and behaves as all-powerful, all-knowing, all-justice, etc. The followers believe in *Him* and are themselves all-powerful in his omnipotence, and they are all under compulsion and delude themselves that they are free; all make the demand for exclusiveness and damn every other "differently minded" person – either with magic words or magic deeds, and the earthly body is often "conjured away" in this (compare for example the "acts of salvation" of the Inquisition, witch burning, the atrocities of political sectarians and their fellow cramped, etc.). In such sects uncertainty about accountability turns out to have an excessively grotesque rigidity. Everyone is responsible and nobody is responsible. The chieftain is responsible to himself only, and thus responsible to omnipotence, as a consequence free of every responsibility – and all this floats in the fog of demonistic doubtfulness. Reason becomes nonsense, good deeds harassment, normal abnormal and abnormal normal – in crazy confusion.

2.2.3 *Tasks that are internal, external and beyond*

The internal tasks are functions of the *autonomic* structures, including the internal organs, called after the pain stage; one speaks of tasks of the heart, the liver, the blood glands, etc. The internal tasks are system-genetically related to *sensory* tasks that one terms external, although they overlap partly in space with "the interior", and these tasks again are system-genetically related with the *idealic*, the conceptual or thought tasks that one can term as being beyond ("beyond" in the realic, not the demonistic sense). Just as the reflexes take their course actually and non-actually, one can also speak of unconscious and conscious tasks. Digestion, for example, is a task of the stomach, conscious in the form of stomach feelings, system-genetically connected with the external task of taking in nutrition and working to obtain nutrition, and with the memories of these (including considerations, etc.), namely, the appropriate conceptual tasks.

The tasks have of course their *evolutional history.* Someome observing a baby says, for example, that its task is finding the mother's breast and sucking, etc. But the baby is still living in chaos, and the tasks ascertained by the observer come to pass unseparated in its experience; they only begin to stand out from one another in the course of evolution (initially very vaguely); the young child "discovers" more and more tasks in this primitive way, e.g., that of excretion from anterior and posterior outlets, later perceived as an opening, but still deeply puzzling like everything else. With the beginning of individuation the individual

tasks separate, but still remain initially magically identical; their interpretation assumes sharper differentiation only gradually. This is also the case with sensory tasks and conceptual tasks. During this the *centralization process* takes place; on the whole, this is the "grouping of things around the human being". The first partners of the infant are mother, father, siblings, etc., then also other large and small beings in an increasingly developing social hierarchy. The tasks are accordingly set by human beings, by the child itself *(self-appointed tasks)* and by partners *(tasks set by others)*; they show themselves in a somewhat closer or more distant relationship to the human being. Like the people, they also count as demonic, the demonism of the people transfers itself to the tasks, just as all demonism structures itself in an anthropomorphic way. The mastering (solution) of the tasks, that increasingly become manifold and arise, is thus always the overcoming of those who set them, in the end the mastering of the "old ones" (parents, etc.), the lord, the lady, (the father godhead, mother godhead), the master, the mistress, so that the adept becomes the master or mitstress himself.

The neurotic, to the extent that he is ill, has got stuck in among the early childhood tasks that he experiences as the one-unique task; the maintenance of chaotic-magic all-oneness. He takes trouble with this, his problem – in the individual type of neurosis – hypertrophic-aged all his life if he does not recover. The genetically adjusting higher tasks are also levelled out, as described, are *substantially* "always the same" tasks, "the same" problem. More or less single tasks drop out in his evolution, which the healthy person lives through, and on the other hand primitive tasks hypertrophy to compulsive stereotypes. The task is experienced as a demonic attempt, as a destiny, life and death attempt, in nearer or further relationship to the person who sets the task and who lets his demonism work in it. So the "proper" task of the neurotic is to overcome the foe-demonism working in and from the person – analogous to the puberty fights of the primitives. He thus squints towards the tester who sets the task when occupying himself with it; he is not fully engaged with the thing to be done; he always (and also mainly) has to keep watching the expression, gestures, etc. of the tester, watching-out to ban the hostile magic, to safeguard his omnipotence – everything "depends exclusively on this". In this way the schoolchild, for example, does not work out the subject of the exercise, but criticizes it, and with it the teacher as "impossible"; at the same time he "demonstrates" himself before his schoolfellows. Some (so-specific) neurotics carry out their fight against the "grown-ups", the authorities, society itself, in an active way, perfectly fitting primitive patterns; beaters, robbers, killer, murders, stirrers-up, the asocial who even delude themselves that they are fighting for "social ideals". The "solution" of the neurotic task is always different from the normal solution of the (normal) task. The one is untrue, unproductive (presumed to disempower the magic), the other is true, and productive. In his own interpretation the neurotic can never solve "his" problem at all; it is there without the human, and the solution would be the "end of all time"; on the other hand, he has always "already solved it" with the method of banning the enemy-demonism. His goal is his start (pp. 112, 113). In this way, has he solved it now or not? Alas, the decision is "the task" again; the same doubt holds true for this, and from the circle of doubt there is no release – apart from the path of cognitive therapy.

2.2.4 *Near-normal and far from normal solution*

The healthy person solves all his tasks (consistent with his biologic structure, pp. 95, 96) and arrives at the healthy target; his performances are healthy. The neurotic, on the other hand, never completes a healthy (real, true, etc.) solution of his tasks; he completes a far from normal, at best near to normal (pseudo-normal) "solution"; he never arrives at a healthy target; he arrives at a far from normal, at best near to normal, target; his performances are never healthy, but remote from normal and at best almost normal; his tasks are never healthy, but remote from normal and at best almost normal. The solution or (sive) performance diagnosis is established by comparing the behaviour of the person being examined to the normal tasks. Normal tasks are those which – as daily and special tasks – are appropriate to the person with regard to age, education, class, profession, sex, etc. Whoever "cannot" complete the proper normal performance, i.e. carries it out false-wrong or deviates from it, is simply sick. Tasks that do not belong to the proper normal tasks are not taken into consideration in the diagnosis.One does not expect a 10 year old to have read and understood Kant's philosophy, a 20 year old is not asked to play with dolls. The fact that the neurotic experiences the tasks differently from the healthy person thus remains disregarded initially.

Only closer research into the neuroses shows the state of the facts of the stepped, layered, evolution front. The neurotic does not experience the normal tasks as such at all, but only "his" tasks, namely those that still lie in the early infantile niveau, and those that lie in the higher differentation stages but are more or less pathologically nuanced (up to almost normal). Also in its hypertrophy and agedness, the infantile niveau is recognizable either immediately or only after specialist insight; everybody sees, for example, that the 20 year old who "dollies" or still has to grasp everything, etc. behaves in a childish way; on the other hand, the neurotic organ functions, the work fanaticism, the place-hunting, the impotence, the brooding, etc. are not immediately recognizable as infantilistic; particularly because these symptoms are woven together in a manifold way with more mature actions, and their pathologic nuance in return only shows up to specialist insight. In the end, many tasks remain for life, and also remain labelled with the same names (p. 96), and the evolutionary biology differences are little noticeable in common, and even unknown. Even the smallest tasks are of course not carried out normally (=really childlike), but at the best near normal, and though they are often enough completed almost normally (as lying within the framework of the "omnipotence"); however, tasks that are experienced as deadly dangerous attacks on the "all-oneness-omnipotence" are only completed far from normally (e.g., the "grownup" daughter can play around with her child-dolls for hours on end, or browse in a book, but cannot help her mother in the house). Perhaps the neurotic completes his task almost normally so long as he is alone, but far from normally as soon as someone is there that he experiences as the (hostile-demonistic) tester (e.g., letter signing only possible if nobody is "looking over my shoulder", or is in the room at all). In other cases it is the other way round. The patient "presents himself", is one of the group, and imitator, has anxiety about being noticed (and is noticeable for just that), or looks sidelong for applause, etc. –

and so overcomes the enemy-demonism of the individual or the crowd. A similar task can sometimes be completed far from normal and sometimes almost normal – according to the periodically altering intensity of function of the sick reflex systems (e.g., the patient can sometimes not cross the shop threshhold, and sometimes go shopping "perfectly well", etc.).

Examples:

a) Internal tasks

The *stomach neurotic* has not mastered the stomach task; he has remained stuck in the infantile evolution stage; the sick gastric reflex systems are hypertrophied and aged. The food suitable for him is therefore baby and infant food; all other food is only suitable to the extent that he has healthier gastric reflex systems, and this only during its peak function (namely the low point of function of the sick reflex systems that occurs in a specific periodicity and is characterized by easing of the symptoms); he "always has to take the sick stomach into consideration" according to the quality and quantity of food and its preparation; he cannot tolerate proper adult food at all, even if he gulps it down (in a cramped way); in this event stomach digestion can proceed in a tolerable way, though with suffering, and all sorts of aids (under certain circumstances) like warmth application, medications, etc., and can reach the near normal target. In other cases a far from normal target is reached, e.g. in perverse reflex connections to the diaphragm or esophagus (cramped antiperistalsis), belching and vomiting, or to the liver with disturbances of bile production and excretion, or intestinal glands and blood vessels with diarrhea, often immediately after (certain) meals, or to the lungs with coughing with or without mucus exeretion ("gastric coughing") or to the cardiovascular system with palpitations, flushing-paling, raising and lowering of the blood pressure, genital erections, or to the sweat glands with profuse sweating, etc.

The *gut neurotic* has "not yet learned the gut functions properly". He is, for example, constipated-diarrheic, often mixed up in such a way that the stool appears normal in the absence of more precise examination; this result must still be termed near normal, but it is achieved with too much trouble. Abnormal targets according to the perverse reflex connection are; antiperistalsis with or without vomiting, or the production of prostate juice with or (almost) without sperm, or in women leukorrhea or heart crises, also with fainting attacks (spasm of the cerebral vessels, (p. 55), "dead limbs" (vessel spasms), etc.

The *eating neurotic* cannot yet eat properly (p. 37). The vegetarian, for example, has stuck at the task "meat eating"; he has "solved" it abnormally in the form of avoidance, meat abstinence, but is left unsolved according to normal standards. However, he reaches the near normal target by eating vegetarian food; he eats vegetables, etc., but only in the special form of abstinence from meat; not so freely and easily as the healthy eater takes his meals. The raw food eater "depends" on the

"raw" habit of eating unprepared food; the infant receives mother milk, fruit, some vegetables, e.g. carrots, etc. The primitive being is at first a herb-fruit eater; the raw food eater, who also appears sectarially similar to the Mazdaznan people and others is "still further back" than the vegetarian who at least enjoys his food prepared. Of course, there is no lack of medical-hygienic interpretations, so-called "motivations" that ought to "give reasons" for the abnormal eating behaviour, but in reality they are only describing it in a "medical" way. During the peak function of his more highly differentiated eating reflexes the patient can consume appropriately prepared food and can reach the almost normal target to that extent. The analogous applies to the many varieties of specialized eating and drinking neuroses.

The *alcoholic* does not drink alcoholic liquids in the same way as the healthy adult, as enjoyment-nutrition substances, which is recognized properly about the time of puberty, but as the demonistic, godly-devilish magic substances whose embodiment makes him overcome all life-death perils, and to lord of the world. He drinks in the manner of the primitive test of ecstasy, the test of steadiness against poison, with "poison" not a chemically defined substance, but the demon death, that is vanquished, demon life that is taken in. As "suckling magic", for him, the alcoholic liquid is successor-analogue to mothers milk (wine is thus really "Liebfrauenmilch"), the sot is thus the hypertrophied-aged "suckling"; he has also not solved the puberty task of drinking alcohol properly, he always "tries" the magic new; he may know the chemical formula for alcohol perfectly well, but all the same, for him as an alcoholic, it is the demonic life-death elixir that he absolutely must have at any price, whatever it costs – like the suckling with the mothers milk. The drunkard reaches the near normal target; he passes (survives) the tippling test, but wrongly; he overdoes the good thing – and that is always bad; he drinks intemperately and excessively, is overpoweringly overpowered. The abstinent avoids the task and arrives at the far from normal target.

The *kidney-cramped* partly sweats out the body fluid that is normally voided as urine; the sweating out is far from the normal; passing urine quoad direction near normal; far from normal quoad the course of function, amount, composition, concentration (possibly stone formation as precipitation) with periodic variations (also colic, etc.). The sweating out can also take place in the lungs (mucus formation, renal coughing), etc.

The *asthmatic* has not yet learned breathing properly, i.e. early childhood pulmonary reflex system are hypertrophied and aged. The task "breathing" can be carried out to near normal, as a result the patient gets air with too much effort, in a cramped way; but he can also arrive at the far from normal target, e.g. have diaphragm cramps in inspiration that ease off in expiration, so that he does both wrongly.

To the extent that someone has not surmounted the childhood task of discovering the *genitals* (as such), as an adult he also "knows" nothing about them; he is, so to speak, asexual, or more precisely, presexual "neutral" (neither male nor female, but both);

he only has a urinary apparatus or a body region that is differently arranged from the other parts, but is "incomprehensible". In connection, more highly differentiated genital reflex systems functions come forward whose actual course is the primitive "sexual consciousness" and are initially a game with the genitals; further differentiations are masturbation, semen pollution, menstruation, coitus, pregnancy and birth. In the main, the genotic has not yet abandoned the early childhood stage, where the "genital's" task has not yet been solved, but is impending; these reflex systems are hypertrophied and aged, the main part of the sick area. Later discoveries occur, so to speak, in the shadow of the early childhood lack of clarity, and the sick differentiations do not pass puberty at all, but the healthy and almost healthy ones do. So far as he is ill, the genotic does not know how to do something properly with his genitals, and this darkness of the unsolved task nuances into his more mature insight. The *abstinent* comes to the far from normal target; he is not, as he deludes himself "asexual" or "sexless" (the genital reflex systems are simply there, they are only sick), but only perverse, for example, he does not touch the genitals, but exercises paramasturbation, i.e. masturbation-like movements in perversley connected regions; the hand "errs" away from the way to the genitals and arrives at the perversely connected site; at least the initial movement to the genitals is certainly equally seldom diagnosed as such playing-in of the perverse reflexes, training) as the replacement rubbing movements; the patient does not know what he's doing, and initially resists the diagnosis in most cases. The abstinent is thus no "better off" than the abuser, i.e. the masturbator who overmasturbates (abuse), indeed, one must say that the latter "is not doing it so completely wrongly" as the former; his sick reflex systems are hypertrophied, but the course proceeds to a near normal finish.

For all genotics the genital has not yet been recognized in its mature dignity; for them it is a sort of child's toy called "genitals" ("cock", "slit", etc.) with which one either dare not play because it is devilish, evil, or with which one must play because that drives out temptation, the evil lust, or may play, because it is godly and creative. Such a game is thus also the coitus of the genotic before and in marriage, including the fertile (poor children!); the patient arrives at an almost normal target, but with central confusion of the sick reflex systems. Thus voluptousness is only attainable under certain quite definite specific circumstances, and always only incompletely, for example with insurance against fertilization (condoms etc.), with certain compulsive preparations (patient must sniff around the anus that has been cleaned with an enema for this purpose, etc., patient must first of all urinate on the woman who is wearing only coquette stockings, etc., patient must first exercise sadism or masochism, and many other oddities); in certain compulsive methods (position or posture, absolute silence because the slightest noise disturbs, woman patient must sit on the man's lap and defecate during coitus, she says "let it all go", and a great deal more); after hypertrophied feelings, especially anxiety and pain, the voluptousness is often clouded to "just a little lust", "almost unrecognizable", it "breaks off suddenly before the climax" and all measures taken "to bring it back" are useless, and so forth. For example, married couples who practise mutual masturbation arrive at the far from normal target; in addition, genotics with hypertrophy of the

genic reflex systems of trophic organs, namely perverse reflex connections from the genitals, so that the expressive actions take place partly at the perversly connected organs or areas instead of at the genitals (e.g. genotic vomiting, genotic asthma, fellatio, cunnilingus, anal coitus, etc.). The genotic woman who bears a child has certainly got "a child", but the processes of begetting, pregnancy and birth are for her, to the extent that she is ill, darkly mysterious events (like the phylic primitive, and the young child in its chaotic-magic experiences every input, inner life and output), and for her the child is a "dolly", conjured up in a puzzling way, quasi a magic "child of the child", a puzzling being, an angel (emissary of God: angelos), a goblin, a dwarf, a devil's emissary of uncanny power against which her personal demonism must be brought into action, that she must oppose with her own demonism by subjugating herself totally ("does not let the child out of her sight", responds to every stirring with magic immediacy, "spoils the child hopelessly"), or by complete revolt against it ("can't bear the sight of the child", stops every stirring at once, always wants and carries through the opposite, somehow rejects the child, mishandles it, may even kill it); in both ways she magically "invalidates" the existence of the child – quite analogous to the young child that keeps "it's child" (the doll or a newly-arrived sibling = mysterious strange being) in its all-oneness, omnipotence, and thus "puts it out of the world" as an individual being. To the extent that she is healthier or almost healthy, the genotic experiences the procreation processes and the child appropriately more maturely, but still "in the shadows of central vagueness". The sick genital can thus also conceive and carry a baby to full term, to the extent that the appropriately matured parts are present. The woman then arrives at an almost-normal solution to the "procreation" task. Far from normal are morbid sterility, abortion, premature birth, a hydatidiform mole excretion, etc., false pregnancy (pregnancy without a fetus, pregnancy-like hypertrophy of the genitals, genotic fatness) etc. The children of genotics are at least neurotically ill, never masterpieces like healthy children of marriage. And so forth.

b) External tasks

Touch compulsion. The patient, 23 years old, "must touch everything that has made a noise" (p. 72). Infants also touch "everything", and are also constantly on tactile voyages of discovery; touching removes the magic from things ("laying-on of hands", etc.). maintains the personal demonism (transfer of personal magic), where the schemes are in suspense in the side of all-oneness. The beings "make" mysterious noises, an indication of their magic, their magic itself, that keeps working; it can be banished if one touches the being that has just made the noise (by the way, also by imitating the sound most precisely, in magic identity). The child also sees that the grownups touch the things and thus make them silent; corresponding compulsory touching as imitative illness; with the "absolutely precise" imitation the magic of the grownups is assumed, and the omnipotence maintained. Normally, the demonism dilutes itself out of magic to myth, to mysticism etc., the beings become more and more physically interesting, as tools and utensils, etc. that one must learn to use properly. There are countless tasks here, they keep getting more difficult. The pencil

is no longer just a thing to grasp, but a writing instrument. The water tap makes a noise, but one discovers that water is used for cooking, etc., and that the tap is turned on and off for this purpose. One also discovers that the sounds are specifically proper for individual objects; they cease to be "the demonic voice" that sometimes appears here, and sometimes there, magically identical and magically transformed, and thus have to be chased after.

The patient is different: she has got stuck in primitive demonic thinking and as soon as they "speak" she has to take the magic away, especially from domestic things, by touching them (early childhood environment); she has no other use for them – "in principle", i.e. as long as the sick reflex systems are at peak function (and with gradually increasing hypertrophy they are in this state "almost always", so that she even has, for example, no time to sleep). Now and then higher differentiated reflex systems are at peak function, then she can deal with the things whose demonism she just knows, and always has to be on guard against, using various sorts of ceremonial. How can she get dressed when her underwear already touches her and rustles? First of all the countermagic "touch it yourself and make it rustle" must be used, but it's already rustling somewhere else – one dare not even move – a "real devilment" that one has to battle for hours on end, and never overcomes, until the spook stops (the intensity of the sick reflex reduces), or a "higher power" inserts itself, exercises forced compulsion, and takes over the responsibility in the name of the patient (mother drives the "lazy thing" out of bed). The patient worked for years in her father's office (higher differentiated reflex systems), it went tolerably well, she was away from home; then, after all, away from mother, who she depended on with all hatred; even with strangers she could "think the magic touching" and thus stop the actual touching of objects, so that her "oddity" usually went unnoticed, but she always had to be careful that it was not noticed and that her secret was not found out, and that consequently her demonism was not removed. For a long time she has not been able to do her office job (extension of the neurosis), she arrives at the near-normal goal; on the other hand, so far as it concerns using household utensils for the purpose for which they are intended, she arrives at a goal that is remote from the normal; only occasionally (peak function of the healthier reflex systems) does something, this or that, succeed. In the essential point, she has not mastered the task of using domestic objects as tools and utensils. Actually, the typewriter was also, for her, only a thing to be touched – like everything else, including the penis of her "lover", with which she played all sorts of crazy games; it was always a matter of touching as a method of magic and, consequently, a matter of demonistic deprivation of power.

The *work neurotic* of every type "plays work". The sick working reflexes are early childhood play reflexes, hypertrophied and aged. So far as he is sick, the patient has not mastered the task "work" that the healthy child meets more and more in the course of evolution, and grows towards, and to the extent that the patient is higher differentiated and, consequently, has learned to work, his work carries a more or less playful note. To the extent that the work tasks can be "settled" as playing, the neurotic can reach the near normal target; these are the simple tasks that take place mechanically

(via the cerebellum). Higher tasks that place more demand on the cerebrum are "settled" nearly normally (performance with too much effort) or far from normally (work avoidance, work abstinence) according to the direction of the experience axis, but always compulsively, as a drill, in a fixed method; for the neurotic, his mechanical-motoristic counts as the only thing of substance on which "everything depends" (p. 62), and the cramp with which he carries out his "childish game" can impress the layman with its outstanding, and even unique performance. This also holds true for cases where hypertrophied and perversely connected genic reflexes take their course in the middle of work reflexes; here, the confusion is especially great to the extent that love activity occurs in the work area, where it has no business to be, and thus as a task and the performance remote from the normal.

Courting a girl has to be learned. The 28-year-old patient has not mastered this task normally, but pathologically. He is, to the extent that he is genotic, a baby-infant, does not yet know anything about two sexes, for him the "women" are "beings with skirts, higher voices, etc.", as once the first "women" were mysterious ghosts that one "must" have dealings with only under the maintenance of self demonism. The patient suffers from severe ("intractable") love hunger, but he runs around the girls in wide circles, and away from them when they're there (hypertrophic hunger and anxiety reflexes); he is a "girl-hunter", he chases them away, he reaches a far from normal target: the loneliness, perhaps he will meet an also-lonely one there sometime. Another one approaches the girls, dances with them, goes with them, etc., but it stays at that; he solves the task "dancing" almost normally (just as the little ones also dance and go with each other); he avoids the higher task "courting"; far from normal performance.

c) Thinking tasks

("Thinking" in the sense of "conceptual thinking".)

The conceptuality of the neurotic is also layered: the sick areas are infantilistic, hypertrophied and aged early childhood thinking, the more differentiated areas are nuanced in a sick way. The thinking tasks are of course individual, but in every case, to the extent that they are sick, "general" in the sense of chaotistic-magic, and to the extent that they are higher differentiated "generality-containing".

Square and Point (p. 74). The patient, 30 years old, a virgin, borderline schizoid: schizophrenic, lies in bed till noon and "thinks", i.e. "sees with the inner eye", thus conceptually a big square, in this she draws a diagonally smaller one, and in this too a smaller one, and so on, till the last square is so tiny that it is doubtful if it is "still" a square or "already" a point. This game of thinking that rather reminds one of "squaring the circle" repeats itself progressively, "leaves her no peace". The patient becomes very cross (like the little child that is disturbed at play) as soon as mother "provokes" her to get up and help with the housework: her thinking task is just far more important, it is even the only important thing, "she has recognized that for ages

after the gibberish of school homework and of philosophies". In this, the patient has not surmounted the early infantile time, where sensorial and then also conceptual shapes began to emerge from the chaos more and more outlined against one another, separated themselves to round-square and straight, and yet changed into each other magically over the point, briefly, in which the problem of round and straight appeared; the later multiplications, joining and separation of round and straight, the various shapes of beings in this regard, and also the two sexes, where only evidence of the ubiquity of the basic problem, the "world problem", the unique problem. This had to be solved, i.e. its demonism had to be banned, it had to be governed, to make straight for round, the point from the square, and thus destiny, life and death, being and fading away in one. According to conceptual hypertrophy, interest in sensory objects had already diminished at an early stage, "everything amounted to the one riddle whose spiritual quintessence she had thought up as the only one". Thus she had to brood and brood, but she had revealed her secret to nobody, and nobody was allowed to disturb her when "the spirit visited her" and she saw the "unique-eternal". Only after the conceptual hyperfunction had diminished could she act "secondarily" as a "secret, veiled philosopher" in the household, but such a task was really unworthy of her. She was not able to solve the central task, and thus completed it far from normally. She repeatedly broke off her brooding in doubt "whether this was a point, then", and so she had to keep on beginning again from the beginning. She solved other household and thinking tasks near-normally (she was fond of reading books on popular philosophy), with more or less significant nuancing towards the main problem, with underestimation and devaluation in face of this. The trophic and genic tasks concerning sensory objects were also unimportant for her. In the trophic she performed the routine tasks near-normally, she was unable to do finer work, in the genic she had experienced puberty as "spiritualized" (as "internal elevation", "only now did the sun rise" after a dentist had looked into the mouth of the 14-year-old girl, found her teeth to be good and thus had declared the girl "to be mature"). Sexuality was "uninteresting" "sublimated" ("one can think all that"), connected to the square-point problem and essentially locked into it (vulva-clitoris-penis, "spiritual" masturbation), the sex was completed far from the normal.

Dogmatism. In the chaotic experience, in absolutism, there are still no contradictions, and thus still no rights and wrongs, no differences in justice, they are still implicated; the all-oneness is also the rights-all-oneness, absolute justice is identical with absolute lack of justice. With the beginning of individuation the rights-all-oneness has passed away, the I and you, each with their own justice or injustice, the ethical problem in primitive early stages appears for the first time; then it differentiates itself more and more to the many individual stages of moral, legal and religious areas, each with their own norms, finally, to the legal regulations, and maxims of the adult, up to scientific jurisprudence. The tasks that the child normally has to master, and masters in steady and sometimes critical increase-elevation are thus thought of as legalities too – in the relevant appropriate unclear way; thus, personal attitudes are compared with those of other human beings (older, younger, male, female, healthy, sick, non-specialist and specialist), and the differences are described in detail as well as related to summariz-

ing and complying with the standards, namely also according to correct and incorrect, rights and wrongs, and here the teaching, regulations, judgements of exemplary people that "must know" ("authorities") is learned. Of course, in this categorical sorting of the tasks, the methods and means of solving them, the solutions themselves and their consequences, the problem of rights:wrongs (good:evil, etc.), namely, the question about the essence, remains, also in the final dilutions of the demonistic interpretation (the rights standards as a metaphysical principle, etc.), until these doubts also find their end in the realic perception of the world. At all evolution stages the healthy person solves his rights-tasks in a healthy, normal way.

The rights neurotic, to the extent that he is ill, has remained mainly in the early childhood stage, at the stage of rights-all-oneness and, consequently, all his higher differentiated tasks, all their rights descriptions including judgement are nuanced according to this. He maintains his rights-all-oneness, his sole right "at any price", "under all conditions", "cost what it may", "inexorably", "without compromise" against anyone that touches them, whilst he also wants his rights, and thus could (magically) destroy them. He deludes himself (if not in these words, then in his symptomatic behaviour) to be the "rights principle", the outer-worldy world justice, the all-justice, that knows, gives, decides, disposes all rights, whose decisions are therefore always, without exception, at least one hundred percent right, even when "the others" declare them to be wrong, although he himself is, in principle, in doubt whether his all-right might not necessarily also contain the all-wrong in itself, as the all-good contains the all-evil – or whether both demonistic powers are principally adversaries, like God and the Devil, the godly and the devilish justice. The "rights of the others" are *My* rights ("*I* will requite") – or a deadly dangerous, death-worthy attack on *My* one-rightness, and thus all wrongs, the unique wrong that can be, and must be exinguished and deprived of power. The rights judgements of human beings (also the judges) only interest the neurotic to the extent that they (apparently or really) are also attacks on the exclusive rightness and absolute untouchability of his rights judgements. *He* makes and "makes", "everything" correctly, "absolutely correctly and right", criticism by others (external criticism) only counts for him as "justified" to the extent that it agrees with his own criticism (self-criticism), and is thus (in magical identity) his own criticism, to the extent that he can absorb it into his own right(s) absoluteness, estrange it in this way, make it his own. Moreover, it is heard away, overheard, not taken into account, "strictissime" denied, opposed away. The patient can learn nothing additional; what he appears to learn is made deprived of the new, magically levelled-out to the general, already-long-known-experienced. For him it is not a matter of really learning something but of removing the magic from the new – and he does not need to know anything at all about this – and also argues this further. He is just taboo, in a magic circle into which nothing can come and from which nothing can go out, a soap bubble that would burst at the least contact and, consequently, does not put up with this, i.e. banishes it magically. However, he just *deludes* himself that he is the only norm, and this delusion is sickness, only a sick person can regard himself and behave as all-correct, all-just, infallible – and he thus never thinks or acts normally, but more or less abnormally, at best almost normally,

never correct-right, but incorrect wrong, at best almost-correct-almost-right. The sole task of the rights neurotic, to maintain the all-correctness, the all-rightness, is, as it repeats itself in most manifold forms, never solvable – but is only "solved" in the banishing of the demonic rights claims of the others. It is not a matter of the "material" task and its solution, and by this the neurotic task and its "solution" differ thoroughly from the normal task and its normal solution.

The dogmatist "is" thus "always" right, even when and where he is wrong. If he (according to "foe" opinion) is wrong, it is just his right to be wrong, and thus his "wrongness" is de-wronged, righteously "made" right, the wrongness is conjured away from the wrong; he contradicts himself constantly, but he is concerned with being right, and he justifies all means to this end. He speaks in riddles (double and more meanings, "don't simply lay down", "always without obligation", "binding" – that is as much as magical deprivation of power); his "certain" formulations are only formalistic stiffness in the uncertain, only "subterranean" (non-actual) further talking or "supernatural" (conceptual) further spinning "inaccessible to your words". He can even admit that he may be wrong, may have done something wrong; on the one hand, all wrongness is contained in his all-rightness, on the other hand, his admission is the method used by the one who is all-right to "make" the wrong he commited right, of "getting rid of" the wrong (the evil, the devilishness). His eventual request (that is: his order) to be excused is the magic excusing of the blame, so that only the insignificant "material" state of affairs remains, and nobody now dare mention blame again (confer the magic forgiveness of sins, the tyrant forbidding a blame that somehow "lets itself be excused" to even be mentioned, etc.). In this way, the rights neurotic can and even must perpetrate "everything" wrong, without being to blame.

The task of the neurotic that is comparable with a normal task can be "solved" far from normally or near-normally – in both the sensory perceptual and the conceptual. A normal task is, for example, to learn to know normal bookkeeping relationships ("credit and debit") and to act accordingly. The healthy person completes this task normally, namely with a normal range of variation (payment dates, etc.) and also thinks normally-legally; it matters, of course, for him that a debt is adjusted in the usual way. The rights neurotic thinks differently. A, for example thinks: every debt must be paid at once, best of all in advance, before it arises, it would be unbearable for him to owe anyone even a penny, etc. He thinks nearly normally, but compulsively, over-correct, pedantically. On the contrary, B thinks: I don't think about paying my debts at all, there's time enough – and more time, the creditor can wait, it is his duty to give credit, but he has no right to compel me to pay and send me reminders, every reminder is an impudence, that one must refute impudently or sarcastically pseudo-reconsidered, etc., he will get "my" money, but when *I* will, not when he will, I don't let myself be compelled (and "compulsion" for B is already the normal reminder etc.): B thinks far from the normal, his method is also compulsive, pedantic in the refusal of the supposed compulsion, in the anxiety about every "loss". Neither of them know the normal range of variation. They are sworn into their method. Both play mine and yours, taking and giving, at the early childhood niveau,

in which the all-oneness ceases and individuation begins. Both of them de-debt the debt: A with magic immediacy of payment, B with transfer of the debt to a non-debt, namely, the obligation to a voluntary act. Credit and debit, mine and yours are thus conjured into the all-oneness, into the all-one right, into the all-justice, in such a way that the patient is the all-ruler over debt and payment, guilt and atonement. The play method has stabilized, mechanised, methodized, takes a compulsive course, "I'm used to it like this", and pity he who dares to disturb the "sacred" custom. The individual cases are all brought to the same level in this general and only valid interpretation, general considerations attach themselves, such as: mine and yours are differences of possession, but these contradict the "community idea". Possession is not community, ownership is theft, as a result, he who is called a thief by other people only restores the injured community and deserves recognition; by analogy, the creditor – is the guilty one; all remains in all and all in one, so all guilt, all debts, are cancelled, as a godhead one can take all from all and give all to all (all individualist-collectivist theoreticians and practitioners). Next come more mature rights ideas that contradict this and thus increase the confusion, but serve well to defend the sole right against every objection. Some patients keep their brain chimera secret, others express them in "opposition in principle", in bluffing, avoiding, hair splitting, demoralizing, etc. ways of talking, woven out of the wrong and almost-right in a strange way, and always out of this comes the fact that the patient has the last word and thus deludes himself that he is right. And all behaviour is staged from the spiritual, metaphysical, godly or devilish, absolute rightness norm, the holy rule, that Kant calls the "moral law of habit in me". The tiniest deviation would mean the "downfall" and must be avoided at all costs (i.e. cramped), and as a temptation, banished. But at times the breakdown comes, then one "lets" oneself go, and in this way rescues (with the arbritary "letting") the sole right. (The *moralist* neurotic and the *religious* neurotic are analogous.)

2.2.5 *Abstinence and abuse*

One can arrange the ways neurotics complete their tasks in two groups, labelling the one as abstinence and the other as abuse. Naturally, every neurotic exercises misuse, false use, abuse in the general sense, and so does the abstinent. The person who abstains from love misuses the love organs, etc. On the other hand, the abuser is also abstinent in the sense that he does not really solve his task, but (supposedly) banishes its demonism, and as a result has not attained the differentiation grade where there is a proper execution; the Don Juan and the Messalina (a consumer of men) do not have the mature capacity for love, their over-ardour is only an aged playing with the genitals, as an abstinence from mature loving intercourse. In the area of his illness the abstinent is just as hypertrophically active as the abuser, only in another way: the love-abstinent is abstinent from the comparable love task, and the abstinence is – also as routine, drill – cramped effort, further on, love-abstinence is not non-sexuality, it is a hypertrophied genic false lead (perversion); so the person who regards sexuality as a sin only sins the more to the extent that he exercises (misexercises) it perversely,

even where he cannot make the diagnosis; the ascetic is not a saint, only a fake saint, he is just as much a sinner as the abuser, only in another, hidden way that is even "less sympathetic" than the "open" abuse. He behaves as though the holy (superior, good, godly) in him banishes the unholy (inferior, evil, devilish), and can thus only be holy and unholy, saint and witch, god and devil, black and white soul at the same time, in mutual proscription – an utter nonsense like the sense of all neuroses.

For now, we use two medical terms for the neurotic behaviour compared with the corresponding normal, for the (in all respects, not genuine) way the neurotic completes his tasks that are comparable to normal tasks. The *abstinent* proceeds in *cramped avoidance*. Thus, the abstemious hunger neurotic keeps far away from the normal threshold, he goes astray and already follows a (his) false pathway at the hunger stage and comes to a false threshold, a wrong "battlefield" and to a false target; meanwhile, the wrong route is easier or harder to make, often the far from normal threshold is more difficult to cross than the avoided almost-normal one, sometimes it cannot be crossed at all ("impossible tasks", e.g. walking on water, scratching through an iron plate with the finger, waking the dead, bringing the stars down from heaven, making people all agree on the same thing, making movement stand still, e.g. freezing the economy, etc.); the "size" of the task does not decide its normality, many a "big one" is only pseudo-big. The abstinent anxiety neurotic certainly approaches the near-normal threshold, but he closes his mind to it in a cramped way, turns aside or back, goes astray, and thus over a far from normal threshold to a far from normal target. The abstinent pain neurotic reaches the near-normal threshold, but fights in spasm *against* it and then breaks into the false pathway: draws back, gives up, renounces painfully, is beaten back. This anxiety and pain-neurotic behaviour is especially meant by abstinence (in the narrower sense), but one could not specify it, and a virtue was made out of necessity.

These abstemious people are schizoids, the cycloids complete their tasks, but the sorrow neurotic does this with too much sorrow and the joy neurotic with too much joy expenditure (too dully or too smoothly), and to that extent, not genuinely. Thus, they are not abstinent. The ways they master their tasks are to be labelled as types of abuse: the sorrow neurotic exhausts himself in shattering to pieces, making small, the joy neurotic revels in completion, enlargement. But the cycloids can also land in a sort of abstinence, so that after a bad experience the sorrow neurotics give up sadly ("it will all come to nothing anyway"); sorrowful loss of courage, the joy neurotics "are fed up with the permanent success (apparent or real)" and "do not raise another finger". In these cases, memory of the similar lived-through courses connects itself to the abnormal sorrow-containing or joy-containing hunger stage, while the sensory behaviour remains inactive or stuck at the hunger stage, and runs "into the sand", i.e. into inactivity. These cases are to be differentiated from the mixed neuroses, where there is schizoid abstinence, and, in addition, a sorrow or a joy hypertrophy.

The *abuser* masters his tasks (i.e. those that correspond to a normal task) as a *cramped conquest*. He overcomes the near-normal threshold directly or indirectly with too much effort (with detouring, creeping round, outwitting) and arrives at the near-normal or far from normal objective according to the further direction taken. The hunger neurotic "manages it" with too much impetus, the anxiety neurotic with

too much (anxious) inhibition, the pain neurotic with too much bother, the sorrow neurotic with too much indolence, the joy neurotic with too much swing. The hypertrophic anxiety and pain functions are particularly characterized by overexertion, but one can also label all overfunctions thus. The abuser overexerts, undertakes too much; in doing this he performs badly or at best usably. He is in no way better-off than the abstinent, and often worse (e.g., the drunkard). He too makes a virtue out of necessity, and often receives undeserved recognition.

In a specially determined sense, one speaks of abstinence as the characteristic of behaviour in primary or secondary *hypofunction* of the hunger reflexes. In primary weakness of will the experience does not surpass the – just weak – approach, and the task is not taken in hand at all. Hypertrophic hunger is not to be confused with the abnormal anxiety-containing hunger of the anxiety neurotic or the abnormal pain-containing hunger of the pain neurotic, etc. The types of abstinence are correspondingly different. The secondary hypofunction is catastrophic (breakdown) or atrophic; in both cases the patient no longer wants to do, or can do, what he wanted to do and could do before, but the broken-down want-person (fanatic) is still cramped, and sooner or later (depending on the specific functional periodicity of the sick reflex systems) the hyperfunction passes over to hyperfunction again; in contrast, with the atrophic hypofunction the cramping decreases. The patient gradually becomes "quieter, older", although the remnants of the fanaticism still make themselves felt; not infrequently, fairly often, the breakdown is the beginning of the atrophic hypofunction, the patient "does not recover any more". The other species of neurotics also experience their breakdowns periodically, and can pass to chronic hypofunction.

This type of abstinence is to be distinguished from abstinence as a hyperfunction. Naturally, during the hypofunction, neither the abstinence nor the abuse of the hyperfunction can be performed any longer. The abstinence in hypofunction is also to be distinguished from the abstinence that can appear in the changeover from a sensory neurosis to a conceptual neurosis (also after previous abuse); here, the sick association framework changes its structure in such a way that the innervation of the sensory muscles more or less switches off from the sick areas, and these muscles are correspondingly inactive; as a result, the neurotic experience takes its course mainly in the conceptual as compulsive thinking, such as mentioned on page 135 in "abstinence of the cycloids"; the previous abuse has, one could say, become conceptual. An anologous abstinence = inactivity also occurs where there is predominance of the sick autonomic functions with switching off of the sensorium (cf. p. 101). Here, a "thought abstinence" can also take place as "absence of thinking" (e.g., in neurotic anxiety to think, avoidance of thinking, of the thinking tasks and of knowledge as the deadly dangerous demonism, etc.). "Thought abuse" is the hypertrophy of conceptuality, on the whole, or particularly the cramped overcoming of the thought tasks.

One can also finally characterize the function disturbances in the *hadroses* as abstinence and abuse, e.g. the dietetic abstinence or the dietary sins of the gout patient. Here, we only discuss the abstinence and abuse of the neurotic as hyperfunctions.

Usually *sensory* (sensory perceptive) attitudes are described as abstinence and abuse. The system-genetically autonomic dysfunctions appertaining to each

are also meant by this. Thus, in the meat abstinent for example, one can find special *autonomic* dysfunctions, e.g., in the stomach, with alterations of the secretion of juices, their quality and quantity (pepsin-hydrochloric acid reduction, etc.), thus dysfunctions "in the sense" of meat abstinence; in meat abusers pepsin-hydrochloric acid profusion, etc. (the doctor orders the appropriate corrective measures in these cases, horizontal therapy). Further, the corresponding dysfunctions of the intestine are related and "express" themselves more or less markedly as constipation – abstinence and diarrhea – abuse. If one does not want to also label the autonomic dysfunctions as abstinence and abuse, one must nevertheless speak in general of misuse, false use, of the internal organs. There is no abstinence and no abuse without corresponding autonomic dysfunctions, i.e. in every sensory neurosis internal symptoms are also found; they may, of course, withdraw behind the external compulsive symptoms, but they are certainly there, and their presence can be proved by the specialist. The analogue remembers his sick sensory experiences and thus commits abstinence and abuse conceptually, in conceptual neuroses, in such a way that he remains mainly within such sick associations of ideas to the extent that he is sick, the corresponding sensory perceptual processes being more or less absent.

Abstinence and abuse are counterparts. Depending on the extent of the neurosis, both are *more specialized* or *more combined*; they can be limited to one area or be spread over several areas. The patient can be abstinent in *one* area and an abuser in the *other*. The behaviour *alternates* according to the intensiveness and extensiveness of the specific functions periodicity of the sick reflex systems; they can also function around "medium" (pseudo-normal) behaviour.

Examples:

Patient G is a vegetarian, a meat abstinent, but from time to time he also cannot stand vegetables; he loses his appetite, almost to the extent of complete nutritional abstinence that lasts for a shorter or longer time; in addition, stomach-liver spasm, persistent constipation, etc. – and drug abuse. *Each spasm eases periodically*. The neurotic nutritional abstinence (see hunger strikers) cannot be accomplished (hunger death is an anatomic illness, hadrosis), in the end, the constipated person still has emptying, even if insufficient; the kidney-cramped person still passes a certain amount of urine through his urinary passages, although he may also deposit a large amount, or even the greatest amount internally (damming-up, swelling, e.g. as pseudo-gout), or may sweat it out. The unreal "if the constipated person does not take laxatives he will never pass a stool" or "if the kidney-cramped person never took a diuretic he would die of uremia", etc. is – unreal, a case of unreality. *Nobody dies from* (pure) *neurosis*. The medical measures named give no explanation of the periodicity of the neurotic functions, they "efface" them much more; they are horizontal therapy, and ease the complaints temporarily, and are correct to that extent, but vertical therapy is better (cognitive therapy), with which the cramped functions normalize, so that the complaints no longer appear.

Patient H is abstinent as regards meat, alcohol, coffee, tea, tobacco, sometimes about butter, he is also love-abstinent, his genital reflexes, whose expression would be courting and sex, are perversely connected to work reflexes, so that he is a work fanatic; he "always" works, never has time, never has any peace, is "always" stressed, and stresses others, his way of working is a dark action of violence with sadistic content, the greater part of his "work" is idling, business in small general tasks (primitive "guidelines"), higher tasks are completed in the way of abuse, but it also happens that he fails in them in anxiety about his own courage, and is abstinent. In addition, he also has significant internal complaints. Also, he praises his ascetism, which he thinks is the only thing that enables him to carry out his "unique" performance (banishment of the deadly dangerous demonism of work, etc.), people must be eternally grateful to him, and there are also persons that admire him.

Patient J is an nutrition abuser, stuffs everything into himself pell-mell, hungers neurotically (like the infant trying "everything", drinks-eats "everything", only hypertrophic and aged), the qualitative and quantitative differentiation of meals has not developed properly - similar to the anxiety neurotic K, who eats "by visual estimate", and also does not know what and how much he should eat, and needs the "omnipotent rule": a milder abstinence. Patient L exercizes alcohol abuse with little food requirement, he "drinks" himself full (analogous to the baby). Patient M is a quarterly drinker: periods of alcohol abuse alternate with periods of "strictest abstinence", with "sacred rules: never again a drop..." etc. The alcohol abstinent is alcohol-sick, like the abuser. Patient N is "really" a vegetarian, but socially he also eats some meat "so as not to be noticed"; the intensity of the abstinence reflexes consequently sometimes sinks so far, under certain circumstances, that performance of the otherwise avoided tasks takes place "tolerably well", i.e. with "slight inhibitions", the anxiety about losing face is greater than the anxiety about meat. Patient O is an alcohol, milk and water drunkard, he drinks what comes in front of his mouth "in large quantities", but preferably milk, solids are "liquified" with a lot of fluid. (See also p. 70)

Patient P, 29 years old, is coitus abstinent, but masturbates excessively, one can say: masturbation abuse, but it is not the normal task of the 29 year old to masturbate; to that extent, "abuse" here only indicates the excess and the inappropriate. Similarly with patient Q, who is marriage abstinent, but a coitus abuser, Don Juan, Patient R is sometimes work abstinent, he has "women on his mind" the whole day; from time to time he "turns himself round", works night and day, "knows no women"; at that time the work reflex systems are in prefunction, no longer the hypertrophic love reflexe systems; the patient suffers from work addiction with anxiety about not getting enough done (i.e. not "everything"), just as he suffers from love addiction during the "debauched time", and anxiety about not getting enough done (end of omnipotence), and so forth.

"With the best intentions in the world" patient S cannot find work; he is work-hungry, and runs around the entire day, but he pursues the false course, a course that does not lead to work, that leads around work in wide arcs, and runs out "into emptiness"

somewhere or other; S is work abstinent in this way, his "work" is the search for work, he is not to be confounded with the vagabond who travels through the world in hypertrophic distance hunger with non-actual or hypotrophic work hunger ("does not want to work"). Patient T is work shy and work abstinent in this way: in anxiety about work, he decamps in front of it, etc. Patient U certainly comes to work, but he fights it, defends himself against it, throws it away as soon as he can, "chucks it", is a permanent striker, complains about "wage slavery", the businessmen, who "are all bloodsuckers", is a "class warrior", etc.: pain neurotic work abstinence. Patient V complains: there is no point in going to the bother, I am pursued by misfortune in any case: sorrow neurotic abstinence. Patient W mocks work and workers and is "happy" in his indigence: joy neurotic work abstinence. One can compel such patients to work, then they simply do forced labour, like machines, mechanistic, at best useable, especially in serving machines which are not concerned with "who presses the button"; habituation to the compulsion, the routine in the forced labour should not be confounded with recovery of the work-sick, and not with healthy, real work. The work abuser overruns the work "leaves himself no time" (hunger neurotic), or overexerts himself hesitantly-carefully (anxiety neurotic), or meticulously, pedantically (pain neurotic), or performs it indolently and piecemeal (sorrow neurotic), or takes it too easy, is careless (joy neurotic).

Every task presents a *risk*, the healthy person accepts it, the profit is normally larger than the loss, has a certain relationship to it. The abstinent does not take the risk; the hunger neurotic holds himself at a far distance, does not know it at all, the anxiety neurotic avoids it, the pain neurotic defends himself against it, the sorrow neurotic renounces it tiredly, the joy neurotic mocks it. The abuser certainly accepts a risk, but the relationship of investment and profit is abnormal: taking the possible equal profit into account, too much is risked, everything staked on one card, inconsiderate and brutal (hunger neurotic), or reckless and "great" management at random (joy neurotic), ("I have everything and nothing to lose and to win", p. 111) - or it is risked too little = risk "nothing", too careful, pedantic, ponderously operated (anxiety, pain, sorrow neurotic) – hazardously in any case. The abstinent protects himself, is stingy with himself and his property, gives "nothing" away, the abuser spends and abandons "totally", dissipates himself and his property; both of them maintain their chaotic-demonistic all-oneness, integrity, all-nothing-possesiveness. The love-abstinent avoids the risk of love; "at all costs" the Don Juan "must" possess "*the* woman" who is "set against him" magically transformed into the individual female characters, "must he" overpower the demonism of the woman, humble the woman, whether in love-lust (type masher, who chases or chases off the "women"), or in anxiety about a defeat with prowling, treachery and cunning, or in sadistic attrition and violence, or as a lover begging pity, or as a favourite who "the women run after", etc.

According to his experience, the "task" of the abstinent, as well as that of the abuser, is to ban the demonism of the task that is comparable to the normal task, and of those who set them. For this, he can naturally only name the physical task that he carries out abstinently or abusively; he can describe it more or less extensively – pragmatically, ethically and aesthetically, he can speak *expressis verbis* of allpower,

providence, fate, magic, wonder, demons, etc., or use words of diluted demonism, like God, soul, spirit, causality, energy etc. – the world perception sense of his behaviour, whether he knows it (*in nuce*) or not, is always to ban the enemy-demonism that represents itself as the "essential" in the physical, namely, to avoid or overcome the task and its representatives "absolutely"; only in this way can the neurotic defend the all-oneness, the all-demonism, the uniqueness and singularity.

2.2.6 *The neurotic habit*

With periodic thrusts (crises), all evolution takes its course constantly at lower and higher speed. During the relatively slow evolution tempo, experience and description alter relatively little, so that we speak of "states" and "habits": one has reached a certain sphere of life, and remains in it for a while with scarce or little noticeable alteration, until – purely biologically – a new evolution acceleration begins, the habit is deserted, the transfer to the new sphere is completed, where one becomes at home again, settles down, acclimatizes. All evolution is a continuous departure from habits, and acclimatization to new circumstances. Each of these forward-moves, forward-steps is a hunger-anxiety-pain-sorrow-joy series, the performance of a lighter or more difficult task; so the healthy person also "hangs on" to his habits, he hungers for the new of course, but then he has anxiety about it, must wrestle himself through, has sorrow about the loss of the previous, and finally is joyful about the objective attained. "*Habits of life*" are those habits that correspond to the principal structure and function of the individual, and thus stay principally the same at each stage of evolution, e.g. somebody is accustomed to get up early, from childhood.

The sick person has a layered evolution front. His habits are formed accordingly. In the sick area, an evolution *from* the infantile level does not take place at all, there is no vertical evolution, only a development *at* the infantile level, a horizontal development, a hypertrophy, an excrescence. The sick habits are accordingly retained, even with aging. In the healthier and almost healthy parts of the sick person, the habits alter themselves up to the differentiation stages attained, but they are nuanced towards the central habits and also made stabilized in this way, so that every change to other habits is more difficult than in the healthy person, and the more difficult the older the patient. In accordance with the, in principle, constant structure of his evolution front, the experiences and descriptions of the neurotic remain, in principle, the same, are series that become *experiences* (experiences of life), and keep on confirming the neurotic in his thinking, doing, and perception of the world. He refers – from his point of view he is right – to his experiences, but they are only those of a person with a sick world perception, and all lie together in the pathologic. He cannot – in contrast to the healthy person – accept alien experiences in the least, and cannot accept the least of their messages, i.e. as something "else", "new". The neurosis always confirms itself - as it always disproves itself. The patient experiences everything new as a demonistic attack on his all-oneness, as a fatal disturbance of the habits running in the all-oneness, as an attempt to destroy them, and with them the all-oneness, the chaotic-magical existence; accordingly, he "must" deprive the

new, as the enemy-demonism, of power, de-new, absorb it into his all-oneness, and only to the extent that this adjustment and assimilation into the habit is possible can he "accept" it; the "rest" does not exist for him, he learns nothing from the experience of others except for one thing, that for him there is nothing to learn. This de-newing of the new consequently turns the new into old, habitual, known: it is seen only as "another" manifestation of the enemy demonistic, with which the patient deludes himself he is in perpetual, i.e. demonic battle. Depending on the type of neurosis, the de-sorcery of the new to the old is nihilist, negativist, severist, pessimistic or optimistic. Accordingly, every neurotic sticks "inexorably", "without compromise" to his habits, defends them in an extremist way with the ways and means of his neurosis, is ultra-conservative (conservativist); also, the hunger neurotic, who is curious, addicted to novelty, always on the hunt for the new, in maintaining his inviolable habit, his untouchable all-conservatism that destroys (nihilises) everything new, and thus turns into chaos. Everything has to remain as it is.

Naturally, the patient cannot help holding onto his habits so stiffly and tightly: they are just marks of his pathobiologic structure, and can only change with this. The "bad habits" (customs) are as little the effects of a demonistic will or a demonistic weakness of will, etc., as they are able to be overcome through "firm will", "self-discipline". The insight that the sick habits are "nonsense" is not a means of removing them, it is only diagnosis (p. 103). Self-compulsion (also in the form of self-warning, self-accusation, etc.) is symptomatic in itself. Autotherapeutic considerations, e.g. "that must change, I must manage to do it to come out of the misfortune, I must get over the sickness" etc., in no way change the sick processes at the biological level. The trouble taken to observe healthy people, and do as they do, belongs to the neurosis, and the neurosis cannot free itself (from the neurosis) with its own ways and means. Moreover, the sick person can only observe healthy behaviour in his own way, namely, sick to almost healthy; he simply cannot find out what the healthy behaviour really is; it is outside his world. At best, he can train imitative behaviour, with a drill, an automatism, but this behaviour is also sick, never healthy, even if it may be serviceable. This sort of concern with the symptoms, that one enumerates them, describes them to the last detail, compares them, etc., namely, the pursuing of a sort of symptomatology, or trying to deduce them from history, and so on, leaves the symptoms, the sick habits, untouched – the same as the diversion that is itself compulsive, e.g. the resolution not to think about it any more, to act as though one were healthy, as a compulsive concern with other things, and so forth.

The patient is also habituated to his habits, not unusually in such a way that he does not count problems as such any longer at all, he "doesn't" know it any other way", he cannot imagine that one can live differently - and especially himself. Some are trained into their problems and see them as a "victory over oneself", as "self-conquest" to bear them without grumbling. Some "feel perfectly fine" at their stunted level of life, which is also reduced in otherwise excellent positions in life, but "being fine – well" is only being accustomed to the cramp, to the incapacity that glitters with "voluntary, heroic" rejection. Some indulge in tacit endurance, which they believe to be the highest form of self-sacrifice (afflictions à la Job, etc.); some are vainglorious in the description of their "afflictions". How could it be if it were different from what

it is! "The illness is my lord, I am its slave, but the fact that I subject myself to it patiently means it has no influence over me – so I am its lord". How could I get along without my customary sleeping draught, my alcohol, my morphine (etc.), how can I sit in the theatre without my inner trembling, how could I exist without my "marital crisis", without the beloved enemy, etc.! The patient can constantly say to the marital partner: I will never get used to your habits – and thus show that in his protest he is accustomed to his custom of protesting. One can also learn to love the yoke that presses and suppresses, one is "born" to the yoke and has an indispensable subjection to it; one can become so accustomed to the yoke that one (sometimes) "does not notice it": it is present, but "deprived of power". One can "train oneself to forget the problems": but then they are only "thought away" (and thus "banished"), not healed problems, periodically they will be more intensively actual. Patient says: they push into consciousness from the unconscious, break through, paralyse the will, etc. Finally, it is the destiny of the unique, the "holy" (chosen-accursed), to bear such an illness, no, *the* illness, *the* suffering, *the* malady, the all-illness (magic: one = all), for which there is no help and "dare" be no help. "I am not a human being any more" the patient complains, with a sort of satisfaction; well, then he must be a sort of being beyond the human!

It is just as unlikely that the patient can abandon his habits through the "power of the mind" (Kant), of the will, through self-compulsion, gymnastics, going walking, recreational trips, taking the waters, medications, meditation, relaxation exercises, etc., (can haul himself out of the swamp by the seat of his pants), as it is unlikely that is he able to give them up through compulsion by others, with advice, urging, encouragement, prescription (bidding and forbidding), distraction, protection, hypnotising, analysing, detailed case history, vague theorizing and dogmatizing, etc. The patient cannot compel himself and cannot be compelled to be healthy or become healthy: compulsion does not heal compulsion. Suggestive methods cannot make the least contribution to the balancing out of the evolutionary difference, the stratification of the evolutionary front: the stratification remains as it is; only within the stratification, namely, within the morbid habits can certain readjustments be brought about (symptom displacement), but they remain at the previous level, even if they temporarily become more or less latent. Methods such as beating and other punishments also do not stop bad habits (naughtiness), at best they change them, i.e. under the circumstances of "punishment" reorganization can take place, e.g. in the direction of "drilled-in being good" or in the direction of "greater care", depending on the biologic structure of the patient, and consequently also its capacity to alter.

Horizontal therapy takes account of the layered evolutionary front, namely, the habits of the patient, and can and will only make the problems milder, without approaching the illness itself. It actually deals as though the patient could remain ill, and at the same time become healthy. Like the habits of expression of the patient, the habits of thought remain unaffected as regards niveau; at best, it attempts to install corrections alongside the sick thinking, and has to experience that the patient only accepts the things he can ingest into his sick thinking, that is, he does not properly learn something in addition, but remains in his habits of thought and defends them against all "attacks" with all the means of the neurosis. For him, the habits of life

count as "the (magic) life", as the only possible method of life. It is completely pointless to adjust to the level of the neurotic, to debate, to "play tennis", to advise him, to teach him, to challenge him, that he ought to think and act in a healthy way: of course he cannot get out of his skin, his cage, that is he cannot get out of his habits of thought: he is simply ill, he can only accept what he already knows, what fits in to his sick thinking; in this process his knowledge may increase, but his thinking remains sick; he can neither think nor express himself, nor hear, nor understand, nor accept in a healthy way. It is not possible to speak reasonably with him. "What is the point in teaching wisdom to a fool, so that he remains a fool". His false logic is unapproachable for normal logic. Despite every human analogy his world is quite different from the world of the healthy, and can only contact it in the (almost healthy) fringe areas. But this does not exclude the possibility of cure; the therapist must only want not to instruct and teach the unteachability, but to remove it.

The *vertical* path of healing is the departure from the sick habits, the biologic process carried out in cognitive therapy. Here, the habit and the symptoms are not attacked as such, but their world-perceptive sense (= false sense) is demonstrated. An appeal is not made to the sick human understanding as the healthy one, but the world-perceptive characteristics and deviation of the sick experience and description are simply demonstrated according to the facts – the only sort of enlightenment where its insufficiency, *nolens volens*, eases and gradually vanishes; "an operation is carried out on the world-perceptive principle". This is the basic difference between the vertical and horizontal methods.

The point of attachment is completely different. The patient is not lectured on how he "should do it properly" (as a sick person that is exactly what he cannot do); instead, in the form of world-perceptive teaching, he experiences that to the extent that he is ill, he is moving in a chaotic raw-demonistic world, and thus that he is fighting with enemies who, in reality, have as little existence as the all-oneness, the self-demonism that the patient deludes himself he is able to and has to maintain. The patient is not given opinions, points of view, suggestions, bidding and forbidding, instructions, etc., that one can dispute, but simple biologic facts that one cannot argue about, but only learn to recognize and accept. That 2 times 2 equals 4 is a fact that one cannot subject to dispute and argument; it has to be recognized and accepted by anyone who wants to learn to count properly; there is no dispute about grammatical syntax and its characteristics; it is a fact that has to be recognized and accepted by anyone who wants to express himself properly. The world-perceptive facts the patient is getting to know are of this type, and towards which he orientates himself in the path of re-examination; the symptoms are only discussed in this world-perceptive sense; they are described in the exclusively appropriate way (primitive-demonistic, chaotic-fairy-tale), translated into words; thus, it becomes clear to the patient that he experiences and acts (behaves) as if he might have to maintain his allness against enemy demons, his all-power against hostile magic powers, his world against the hostile world, and as if exactly this banishment is his world task, his world problem. The cognitive therapist does not "fight" with the patient, and also not in the field of his symptoms, and the resistance that the patient "must" show to the therapist, like other persons in authority, that is as deadly, dangerously experienced magic beings,

is scattered to the winds and disappears the more the patient recognizes that the therapist is simply only showing him (checkable) facts, and does not "want anything" from him. As well, the student is also not there to argue with the teacher, of, for example, French, but to learn, and the conversation is normally beneficial. Cognitive therapy is just as little a grey theory as language teaching; it is living practice. It is the practice where the patient changes on his own from his world-perceptive fog, his delusion, his doubts, to realic clarity, and thus "unlearns" his sick habits in an evolving way.

2.3 The recovery task

2.3.1 *The horizontal and the vertical task*

Recovery belongs to the illness; it takes place in the course of circumstances that one calls "therapy" or "treatment", with the therapeutic materials and functions in adverse partnership with the sick. Every wave is a hunger-anxiety-pain-sorrow-joy series with predominance of the hypertrophic stage or stages. With regard to recovery, the series is described as hunger (will) for recovery, anxiety before the threshold of recovery, pain as the fight for and against recovery (crisis, painful struggling), sorrow as exhaustion after the struggle (reconvalescence), and, finally, joy as the completed recovery, joy about the target reached. Also here, the pain or (sive) threshold stage is the task, namely, the recovery task.

The *horizontal* course ends in a more or less farreaching approach to latency; the patient retains his sick reflex systems, their function rises periodically to new waves, the patient remains in his sick habits, including his habits of thought, his chaotistic, raw-demonistic world perception, where "the illness" is fate, life-death demonism, that the patient must ban with his own demonism, strengthened by the magic of the doctor and his methods. The patient takes the therapist into his service in this way: he "lets" himself be treated, takes over the demonism of the doctor, who he regards as an authoritative being, as once his father was, against whom he also must defend his all-oneness.

The neurotic can, of course, also only experience the recovery task, and the person who presents it, according to his neurosis; nihilistic, negativistic, severistic, pessimistic, optimistic. He cannot be healthy with the therapist and sick elsewhere; much more often his symptoms are particularly actual with the therapist, as the "great magician"; of course, the symptoms often blur or are displaced owing to unintentional or intentional personal or drug etc. suggestion, with which, in the latter case, are associated the pharmacological and other consequences: In this way, the therapist is magically destroyed: he "can't do anything", his methods do not work at all, one must look for "the right one", run from one to another, complain and question everywhere – and find that none of them know anything, none can help, and that it is pointless to go to a therapist at all, one simply has the all-illness, that one has taken to oneself as Saviour, and for which there is no help. Or the therapist is negated; one is

refractory-obsequious, one goes to him "armed", "loaded with all rejection, all prejudice (prejudgement)", unapproachable, one scarcely hears, and misunderstands what he says, for it is not important, one only goes to him (knowingly or unknowingly) to confirm medical incompetence and thus maintain the all-oneness. Or the patient cramps – fights with the therapist; is resistant-obliging in a constant fight with him and his prescriptions, reasons in all directions, vilifies him and to him, etc. One can stay "true" to "his" therapist out of comfort, in anxiety about a change to a new therapist, or out of the habit of having him as a suitable opponent to fight; others run from therapist to therapist in anxiety that the therapist might "recognize" them, find out their "secret", or in concern to "finish off" one enemy demon after the other. Or one remains "true" to his therapist in the pessimistic opinion that all is lost in any case, and it is really useless to take any more trouble; the therapists are all the same anyway. Or one is healthy "at the flick of a wrist", or does not visit the therapist at all, with the optimistic opinion that the (over)optimism is not an illness, or, if there really are problems, that they are insignificant and really quite pleasant. Professional and friendly, occasionally also beloved, namely, trophic and genic attitudes to the therapist are floating in all of them, in the manner of the early infantile child; father relationship, in confusion and chaos – depending on the accent on the one or the other connection and always with hypertrophic demands.

The recovery process in the *vertically* directed course is completely different. It is, of course, also a hunger-anxiety-pain-sorrow-joy series: the hunger aims at lasting healing ("I want to be completely healthy, I'm fed up with being ill all the time"), then comes the anxiety as to whether one can manage it, what it will be like when the previous habits that were "pleasant" in spite of all the problems, because "one was familiar with them", have been left behind; the struggle with vertical progress attaches itself to this, namely, the overcoming of the recovery task, after the struggle the patient is exhausted in a sort of reconvalescence, and finally moves into the joy in the completed recovery. This is the total course; it is composed of many individual series. The vertical therapy of neuroses is *cognitive therapy*; it is a tough, matter-of fact method, and it presents the most difficult task, which the patient has to complete if he wants to become really healthy. "Leave the previous habits of life! Give up the previous (morbid) *Weltanschauung*! Relearn in a world-perceptive way! Perceive yourself as you really are, and recognize the world as it really is! Achieve health for yourself by working for it!"

During cognitive therapy there is an increasing adjustment of the evolutionary differences by hunger-anxiety-pain-sorrow-joy series. The recovery work in the narrow sense is the solving of the recovery task (namely, the pain stage), the struggling for health; it cannot be given to the patient as a present; he has to earn his entry into the new sphere of life; he must work himself – like the mountaineer who climbs to the peak led by a guide, like the student who reaches the class and school target under the leadership of the teacher.

The therapist cannot "treat" the patient "with indulgence", cannot "make" him healthy, and cannot become healthy "instead of him", i.e. relieve the patient of the recovery work that brings about the adjustment of the evolutionary difference precisely, the normalization of the evolutionary front. The vertical recovery work is

not in the framework of the previously customary methods and means and aims, but in a completely fresh area, namely, the world-perceptive; whose ways and means are world-perceptive clarification, giving up the demonistic to the benefit of the realic-biologic perception of the world *(Weltanschauung)*. Cognitive therapy is a therapeutic lesson that leads the neurotic to cognition, namely, to realic cognition, by means of cognition – and thus to real recovery. The internal and external cramped ways of expression (organ symptoms) also normalize themselves in accordance with the maturing of the morbid *Weltanschauung* to realic cognition, namely, according to the maturation of the sick nerve-brain functions. The question regarding the world perception of the neurotic and its answer in the framework of realic cognition, the right enlightenment about the world-perceptive sense-nonsense of neurotic thinking and acting, experience and behaviour according to the facts, is a new path to healing, it is the way to real (definitive) cure: the differentiation stage reached cannot regress again. The sick, the healthy, and the therapists must thus also relearn: that there is a way other than the customary horizontal path; there is also the vertical. The way through it is simply a biological procedure, has nothing at all to do with demonism; on the contrary, cognition that "demonism" is only interpretation, fiction, and does not really exist, is an essential part of it. So far as the biologic differentiation capacity extends, so far the patient travels along the path of recovery; whether and to what extent he travels along it does not depend on a demonistic fate or the good-evil will of the patient (or the therapist), but is a property of his biologic specificity.

Everybody "does his best"; nobody can do more than he does, but also not less. The person who reaches full recovery must also, first of all, adjust himself to "the new life"; in the end it becomes "a matter of course" for him; he has not only forgotten the problems he once had, he has overcome them, he cannot even think that he "was so ill once".

Naturally, the patient can only approach the vertical recovery task according to his neurosis: he ought to grow out of the neurosis only and in the course of the therapy. He also brings his symptoms, his customary attitude, to the cognitive therapist, and also sees the father-replacement-successor in this therapist, the god-devil, the demonic lord over illness and recovery, over life and death; initially, he can also only react to him symptomatically (see above), and "maintain his allpower". But the cramp soon eases off – the more that the patient understands that the therapist does not want to "rob" him of his symptoms, does not "attack" him; so he has really no need to defend himself; that the therapist does not criticize him, neither praises nor blames him, but informs him of the plain and simple facts, and also makes no demand that the patient should believe them; in contrast, with the proposal that he should check them himself, and express his deliberations, doubts, thoughts and opposition freely. He learns increasingly to understand that the therapist *does not want to persuade* him, but *to convince* him, that he does not want to overpower him with some "theory" or other, but simply tells him the truth, that he presents him the facts that can be checked by everybody, with the submission that he should concern himself with them – exactly as there are facts demonstrated in every other instruction, and there is no perpetration of suggestions (one cannot even teach the alphabet to a schoolchild by suggestion, let alone the data of the differentiated world). He learns

to understand that the therapist is not a demon at all, does not behave as if he "could do what he likes with the patient"; in contrast, lets his simple humanity be recognized by the psychobiological facts, and thus makes it possible for the patient to recognize his own humanity and grow into real human nature. There are only human tasks, no superhuman, subhuman, no beyond the human; thus, the vertical recovery task is also simply human – and thus the cramp that "confirms" the super-subhumanity of the tasks disappears more and more, both the cramp in the attitude of the patient to the therapist and his pronouncements and the cramp in the rest of life. And all his doubts lose their validity the more they are perceived as simple interpretations, and early childhood ones at that; they are now only of historic interest, they are, so to speak, without content or objects, the fictionalism of the demonistic thinking is seen through and departs, the patient perceives that in his symptoms he is struggling with "powers" that actually do not exist, he unlearns the demonisation of himself and the rest of the world, he becomes a true and genuine person.

The cognitive therapist takes note of the symptoms, including those showing themselves in the treatment hour, and addresses the work of clarification with the first words that he speaks. He does not oppress the patient with questions, "doesn't squeeze him dry", he knows people and knows what he is about, without long speeches, analysis, etc. The patient must know that the therapist is not nosey, but only asks his questions as inducements, "tips" for the sick person to become clear *himself* about his symptoms, and their genetic and episodic relationships, and in this way obtain world-perceptive insight: the pronouncements of the patient "only" serve as an example used to discuss and clarify the world-perceptive abnormality; so there is no need to indicate "countless" symptoms and memories, the world-perceptive clarification holds good for all symptoms, and in this way the process of therapeutic evolution comes to pass not only in the area of the symptoms discussed, but also in the areas of other symptoms which the patient often knows nothing about, briefly, in the entire personality.

The cognitive therapist only interests himself in his patients therapeutically, that is professionally, he regards and treats their personalities "impersonally", factually, his friendliness is human friendliness, but not friendship, and even less sensuality, he does not "love" his patients, he can do nothing with their "love", he does not want their "trust", expecially not as "blind trust" – and he says to them clearly and soberly that he is only related to them in a therapeutic and professional manner, and that "invitations to the villa", etc. do not go with the therapy, that he presupposes no "trust", only conviction about his specialist knowledge, the "truth behind his doctor's plate" in his patients. Nobody can be cured "for the sake of" or "by loving" the therapist, and also not by the love of the therapist. The patient must learn to separate profession and love. It is not unusual for a friendly relationship to develop *from* the treatment after it is concluded,but during the treatment there is no place for it. "Official" is not "private". Whoever lets himself be tempted out of his professional attitude through "kindnesses", gifts, or even sensual advances by the patient, etc., whoever closes an eye "to do the patient a favour", i.e. renounces the necessary clarification of the facts, only shows that he knows nothing or not enough about neuroses, and has lost his chance just as much as the therapist who expresses

impatience, insult, or other excitement in word, expression or gesture (even if the patient aims at insulting and provoking him); the patient triumphs over the therapist and breaks out of the therapy (by the way, that does not mean that the therapist "has to put up with everything", if necessary, he says quite calmly to the patient that he knows of course that the sick person can do nothing for his sickness, but that in view of his experience of the poor prognosis in such cases he must refuse to continue the treatment). The therapist should neither demand nor accept "favours": they are to the detriment of the therapy (the patient refers to them, obliges the therapist to himself, requires friendly forbearance, etc., a sort of bribery). "Promises" are treated like other symptoms, the therapist does not take advantage of the "enthusiasm" of the patient. The therapist takes care that the patient is not "treating" him. Therapist and patient are not put on a par in the therapy, both are, of course, "only" people, but the therapist is the leader-teacher, the patient is the led-student; this situation does not mean ruling and subjection, not authoritative vanity and worshipping, not holy words and faith, but teaching and learning. Cognitive therapy is a socratic dialogue.

The cognitive therapist has to be exemplary in every respect, and must be healthy. The therapist ought to be married. Only fully matured personalities can practice this therapy. It can be learned. Cognitive therapy is not more difficult than a serious surgical operation, but it takes much more time. The beginner learns, the candidate trains himself, the master can carry it out.

2.3.2 *The stages on the vertical path to recovery*

Every experience is a hunger-anxiety-pain-sorrow-joy series; the hunger stage is the initial stage; without this, there is no experience. The healing experience begins in the same way, the vertical path to recovery with its hunger stage, *recovery hunger* or *will to recover*. Where there is no recovery will, there is also no recovery path. Here, the hunger is evolution-hunger in the sense of differentiation hunger, a function of the sick hunger reflex systems and thought cells that enter a delayed higher differentiation in accordance with their biologic specificity; the patient describes this hunger with words like "I finally want to become really healthy". This hunger, which is characterized here according to its direction, is different from horizontally directed recovery hunger, to which the habitual course of the illness is attached.

When vertical *recovery hunger is not present*, the vertical path to healing is also not taken. These patients do not know that such a path to healing exists at all, and should they hear about it or read about it, they simply do not consider that it applies to them, that it is necessary, they are much more of the opinion that "something like that" is only for others, and may even advise others to let themselves be treated in this way, even accompany them to the cognitive therapist, and are – particularly the relatives – astonished to experience, by chance, that they themselves need this type of treatment. They "don't want it", *they* do not want to be treated like this, they "do not understand what the therapist wants from them", "*they* do not want to be as healthy as *that*, that would be boring"; "I would have to subjugate myself to you, and I cannot do that", their differentiation is settled; they remain ill. But,

nevertheless, it can happen that (horizontal) recovery hunger takes a vertical direction if the patients hear about the possibility of becoming truly healthy, orientate themselves, make an attempt by chance. Of course, one cannot compel the patient to have vertical recovery hunger or to get it, and he cannot compel himself either. Principally, cognitive therapy works without compulsion, it only leads away from compulsion, and compulsion cannot be cured by compulsion; it can therefore not be seen as a good start in the treatment of compulsion.*

The patient must of course experience that cognitive therapy exists, it is also correct when the advantages of real recovery are laid out for him, e.g., by relatives or recovered patients: not unusually, under such circumstances the vertical recovery hunger reaches an intensity that is sufficient for treatment. The patient can also be accompanied to the therapist by relatives, e.g., if he at first has too much anxiety to come alone. But one should not compel the patient to go to the therapist; one should not bring him by force, with threats, etc.: otherwise he closes himself radically to the therapist, who he mistrusts as a "fellow conspirator", and also experiences as a compeller, against whom he sets about defending his all-power with all the means at his disposal. The patient must come himself, of his own free will. The therapist also dare not persuade him to accept treatment or "coerce" him in any way, he says: "I do not persuade or dissuade, whoever comes is welcome". But he is obliged to explain the need, the path and the aim of the treatment to the patient. In this sense, cognitive therapy in mental hospitals, where the patient is admitted more or less by compulsion, does not have a good prognosis, quite apart from the fact that the patient has been removed from the front line of life where he should work and where he should also be treated; moreover, the doctors in the institutes often do not have the necessary time for the individual patient.

Married couples are best treated together (separately, possibly after instruction together in the general psychobiologic facts). If this is not possible, there is the hope that with the recovery of one partner, whose behaviour changes because of this, the other also learns to "live healthy", without noticing it. The treated marital partner should, however, not "lecture" the other one, not want to be a cognitive therapist, otherwise the neurotic attitude of the partner directs itself against this attempt at clarification and only leads to increased dissension. Therapy is a professional matter, but married couples are in a love relationship. For this reason the doctor does not treat his own family and relatives. If friends are treated, the friendly relationship is switched off during the therapy. Profession and love are not to be confused or fused, otherwise there are false demands, disappointments, separations.

Sometimes the married partner under treatment is "influenced", or even stirred up against the therapist by the other partner (who may possibly have only just sent the patient to the therapist) due to anxiety about losing the partner and the all-one-

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* Here, and in the following, "must" does not refer to compulsion, but to necessity – as in the phrase: he who wants to reach the summit must climb up there, but nobody compels him to do so.

ness, and thus losing all-oneness itself, so that the treatment becomes more difficult or even impossible to carry out. It may also happen that the other partner "drops in" on the therapist and "gives him a piece of his mind" based on deficient knowledge, and possibly makes all sorts of "suggestions", with the desire that the therapist should turn the patient into what the other partner thinks he or she ought to be.*

If one partner in a marriage is neurotic, so is the other (sick marries sick – a biologic law of nature): he "wants" the therapist to "properly tailor" the patient to the ideas of the partner, who is certainly also sick. Here, conflicts are sometimes not to be avoided, also here the therapist must be and remain the therapist. Sick marriages almost always become better to normal in the treatment, but it also happens sometimes that a sick marriage breaks down completely with the recovery of one of the partners, and there is divorce. Cognitive therapy is not a marriage putty. Its task is simply and only to lead the sick person to recovery. Sick children come from sick parents; sometimes, in their neurosis, the parents produce open or hidden resistance to the treatment of the child they have "entrusted to the therapist". Naturally, one cannot talk with neurotics in the same way as with healthy people, and not with laymen in the same way as with specialists. Almost everyone believes himself to be at least as experienced as the specialist in such matters as "personality", "mental-spiritual processes", "character", etc., especially the neurotics, who know simply everything and are know-it-alls; the specialist must see how best to come to terms with this. "Good friends" and other would-be clever people take trouble to tempt the patient out of the therapy, and some succumb to such suggestive talk. Many doctors, theologians, etc., also believe that they are "well-up in the mind and soul", because they have studied medicine, theology, etc., and are able to make judgements about psychobiology and can "give an opinion" on cognitive therapy, although their knowledge of it is perhaps limited to the name. Here, one must often simply keep quiet.

If the vertical *recovery hunger* is too weak, the prognosis is usually poor. Such patients probably say: "If I really could live like everyone else!", but in this there is the satisfaction that they are "bearers of fate", elected-accursed only to see "the beautiful world" from afar and to overcome its magic (cf. Jesus on the roof of the temple: "Get thee behind me, Satan!"). "I would like to, but I don't have the strength" says the patient, and instead takes his tablets or pills. He would like "for the life of me" (he says) to get healthy, but at the same time – retain his illness; to work for health, to give up his unpleasant-pleasant life – no, he does not want that. It can, however, happen, if the patient turns up at all, that during therapy his weakness of will is removed, and the treatment thus arrives at a

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* "Information visits" from relatives are mainly unpleasant. The visitor, neurotic himself, is usually a complete stranger to cognitive therapy, has no idea what is really going on, but demands information as if he were able to assess it, expresses himself critically, etc. The therapist can only give information about some general facts, and cannot go into details, or even discussions, and the visitor objects to this, including reference to professional secrecy. Telephone "enquiries" of this sort are even more unpleasant.

satisfactory result. The will to recover can, of course, not be "awakened" or "strengthened" by "encouragement" and other suggestive approaches, the patient might only have the will, he could, of course, if he only wanted to, etc.; one can not conjure up or hitch up the will with the will, or alter the weakness of will to become strength of will.

In other cases, the *recovery hunger is sufficiently intensive* for the patient to present himself, but, at the same time, this is, nevertheless, "sick hunger", even if one labels it "good will". In other cases it is too intensive, hypertrophic. The patient then suffers from recovery greed, recovery addiction, he is in too much of a hurry, cannot wait for it, throws himself into the therapy, finds everything a matter of course, is already finished at the beginning, he says: "I *must* manage it, I am bound to become healthy in any case", i.e. he wants to force recovery with his will; certainly, he has already conjured it up, by or with the will "everything" is already finished (magic immediacy). He overruns the recovery task, but with this he does not recover, he nihilizes only the illness, the therapist and his methods. He does not know healthy hunger, he believes his will is healthy, even particularly "active" and with this hunger as a demon he can magically extinguish the "illness" as the enemy demon, conjure it away. Concerning this, it is made clear to the patient that his presumed "steel-hard, inflexible, fanatic" will is nothing more than cramped hunger, and above all, that the will is no guarantee for fulfilment, but only the first stage of the course; here too, "the belief in demonism" must go. The patient must learn, and learns to have patience, to wait and to work quietly. To grow up from 10 years of age to 15 he must wait exactly 5 years; the evolution takes place at its own biologic tempo: the "will" can neither accelerate it nor slow it. It is seen that the more patiently the patient is striving for recovery, the sooner he arrives at the target; certainly, over-patience is just as much a symptom as impatience (indolence, fatalism, pathologic inhibition, etc.): impatience and over-patience are both poor taskmasters. "You say yourself that I must be patient, so I wait and do not need to do anything", says the patient: he must learn that only calm, steady work leads to the target, and that his oscillation between impatience and over-patience is a "therapeutic symptom". "I've already been under treatment for a fortnight and do not notice any improvement, and I carry out the therapy day and night" says the patient, and fidgets with his hands and feet; he gets to know that the evolution takes place steadily, that it cannot be forced, that he is doing too much "good", and thus bad with his "permanent therapy", that the thought cells, whose actualities are the "therapeutic thinking" can also function in hypertrophy, that he cannot ascertain at every moment with a foot-rule whether and to what extent, he is already better, etc. He would then like to "do *something* more" to promote the therapy, and must understand that there is only *one* path upwards, and that he is following it (in the cognitive therapy). "You are a miracle worker, doctor, I am healthy!" says another patient as he comes to the second or third consultation; in this way he has "overpowered" the doctor and his therapy, but – he gets to know that he is only in a demonistically apprehended suggestion, whose solution we approach at once; the therapist says; "Well, so we want to start to work!"

Vertically directed recovery hunger can also be *directed far from normally* and *near-normally*. When *far from normal* it more or less resembles horizontal hunger, the patient behaves more or less like the patient who has remained in his usual over-gallop: he rushes about restlessly on deviations and false paths, steadfastly from doctor to doctor, from cure to cure, from quack to quack, and the sillier the "healing method", the hungrier he is for it. He wastes time and money, he never has time or money, it is "all the same". He persists nowhere, or carries on to the end, he is everywhere and nowhere. He can never "be touched", "fixed down", everything that he says and does is "without obligation", "at liberty". He is always "ready in a second". "You certainly thought that one out quite well", he says to the therapist, en passant. The searcher for healing searches for the miracle, he even demands it in maintaining his self-demonism; the healing miracle has to be ordained to it, he dare not let go of it, he must feel it everywhere and chase after it, worship the therapist of the moment as a mircale worker (suggestive diminution of symptoms), and soon thereafter curse him and leave him in disappointment (cf. Hosannah! – Crucify him!), he must "feed on", "devour the therapy", no matter what it is, this or that, the all-therapy, namely, ban it – and it is clear that he can never come to recovery in this way. But instead of learning from the failures that he is wandering around on the false paths, the permanent rambler redoubles his haste to gain possession of the healing magic. Where there is talk of a miracle healer he must go there; in this way, he runs in large circles around real therapy, the real recovery task. There must be healing for me, too, he pretends and says, otherwise, I would not seek restlessly for it, the inner voice drives me on all the time – but this means I will really never find it, that there is no healing for me – thus I have overcome the healing miracle and those who bear it, thus the unattainable is always already attained and the attained is always the unattainable, the incurable is the cured, the all-cured, the all-healer, the miracle worker of cures, the Redeemer (Heliand) who fuses all redemption and all harm into his all-oneness, and holds it in his all-oneness. In his incurability he finds *his* satisfaction: nothing and nobody can help him, the all-helper, and thus he must travel on to deprive all healers and all healing magic of their power and adapt them to himself.

But sometimes the patient learns to alter his view to the almost-normal direction (a purely biologic alteration of the passage of his striving for healing). He comes across cognitive therapy "by accident" and the "contact" may be more or less fleeting (he "floats past it") or lasting "sticks to it" (he carries on to the end). At first he "only sees a modification of the well-known" in the vertical method (that which is really "new" is good for nothing, and the old is good for nothing anyway, because it was not able to help me), "one can give it a try", "can listen to what the man has to say", one really knows in advance that it is nothing, that he is just another nonentity. Thus, the patient must learn anew that vertical therapy is principally different from horizontal therapy, that it takes its course in neither the raw nor the psychologic-causalistic magic faiths, but leads out of them. If the adjustment of the recovery direction moves towards the normal with this, the patient has already gained a great deal; if it does not, there is no basis and he is incapable of real healing work, even has resistance to it, and he even "takes to his heels" due to anxiety about it. Another sort of "always being on the move"

is "wandering thoughts" during the therapy session: the patient certainly sits in his chair, sits out his hour like a good chap, but "his thoughts are far away", he does not listen to what is said to him at all, or only hears it in fragments, obliterates the words, is "as if drugged", and the therapist must at first make it clear to him that he is withdrawing himself from the therapy in this way, and that he thinks he is destroying its supposed magic, maintaining his beyondness, unapproachability, freedom of movement, absoluteness, all-demonism, all-oneness.

A *near-normal* direction of the recovery hunger is also not a guarantee of success. The patient certainly rushes at the healing task vertically, but he can still deviate at a succeeding stage (depending on specificity). It is necessary to point this out from the beginning in the expectation that the patient can at least "digest" so much that he does not break out; as a rule this is successful. The more the patient grows out of his chaotic-magic *Weltanschauung*, the more he learns insight that the therapist is not an enemy-demon, the healing task is not a demonistic deceit of the therapist to "overthrow the patient", and, in this way, the demonism fades away on the whole, and, consequently, the demonism of the symptomatically-experiences tasks: they become increasingly purely human, and really realizable. Recovery hunger with a near-normal direction permits in itself a good prognosis.

The second stage of the recovery process is the *anxiety stage*, the stage of evolutionary anxiety, anxiety about the recovery task and the recovery, from "eating from the tree of knowledge" and the "ominous consequences". It is a function of the sick anxiety reflex systems and thought cells that enter a delayed higher differentiation according to their biologic characteristics (p. 148). Where the vertical recovery hunger is not present there is, of course, no vertical recovery anxiety, etc. The recovery anxiety can be more or less intensive, also in relationship to recovery hunger. The direction can be *far from normal* or *near-normal*. Anxiety directed *far from normal*: patient does not trust himself to visit the therapist, conceals himself behind his symptoms, is scared of the task from the "beginning", resists, has a thousand and one excuses, e.g. he has no time, no money – but he has time and money to be sick! – one must "tell everything", reveal the most intimate things, betray ones "secrets", and thus "surrender oneself", "deliver oneself up to the therapist-demon" (i.e. surrendering the all-oneness), the problems are too serious "at the moment", they're not really so bad, even not there at all, there's plenty of time, one wants to or must make a trip, try-out something else; there are other therapists of course – Oh-ho!, cognitive therapy may be good for others, for him it is unsuitable, one has heard all sorts of negative things already (can be true, but can also be misunderstood, exaggerated or lies), only go to him if he helps you; then I'll go too, appeal to the love of the familiy: I cannot, don't make me, you must understand me, etc. In anxiety about the task of going to the doctor one takes to ones bed, or "compels" the family in some other way to call the doctor, "forces" the doctor to come and has thus already taken possession of him and his magic, and retained the all-oneness. Or one dares to visit the therapist, but accompanied, i.e. with the protector, for he must also report to the therapist "per pro" ("you say it, I can't", in this way one is "without obligation", has said nothing, what the other person says can be wrong, etc.) Or one speaks with

reservation, evasion, subterfuge, stutters something out, tells the therapist all sorts of lies, lies like a trooper, floods the therapist with nonsensical talk, does not let him speak, or stays dourly silent, shivers, sweats, the thoughts are gone, so one cannot express them (how fine! one is rescued!), etc. One finds the therapist unsympathetic, his beard is awful, the tip of his nose upsets one, etc., "I could not let myself be treated by *him*". One makes an appointment for the next session seriously, or "just to get out of there" ("that's not for me", "it's too up in the air for me"), and either "just" does not go, or comes too late (appointment anxiety), or cancels the appointment with all sorts of excuses, faking or misusing all sorts of facts ("you must understand, doctor, if only this major piece of work had not been forced on me just now", etc.) One wants to change the method oneself, high-handedly, but the therapist does not let himself be diverted from his ABC. One misunderstands the time-arrangements (discipline) of the practice as compulsion and refuses to accept them ("I can only come twice a week". "I will now miss out three to four weeks". "You think we have to dance to your tune, – no, no, my dear fellow", triumphs the Chief Executive; but the therapist makes it clear to him in a friendly way that there has to be order in the practice – also on account of the other patients – just as much as in his company, etc.). "I know that I can only become healthy through you, but that is precisely why I cannot come to you, for if I do not become healthy – no doctor can give a guarantee – then I would have nobody else I was certain would help me". "If I lose my belief in the demonistic powers and were healthy and this power was nevertheless there, then would I have to be sick again, or fall into ruin?". "I would really like to be healthy for the life of me, but if I only knew what would become of me then" (anxiety about the loss of anxiety that warns against harm, and as a result protects against the loss of the illness as the "only way of life", that guarantees the maintenance of the all-oneness, all-power, of life, of absolute purity, etc.). "If I do not become healthy now, that would be frightful, I would be ruined, I could never bear the scandal and disgrace". "I am perfectly content with what has been achieved", praises the patient after a few hours, in his anxiety about the work of healing, and its success or failure, he "buys himself out" with praise or the offer of an increased fee, etc. "If I really have an organic problem, as I believe – the doctors cannot know that of course – then your treatment would be unsuccessful after all". "I am mentally inferior" parries and parades the patient, "I learned nothing at school, I do not have the basis for a profession, you will not be able to do anything with me either, I am simply a born psychopath" (and thus charmed against all the tasks and demands of mortal life). In this way there are all sorts of apparently logical "arguments", prejudgements, subterfuges, behind which the patient takes cover. He adopts a far from normal direction that winds up opening into the horizontal line: everything stays as it was. Some seek to justify their sick evasion with false statements that they have become perfectly healthy owing to a stay in a sanatorium, or through herbal tea, or medicines, etc. With appropriate clarification, recovery anxiety may yet change to the near-normal direction, and this happens often. In some neurotics, however, the neurosis prevents the loss of the neurosis (healing abstinence).

If the direction of the recovery anxiety is *near-normal*, the patient appears, and concerns himself with the work, but at first with too much anxiety (inhibition).

He is unpunctual*, goes astray, must go to the lavatory again before the session, slides restlessly to and fro in the chair, sits ready to flee on the edge of the chair (Do not lean back comfortably! That would be too magically dangerous: if there were to be an "attack" one would first of all have to straighten up, and thus lose time), fidgets etc., plays about with the upholstery buttons on the chair and twists them off accidentally, shrinks from the (magic) look and sight of the therapist, conceals name and address, goes red and pale, sweats blood and water, probably weeps too, cannot think ("as though the thoughts are blown away", "completely stupefied"), has to yawn, becomes tired (anxiety spasms of the cerebral vessels with reduction of consciousness-clarity) – in short, shows the individual symptoms and signs of anxiety.

He experiences the therapy session as Judgement Day, an examination and decision about eternal life or eternal death, is constipated (in the widest sense, dumb, buttoned up, obdurate, at a loss, defiant, refractory, has to have every word forced out of him, stutters, distorts, lies, only hears single words, and these vaguely, "everything like a dream", is also internally constipated, etc.), or diarrheal (in the widest sense, gossiping, devious, unbridled, talks round the symptoms, hides himself behind a deluge of words, "must say everything" – as in the confessional – "not forget anything", and of course forgets the main point, namely, the therapy, he vacillates in *front* of the threshold of recovery, of healing work, and defends himelf anxiously against the therapeutic explanations – including the way he lets them happen to him like water off a duck's back (without getting wet), that he subjugates himself and thus does not let the therapy reach him, negates it). In both ways he is unapproachable, like Faust in his magic circle. And he should now leave this "safe" Ring of Power (Tolkien)? He should give up his habits of life, the methods of life that guaranteed him life up to now (eternal, demonistic)? He should give up his "only-unique mission", his "world saviour role", i.e. understand that all this is only delusion? Is the therapist who demands this of him not the frightful tempter to (eternal) death, death-god-devil himself? Healed, the patient should do that from which his anxiety currently warns him "on oath", protects, and give up that which now means "everything" to him, on which being or not being depends, (i.e. the all-demonism, the magic power, in reality: his symptoms). He should let loose, accept the normal range of variation, i.e. lose the previous balance on the imaginary line over the bottomless pit, achieved with difficulty, but at least "safe", and thus lose himself, fall into the bottomless pit, i.e. become earthly, walking comfortably on the earth, be a mortal among mortals? He should understand that he is guilty of sins of commission and sins of omission (abuser or abstinent), while he had and has the faith, precisely as a consequence of his behaviour to ban, to deprive of power, the godly-devilish temp-

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* Normal range of variation recognized, naturally; but if the patient comes significantly too late or too early regularly, habitually, "methodically", then he has a neurotic understanding of "appointment" (as a demonic compulsion that has to be deprived of power).

tation, sin, eternal death and eternal decay? He should give up the belief in himself (i.e. the self-worship) – does that not mean: to despair of himself; he should doubt himself and his judgements – does that not mean: only to be confused all the more? (No, that means: to perceive his erring, to disentangle from the confused – there is no other way to the normal, to health). "Up to now, I have succeeded in everything" – by which the patient means the logic of the sick events, the compulsive-consequent series of his (unperceived) failures or false successes – "how will it go on without this sleep-walking safety?" "Perhaps I have to thank my neurosis for my success, what will become of me if I lose it?" (only a healthy, fully productive person). Patient should perceive that his entire previous life has been to a significant extent "a single major nonsense" – how frightful! etc.

The therapist explains the demonistic interpretation to the patient; he appears to him to be the enemy-demon (god-devil), as the father once was, against which one must uphold oneself rebelliously or submissively, obstinately or meekly, intimidated or pampered, and whose demonism one must deprive of power "in one way or another", even if it appears in the form of a "task". In reality the therapist is "also only" a human being, a reflex being like the patient, only a specialist; the demonism is left. He is not a father confessor (with the magic capacity "to constrain and release"), but a signpost.*

The more the patient sees through the way of demonistic interpretation with which he experiences the therapist and the recovery task, and in addition makes the acquaintance of the cognitive way of thinking and accepts it, the milder the anxiety becomes. At first he agrees, with reservations (even the slightest, most hidden or also unconscious reservation remains the protection of the "total" all-oneness, of the "complete" magic, of the total negation, e.g. flowery phrases like "perhaps", "could be", "so you say", etc., or similar expressions or gestures, including one's thought); at first he takes down the outside walls of his magic castle and heaps the material up on the inner walls; at first he misunderstands the *therapy* as ("just") *theory*, learns it by memory but not by heart, does not try to apply it or make it part of his life-practice ("the theory is very nice, but only if there were demonism"); he holds off from renunciation, on the "absolute protection" of his imaginary magic circle, round which the enemy spirits are storming; at first he brings up the fearful question of if he will succeed – with doubt about what might happen in one situation or the other (if I don't manage it, I have to remain ill, am destroyed, and if I manage it, I am threatened by

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* Many a patient asks to be allowed to smoke; the therapist, who of course does not smoke in the therapy session, does not forbid this, but points out to him that in this situation smoking is a symptom of anxiety for tranquilizing-narcosis, i.e. intended to serve as a protective magic against the therapist and the therapy, and that we want to remove the anxiety not deaden it, and that the therapy session is not a social meeting, so it is unsuitable to smoke during it. Other compulsive methods with which the patient deludes himself that he can make himself invisible, untouchable and unassailable are also clarified analogously, and gradually disappear.

the "mortal" duties and rights of the healthy grown-ups from whose performance my anxiety has protected me up to now); he explains that he is satisfied and eternally thankful for his previous success, owing to anxiety about continuation of the therapy, about the final step to recovery, which seems to him to be the "final step" (after which there can be no others, "everything gone"); in the anxiety about the "threatening" independence he does not want to lose the leader, but wants to continue the therapy "forever" in anxiety about the end of the treatment as "the absolute end", etc. But more and more light comes through the world-perceptive fog, the sick reflex systems lose their intensity of function and make gains at the biologic niveau, and the more his interest in the real world grows, the better he listens and works and verifies what he has heard into his inner properties, and with this the application, and, consequently, the improvement of the symptoms is self-adjusting.

The periodic episodes of anxiety excitation when the patient despairs and would like to "chuck everything" also become milder, the directional swings of the anxiety reduce in size. "At first I thought, and certainly also said: you frightful person, you want to take everything away from me, now I see that it is more correct to say: you wish to give me everything, namely health". Therapist: "Certainly I wanted, and still want, to take your *all* away from you, namely the illness that was your *one and all*, the demonism that for you meant your existence. But how? Did you not want to get rid of your illness? So, how could I *take* something from you that you wanted to get rid of! And how could I take something from you that you do not possess at all, that does not exist: the demonism! And thus I can also not *give you all*, you have to earn health yourself. I only show you the facts, against which anxious withdrawal and defence is completely out of place: facts remain facts, whether you – or I, who present them to you, like them or not, whether you close yourself to them or not, they do not let themselves be conjured away in your way or any other. No therapist can compel the patient to come to him and live through the therapy, but the person who does not come cannot be treated, and the therapist only does his duty by making the fur of the patient wet so that he can wash it. So, I only have a therapeutic interest in you, but it is up to you whether you come or not, I only make you aware that it is a neurotic mistake to throw in the towel in a critical mood, whose appearance I warned you about; there, you simply have anxiety about your demonism – which actually does not exist, and which you therefore cannot lose. The illness is also not a demonism; it is a biologic fact, as I explained to you. Think about the knight who travels through the magic forest to the sleeping beauty, about Siegfried, who came to Brunhilde through all sorts of terrors: he who does not let himself go crazy with his anxiety, and comes to the right target."

Anxiety also radiates into the pain stage; shortly before the threshold it often reaches a high intensity: the decision is imminent, the "last warning" appears: stop! Perhaps you are going to perdition after all! The "final" step, like the "first" is the most difficult: all bridges, even the smallest (magic) connection with the past, with childhood-illness, with mother, will be broken, I will be entirely dependent on myself, completely independent, responsible, without help and thus "helpless", will have no more excuses I can make, and unable to demand any more attention to my suffering (which is really not there any more) – how can all this be done! Could I not keep a

little bit of illness, a little symptom, i.e. a little, hidden magic, which is of course the entire magic, and thus rescue my demonism, to which I have to thank for my life up to now? The most difficult thing is to separate oneself from the thing one deludes oneself one has. It is most difficult to give up the belief of having something that does not exist at all. The departure from a delusion is also painful, but the healing operation must take place. The "scalpel" of the cognitive therapist is the world-perceptive clarifying word. Meanwhile, the patient has learned to have doubts about "his" signpost and the correctness of his point or view, to see through the demonism as a mere interpretation, and to give up his belief in its reality. In this way he also survives this recovery crisis. In near-normal-directed anxiety the prognosis is generally good, it is unusual for the patient to fail "at the last moment", but even then he has already experienced an extensive vertical improvement.

The third stage is the *pain stage*, the healing work in its narrower sense, the painful wrestling with recovery, the departure from the "ancient idols" from such difficult and oh, so trusted custom, the practical unlearning of the previous demonistic and the practical learning of realic *Weltanschauung*. The recovery pain is a function of sick reflex systems and thought cells that come into a delayed higher differentiation according to their biologic characteristics – like all sick reflex systems that normalize themselves in the course of vertical therapy (p. 148, 153, etc.). Recovery pain can (not unusually, also as an actual feeling) be more or less intensive, also in relationship to the other species of sick reflex systems. It can (seldom) happen that the patient still fails in the pain stage, gives up the "struggle", bails out, takes to "victorious flight": *far from normal* or changes itself during the therapy to the correct threshold and its crossing.

At first there is the struggle against or with recovery and the therapist in the form of a cramped recalcitrance or yielding; the patient defends his neurosis – with the methods and means of his neurosis, so the pain stage is nuanced towards the hypertrophic species; the pain neurotic defends himself the most vigorously. At first, the patient believes the doctor to be the godly-devilish tempter, the enemy-demon that he must deprive of magic, and the cognitive therapist who of course wants to "get at" the demonism of the patient is an especially dangerous person for him at first, even the main enemy, who he has to wrestle for "existence". The other doctors are "treated" by the patient, but the cognitive therapist treats him. The facts do not allow concessions, or any compromise with the abnormal: there is one path to healing and that is why the patient has to follow it, but the normal range of variation has to be recognized, i.e. the path is not a "thought out" mathematical line on which one must maintain a cramped balance, but only – a pathway. The therapist does not fight with the patient, but is his leader; fighting by the patient meets emptiness. In cognitive therapy the establishment of symptoms and their characterological, etc. description (e.g., boastful, arrogant, defiant, lying, pedantic, etc.) is not criticism or insult that could offend the patient, but cognitive diagnoses – just like the diagnosis of pleurisy or heart disease, etc. It would not occur to any gout or tuberculosis patient to be "indignant" about a specialist diagnosis; the neurotic also has to accept this for himself; he must learn to hear the truth and to accept it after consideration. The patient

can, may, even should bring out his arsenal of doubts, objections, criticism, etc., so that they can be discussed; he can refer to his official authority, he can "let swing the most finely sharpened weapons of logic": puzzle out pseudological distortions, he can stab and prick to his heart's content, assume touchy sensitivity, take offence, implore protection (also with tears), request "kindly understanding", arm himself with watchful compliance, tense passivity, attempt to "make" himself impregnable and inviolable with praise, base flattery, admiration, he may adopt the hedgehog attitude, "strike a defensive attitude", twist and turn as he will, none of that is of any use against the biologic facts and the therapist who relates them.

The therapist is and remains the therapist, remains calm and friendly, he clarifies – other than this, he does nothing. He is neither the opponent (except as a discussion partner) nor even the enemy of the patient, he brings cognition – other than this, he does nothing. He knows that the patient can only be a misunderstander within his neurosis and that one can only grow out of the misunderstandings to the extent that one perceives and clarifies them as such and, consequently, gets to know the correct relationship; the insight that misunderstanding is a misunderstanding means the beginning of its end. He informs that many objections are affective means for the maintenance of the neurotic taboos, of neurotic all-knowledge, are a sign of still insufficient insight, unformulated confirmations. He cannot "make" it easier for the patient to recover than what the biologic evolutionary path brings with it, but he can also not "make" it more difficult. However, he who nevertheless "closes an eye" deals unmethodically, even against method. The therapist has to limit himself to relating the facts (like every educator), everything else is evil. As a balanced personality he does not speak in the pastoral Our Father tone, but is acquainted with humor and jokes, there "can" be laughter during the session, many jokes are valuable as illustrations of facts of life, as are "vernacular", "infant expressions", proverbs, familiar quotations, quotes from poems, etc. He who is a neurotic himself cannot be a cognitive therapist. Notwithstanding dignity, the sessions must proceed in an unconstrained way, "relaxed", and proceed pleasantly; in this way the patient lives-himself-in to the harmonious mood of a healthy concept of life, so this mood dare not be "made", it must be real. The therapist cannot "be upset" by the patient, he is not fanatically stiff and dour, arrogant, pernickety, pedantic, vehement, melancholy, reckless. He does not defend himself "indignantly" against the attacks, but explains the (demonistic) sense, read: the nonsense of these symptoms, too; he points out that the therapy sessions are not debating sessions, but teaching and learning sessions, and that "opposition in principle", an "a priori rejection" is itself a symptom, and thus non-therapeutic, and only takes place in maintenance of the supposed all-knowledge; the patient has however to check and recheck what the therapist says to him. However, the therapist is not a sufferer that the patient can use as a whipping boy, on whom he can vent his spleen "because he dare not be offended by anything". If the patient pushes it too far, if he shows himself to be unteachable (bad prognosis), he is dismissed in all friendliness, but the therapist certainly has a great deal of patience, and consciously considers whether there is still a chance, as a great deal depends on the decision for the patient.

I like to compare the therapist : patient relationship with the mountain guide : mountaineer relationship. The mountaineer wants to reach the summit, so he seeks out the mountain guide: hunger stage. The guide discusses the route with him, but does not encourage or discourage him, but he gives him his judgement if he considers him unsuitable. The preparations are carried out: anxiety stage. Then the climb begins, the pain stage, the "struggle for the mountain". The guide knows the way, he does not allow any interference with the goal. He is the specialist. The mountaineer must climb by himself, the guide can only guide him, but not carry him up in his rucksack or pull him up on a rope; he is neither a porter nor a rope-puller; if he were, the mountaineer would not accomplish anything; one can also pull a baby up in this way. The guide can also not climb up for the mountaineer: the mountaineer must do it himself. So the mountaineer is not to hang on the rope, he is not to pull on the rope, if he tries to "pull down" the guide (probably as a sort of test to see if he is stable) he is given appropriate teaching, and if he cannot stop doing it, he is taken off the rope, the tour is broken off. The guide also does not encourage or discourage the mountaineer en-route, he gives him no suggestions, he does not force him to continue, if it really does not go, he is, as guide, responsible – also in the sense that he hands over to the mountaineer the responsibility in his province. The guide does not push the mountaineer over the precipice, he does not let him fall, he does not let him down. Both climb in the same direction, are neither opponents nor enemies. The therapist can also be the *signpost* to recovery: the signpost cannot coerce the person seeking the path to take the correct path, he can only show it to him; if he does "more" he does less, and is not a signpost, but a pusher. The patient learns to understand this.

With time, the cramped ardour and the intensity of the symptoms ease off, on the whole. The patient struggles less and less against recovery, but all the more for it, and thus first learns to understand his task properly. Periodically, *critical* situations occur (often with tears), but these surges also become lower and lower, although sometimes, just at the end of therapy, as the "final step to freedom", a more intensive crisis is lived-through once again, a very near to normal excitement, also like the quite similar characterization of major experiences (decisions, progress) in healthy people. The improvement strides forward without the patient noticing it in each case, just as the adolescent also does not always notice his (continuous) growth. Usually, friends and relatives notice his progress much sooner than the patient.From time to time, of course, the patient convinces himself that there is progress and about how much he has already gained. The more intensive the problems were, the more noticeable the improvement: if a very serious pain lets off only a little, the patient counts this as a "great success". Minor problems, such as those that are regarded in a hypochondriac way, or those that persist during progressive improvement, are often very stubborn, and every patient opposes giving up "the last" (meaning that the slightest symptom, the slightest remnant, is still the entire demonism, and the patient has thus "lost" nothing whatsoever), i.e. according to specificity, these morbid functions have a relatively slow rate of evolution to the norm, or, (as remnants) have reached the highest possible approach to the norm; the patient has to be given an

explanation about such facts, and also concerning the fact that "the last little bit" is no longer "the whole illness" (demonically interpreted), the patient has thus not rescued hs demonism with it, apart from the fact that there is really no demonism at all.

Many symptoms that the patient has not noticed or not diagnosed, disappear in the course of cognitive therapy, without anything having been said about them at all (p. 147); on the other hand, the patient first learns to perceive many of his sick functions as such as his eyes are completely opened concerning the neurotic symptoms, so he becomes an observer of human nature, far better able than the usual to differentiate between healthy and sick functions.*

The therapist also does not ask at every session: how are you, how are the problems? Rather, he informs the patient, who is elaborating that the problems are this and that, not yet better (although expected) or "already almost gone", that with such long-winded statements about symptoms no therapy is being carried out, only time wasted. But he does not forbid such reports, he clarifies; from time to time the status is briefly checked. Many patients like to enter theoretical discussion (e.g. about the methods, about themes that are peripheral or have nothing to do with the therapy), out of a liking, or anxiety about the therapy work; the therapist also does not let that draw him onto thin ice, he gives information within the framework of the necessary, he does not refuse to answer, he only draws attention to the fact that we have to concentrate on the therapy, that the patient should not become a trained psychbiologist or an expert, but healthy. We do not have years of time, only as little time as possible, as much as necessary; in general, 10 to 12 weeks; on the other hand, the therapist and the patient dare not tie themselves to a date by which "it must be completed", the patient will otherwise be confirmed in his appointment anxiety, but this should be removed along with the other symptoms.

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* Not a few laymen and doctors, including those in high official postions (the level of the official position is no guarantee of the level of the medical capacity), are of the opinion that medical entry into the symptoms "breeds" the neurosis, best of all, the neurotic should not notice that he is neurotic, his problems are imaginary in any case, and consequently are not there (!); healthy people could also become neurotic owing to information about neurotic symptoms, best of all, one hushes up the neurosis – an interpretation that betrays a total lack of knowledge about the nature and significance of the neuroses, or a neurotic anxiety about self-knowledge and knowledge of others. Of course the diagnosis of an illness can as little "cause" the illness, or its worsening, as a diagnostic ostrich policy is able to cure it. The hypochondriac does not become a hypochondriac or "more hypochondric" due to the diagnosis of his hypochondria; the cancer patient does not become a cancer patient "due to" the diagnosis of his cancer, and the cancer does not proliferate "because of this", etc. For every disease, diagnosis is the prerequisite for therapy. The undiagnosed or hushed up neurosis nevertheless exists, and is up to mischief. In cognitive therapy the neurotic does not concerns himself with his symptoms in the style of hypochondriac "fine diagnosis", but only therapeutically.

Some symptoms stand out more with the lessening of others, and even come into the foreground. It then looks as if they have worsened; in reality "they only seem to shine brighter after the equally bright or brighter lamps have died or gone out". The patient also has to be made aware of possible symptom displacements so that he is not taken by surprise and comes to false judgements. Suggestive states in the patient are carefully destroyed. To do this, they must of course be diagnosed, the therapist must notice whether the patient believes him rather emptily, finding himself in an (undesired) suggestion, or whether a true insight, a real step forwards, has been achieved. He must also watch out that the destruction of the suggestion is not taken up again as a suggestion, knowledge must take the place of belief, doubt-free cognition the place of doubt. Often, after healing, the patient no longer knows he had certain symptoms; in accordance with the higher differentiation of the reflex systems, including the thought cells, not only the symptoms disappear, but also often the memory of them, the patient only knows in broad terms that he was sick, and how sick. It is very interesting to note down all the problems the patient complains of at the beginning and then produce a list in the event that he has lost certain symptoms and the memory of them (already during treatment), and argues that he has never had them.

The fourth stage in the recovery process is the *sorrow* stage, the stage of evolutionary sorrow: the healing work in the narrower sense, the wrestling for recovery, the departure from previous habits, from the "old faith" is completed, the demonistic *Weltanschauung* given up to the benefit of "interference thinking", and then to the benefit of realic *Weltanschauung*. Recovery sadness is a function of the sorrow reflex systems and thought cells that have reached their delayed, highest possible differentiation in the course of the therapy. Here, it has to be considered that (as in the other stages) the recovery pathway is composed of a series of individual progressions, evolutionary steps, that enter, biologic-symbolic, into the whole (just as many other smaller hunger-anxiety-pain-sorrow-joy experience series enter into the totality, the greater experience). Here, the total experience "recovery path", is presented. In the partial results, for example, the sorrow stage is sorrow about a partial progress, about a partial loss of the illness (also in respect of demonistic interpretation); in contrast, the sorrow stage of the total course is "vertical reconvalescence", sorrow about the final overcoming of the illness and its demonistic interpretation, about the final loss of the previous habits.

These sorrow stages are thus not to be confused with the horizontal sorrow stages, or with the sorrow stages or the sorrow neurotic; horizontal reconvalescence also lies in the episodic course of the illness, in contrast, the vertical is a stage in the differentiation process that leads out of the state of being ill, the stage where being ill is on the whole overcome just now. The sorrow stage is far from normal if a false direction has been taken in an earlier stage (symptoms still present); otherwise it lies in the differentiation direction towards the norm, and is itself so near normal or similar to normal that it has to be placed by the side of the normal sorrow stages according to normal struggles, tests, decisions (e.g., birth, puberty, etc.).

So, the old Adam has been taken off and the new one put on, but the next "suit" is not yet a really good fit ("what do I get out of it?!" "now I'm missing

something: my illness", etc.), one misses the old, worn-in jacket, even if it was torn and threadbare: the sorrow is directed towards the given-up habit, even if it was problematical, and it often costs tears. One is worn out after the "drastic treatment", just as one is after every hard struggle, and the battle for a healthy *Weltanschauung* is certainly the most difficult task the patient has to solve. Was it really necessary to give up the demonistic *Weltanschauung* completely, in which everybody is still living – and also the belief in the immortal soul? Yes, it was necessary, one agrees, the chaotic-magic *Weltanschauung* "was" of course the symptomatology: one cannot simply get rid of one without the other, and with the surrender of the demonistic interpretation in *one* point, one has given it up completely, if one has recognized it once as primitivistic fiction, then forever, in principle; there are no exceptions in a *Weltanschauung* – and there is no way back. But has the world not become colder, more boring, less interesting, simpler, poorer, and even more primitive? One has given up the "golden" childhood with its playing for all-power, the "father-mother-parents house", the "protection of the fortress of the Holy Grail", the belief in creation by the magic-god and eternal salvation-damnation, all the complicated interpretations with their unlimited possibilities, their lack of obligation and their "emergency exits", and exchanged the high responsibility, the duty and the right, for normal performance in profession and love, the view of hard facts, life in a world denuded of gods and devils – was it not "nicer" before? One has recognized one's world duty, one's unique role, one's role as Saviour, as "humbug", and has become a human being – "just" a human being, one among the others, with "only" human tasks, in which one finds satisfaction. The dream is over, the world perceived in its biologic reality, the delusion of absoluteness has yielded to the truth of being a part of the membership. The new world has not yet been put together completely, there is still a lot of rubble around, but out of the ruins of the old world the new one is forming already, great and rich and beautiful.

Finally, the *joy* stage. Every evolutionary step in the healing process has, of course, its joy stage. The further the recovery progresses, the more the stages normalize, including the joy stages. If the healing work goes wrong in one stage, then the joy stage is far from normal, too, in a specific way, depending on the type of neurosis: it is falsely accomplished, a false target is reached, the joy is nuanced according to the hypertrophic species of feeling, or overemphasized in the joy neurosis; so, this joy stage resembles the joy stages in the horizontal course of illness, but the symptoms are correspondingly milder if the recovery has already taken a step forward. The recovery can also remain incomplete with a *near-normal* direction (depending on the biologic differentiation capacity of the sick structures), there, the joy stage is also still incomplete (in each specific type), the way of thinking is interference thinking that comes the nearer to realic thinking the further the recovery progresses (in the whole or in detailed structures).

In complete healing the joy stage is also healthy – like the joy stage of a healthy person after a special performance: it is complete, recovery is reached *from* (not *in*) the illness, the new world has taken definite shape and one has got used to it. It is all over with the demonism and its "eternal as-ifs", but one has only lost the fiction, not the world of real facts, rather, one has just gained this world. All cramping

has finally disappeared with the demonistic delusions, the unearthly spook has vanished to nothing, one is on the earth now for the first time, born in the world as it is, into true humanity, has only now perceived the high dignity of human duties in profession and love, and gained the capacity to fulfil duties and tasks for which one is responsible individually, out of the individualist-collectivist one has become a partner, a mature member of society – can there be any greater happiness!

One can differentiate between the theoretical (verbal-instructional) and the practical (experience-behaviour) sides of the recovery process, but one may not separate them from one another: the practical improvement progresses according to the theoretical clarification, which precedes it (see Section 2.3.5). The practical recovery task is thus the *application* of the theory, and according to this the stages of the recovery path can be described as hunger for and anxiety about the application, then the application itself: painful struggling against and about leaving the hitherto, the move into the new sphere, that is at first experienced as weird-threatening doom, etc., then departure from the hitherto, wrestling oneself through, further-on sorrow and joy about the completed application, the progress achieved. Anxiety about the application is often the most recalcitrant symptom. "I certainly want to do so, but I simply cannot do what I want to do in the right way". With the genetic lessening of anxiety, however, the patient learns to do what he had only known about – and doing is better than knowing.

2.3.3 *Crises*

The recovery task is not solved smoothly, but in a series of stages, evolutionary steps that keep on moving into one another and are often critical (pp. 169, 170). Normal evolution also proceeds in this way. A mountain is also not a smooth, a steep elevation, but ascends gradually over smaller foothills to the higher summits and the highest peak, and the mountaineer can only reach his target over this up-and-down, but here, downwards is also forwards, not backwards. So the symptoms do not disappear in a smooth, even line, but in a curved one, and here a downwards in the ascent is not a "regression", but a decline in the progress. What the patient has really learned, what has gone into his flesh and blood, he cannot lose again; a relapse is out of the question. So the gains mount up.

In *crisis situation*, the sick reflex systems, especially the pain reflexes, function relatively intensively. The patient sees himself faced-by and in the midst of the partial tasks, which are more difficult than those completed previously, or seem to him to be so – like the mountaineer who keeps on seeing himself facing ever-steeper walls again and again. The patient doubts more than usual if he will succeed, if it would not be better to break off, if he should be satisfied with what has been achieved; the problems are, or seem to be, more intensive, especially if they were suggestively covered-up previously, or stand out more, or are heeded more alongside the definitively faded problems. The patient is in danger of letting himself be led astray and of breaking out of the treatment. From the very beginning, the therapist does not fail to make the patient aware of the occurrence of such crises, and to explain

them: if the patient has been prepared for them they take place less severely and are easier to pass through.

Progression by crisis, namely crises that the patient lives through near-normally, are accelerations of the differentiation speed, evolutionary thrusts; one prefers to term them *"enlightenments"*. One should not interpret such processes demonistically ("inspirations", etc.). The "light of cognition" is not a demonistic power or emanation, etc., but a somewhat illustrative term for the fact that the patient becomes more "brightened-up" (bright head, a light has gone on for me, His Serene Highness) the more he grows out of the darkness of his chaotistic-magic, his demonistic world. The enlightenment is not given to him as a present, it does not fall from heaven, it is a degree of differentiation that is attained in the course of the recovery work. So this work is not a "factor" that acts on or effects the differentiation from outside or inside, – that would only be another demonistic interpretation – but it is differentiation itself, described functionally. The patient differentiates himself by working in cognitive therapy, he does not have to apply a method mechanically "to" the evolution, but his work is identical to the evolution, just as any course of study is higher education, but does not effect it. Cognition is not a means that acts on the symptoms, not an instrument one uses to operate on the sick *Weltanschauung*, not a medicine that calms the sick cells, not a magic that puts the problems to sleep or wraps them up – no, it is a degree of differentiation that the cognitive therapist has in advance of the patient and that the patient reaches during therapeutic instruction. The patient likes to ask what "else" he could or should do apart from the work in the therapy sessions; at first he lives in the usual belief that something mechanical ought to happen to him, at first he cannot think that "the talk by the therapist" is all, nobody has ever become healthy from "conversation", perhaps a tranquilizer, a "nerve-strengthening medicine" in addition, electrification, or something like that, eh? Therapist: the "conversation" is not a social discussion, not a tittle-tattle of suggestion, but factual instruction, all differentiation takes place in the way of the instruction, and only thus, the healing work happens in the therapy sessions and progresses, consciously or unconsciously, at the other time, and anyone who thinks he ought to or could do something extra for it interprets demonistically, and is looking for means from horizontal therapy, which we have just left behind, he is untrue to vertical therapy, and we have no place for horizontal means in any case. The mountaineer also only follows his path, puts one foot in front of the other – what else should he do?

It is emphasized that the recovery symptoms are probably not a set of new symptoms in addition to the old ones with the neurosis worsening in this way; they are only a mark of how the individual neurotic experiences his tasks and his attitude to them, and are special forms of the neurotic symptomatology altogether.

2.3.4 *Destruction of suggestion*

Not unusually, symptoms disappear "at once"; after one or two consultations the patient declares he is healthy. Such "successes" can be reached intentionally or unintentionally by every therapist, they are suggestive, and always of short duration.

One should not be satisfied with them; I say: now we have to start to work. In other cases there is at first an intensivation of the symptoms, anxiety about the recovery work and its consequences, (about recovery and its actual "demands") joins itself to the actual symptoms; anxiety about the therapist, the painful struggling, etc. In one way or another – they also appear alternately – the patient "withdraws himself" from the therapy, i.e. the patient misunderstands his experiences on entering therapy in such a way that he thinks he does not need to come any more, or that he will only become more ill through the therapy, the one says: *veni, vidi, vici*; the other: that is not for me. The therapist informs both of the true factual content. During the course of treatment the patient also keeps on slipping off into suggestive comfort time and again: he believes the words of the therapist like the gospel, and thus saves himself the work of checking, learns simply by rote, not thoroughly, and deludes himself that by putting a new hat on the old head he has obtained a new head.

"You know everything", he says, "so what should I bother about?!" Another "believes nothing in principle" and says, overbearingly: "You have thought up a very fine system for yourself and want to suggest it into me; Prof. *H.* said the theories a pyschotherapist uses to achieve his successes do not matter, principally, his successes are and remain the effect of personality all the same. So what should I verify? Treat me! I am ready to believe everything, unconditionally, if you only make me well" – and similar nonsense.

We destroy suggestion wherever it appears. But the simple assurance that one gives no suggestions can also be interpreted as suggestive, even as a particularly subtle form of suggestion and, to this extent, has no value. The destruction takes place in the way of clarification about the nature of suggestion, and how it differs from true progress in the given case. An insomniac sleeps fully eight hours in the night after the first visit, he is "beside himself with happiness", "a miracle has happened". Really, he has only taken with him reassurance that he has finally found the right therapist-demon, who carries out the battle with the "night-sleep-death" demon for him, being on guard at his bed as the powerful protectress "mother" or the requested angel once did. The therapist makes this state of affairs and its interpretation clear to the patient: the patient has not gained anything yet, the therapist is just as little a demon as the patient who "engages" the demonism of the therapist, or as the night that wants to embrace the patient as "deadly power", against which he protects himself by staying awake; man is a reflex being, and getting to sleep is the sinking down of the functional intensity of the reflex systems, etc. Or: "I never closed an eye last night, inspiration came over me; your teaching stood before my spiritual eye in heavenly clarity; it was like blessed ecstasy" – now, less blessed qualms of conscience followed the "blessed exstasy" in the therapy session, but a wholesome one: a step out of the demonistic interpretation into cognitive insight. "I come now to the Lord Jesus Christ", a patient once greeted me, but he soon had to recognize that I am "also only" a man, that "faith" does not move mountains, although it can feign such movement and other things (hallucinatively), that neither I nor anybody else can conjure the patient healthy ("say only a word, and my servant will be healed!", "thy faith hath helped thee" – a charming illusion and a sour disillusion); but the patient must work for health honestly. Enthusiasm, adoring, is not healing work, blind faith,

and a priori rejection are both neurotic conduct and behaviour, not therapeutic, not healing work, but their neurotic avoidance and opposition, defence of the neurosis, whose healing one hands over to the therapist, thus acknowledging him nevertheless (as a demon!). The cognitive therapist is not a psycho-therapist, and the Prof. *H.* quoted spoke about suggestive therapy without having the faintest idea about cognitive therapy. I have not "devised a theory", but founded and accomplished the science of psychobiology, with the science of biologic nerve function. And can the student call on the fact that since the teacher "knows everything" he needs to learn nothing? Many a neurotic student does that, but then he just learns nothing. Learning is work, checking the things taught, and thus taking it into his knowing and doing, his intellect and reason, his "flesh and blood", etc.

He who finds himself in suggestion does not know it, as regards the suggestive field. Suggestion and knowledge that suggestion is present are mutually exclusive. As soon as the person influenced by the suggestion is (made) aware of the fact, or even only the possibility of the presence of a suggestion, it begins to be removed, and with further evidence is dissolved completely and definitely. The patient is "taken aback" and "awakens". This means that every medical, political, religious, etc. suggestor must detect every trace of "awakening" (critisism, etc.) and "nip it in the bud", dull it again with suggestions, suppress, forbid, otherwise his overlordship, his prestige is gone. In cognitive therapy, suggestion is also detected, but in the sense of its removal. The diagnosis of whether it is suggestion or true progress is not always easy. Then, one can apply a counter-suggestion, e.g., say to the patient who can now sleep again: you were excited today, that will cost you a night's sleep. Naturally, one dare not announce that these words are suggestive. If the patient then really does not sleep, then suggestion is at the least present in the improvement of the insomnia; he who can really sleep is not affected by a suggestion that he will not sleep. The healthy person does not let himself be fooled or persuaded.

2.3.5 *Cognition and experience*

Cognition is, as already said, not a medicine or an instrument, but a degree of differentiation. It is communicated in words, the higher differentiation first takes place in the field of words, description corrects and normalizes itself. But at the same time, by this, the described (associated) experience differentiates itself. So cognition is not simply a theory, not just words (like "ex-cathedra philosophy"), but also experience and practice. Experience and cognition are not contradictions that one can play off against one another, as one is used to doing with practice and theory. Cognitive therapy does not concern itself with "gray theory" that has nothing to do with the "golden tree of life", it is medical practice. Experience is primitive and higher differentiated, and higher differentiated experience is just as much cognition as highly differentiated description. We simply term realic experience and description cognition, and the demonistic in its various degrees of dilution as the preliminaries to cognition, in the end, precognition. The association experience : description, phenomenal : phenomenological correspondence, the biologic cohesion of the ex-

perience with its description, guarantees (approximate) homogeneity in the completion of differentiation of both the thought cell areas and their actualities – not only in the therapeutic, but also in vertical instruction of any other kind. Experience teaches this. This is the essence of instruction anyhow. The experience described differentiates itself according to the verbal explanation, penetration, individualization. At first, the description is a sensory perceptive word series to which the conceptual attaches itself, installation into the conceptual sphere, and also into the association network of the higher conceptual zones (of comprehension and reason), and only after this has happened has the student "comprehended", understood, the words of the teacher; the sensory perceptive experience and the attached conceptuality also differentiate themselves accordingly to this, so that the experience is also comprehended and understood. This also applies to the experiences of feeling.

This state of affairs possibly does not confirm the ideocratic interpretation, according to which "the (sensory perceptive or conceptual) word", "the logos", "the idea" are the creative cause of the experience (of the things, even, the world). It remains a fact that the experience is there first, and then the description follows; one can only describe "something", i.e. the experienced, it is nonsense to assume that one can describe "something" one has not yet experienced – in one form or another – in the sense that the description can be there before the described. It is equally nonsensical to assume that one can remember a not yet experienced feeling or a not yet experienced sensory perception. The teacher describes what he has experienced, the student can only hear and understand the words of the teacher according to the evolutionary stage of his cerebral cortex, i.e. also according to his associations between experience and description, but the teacher always goes a little over the capacity of the student, speaks from a "superior standpoint", namely, from one that experience shows the average student will shortly reach; if a student does not reach it, according to his biologic structure, the best teacher cannot adjust this, he is not a magician, he can no more make a genius out of an idiot – and vice versa – than an elephant out of a cherry tree.

Thus, in verbal instruction, the differentiation of the described attaches itself purely biologically to that of description (not "caused" by it) – in a similar way as when the water level in a pipe is raised, the level in the communicating pipe also rises. In addition, in "visual instruction", the thing described is demonstrated sensory-perceptively, often also remembered, but the instruction never takes place without words, bare "looking" hardly ever happens in mankind as a differentiation process, in man, experience and description are only associated in actuality, but there is no causal nexus. In cognitive therapy "visual instruction", phenomenally, is usually conceptual: the patient remembers the symptomatic situation and its relationship, and describes from memory, but he also has actual symptoms with the therapist that he describes directly. The practical demonstration of comparable healthy behaviour has not therapeutic value. The anxiety neurotic, who cannot board a train, cannot travel in a car, cannot sleep, etc., also does not learn to do these things by observing healthy people. He experiences how they do it often enough in any case. The person who has anxiety about eating meat (vegetarian) sees often enough that the healthy eat meat, and how they do it, but he does not learn to do so himself from this; he even deludes

himself that the others are doing it wrongly, or that meat dishes are, of course, unsuitable or damaging for him (in the raw demonistic sense). The person who is a crank remains one, even if he is compelled to join a society, he is alone there, too, and whoever believes that the neurotic is made well by compulsion has no idea about neurosis, and is probably even a compulsive neurotic himself. To force or attract the love neurotic into "marriage" is almost a national crime. "Imitating" is possible with the patient, so far as it concerns sensory reflexes that can take an imitative course, but imitating is not true, real doing, only sham-doing and drill. Internal functions do not let themselves be demonstrated or imitated; for example, one cannot very well give a demonstration of passing a stool to the constipated, it would be pointless; it is of no value for the impotent to observe regular coitus, etc. The course of concepts also does not lend itself to demonstration. "*Weltanschauung* therapy" therefore cannot work essentially with the methods of pedagogic "visual instruction", but with verbal clarification – in conformity with the empirical knowledge that experience differentiates itself according to description.

2.3.6 *False approach by the sick person*

Only in demonistic interpretation is there a possibility of "causing" the differentiation, according to which the circumstances under which the differentiation takes place have causality faked-in as an effective power. In reality, such causes do not exist. The differentiation takes place to the extent that it, in fact, takes place or does not take place: characteristic of the biological structure of the individual. The best therapist can do nothing if the cerebral cortex of the patient is not capable of differentiation, and the most willing patient can do nothing about moving his cerebral cortex to differentiation, he can only work as usual, and must await if and to what extent the differentiation takes place autogenically. Impatience is a poor teacher. "Tied" to a time when recovery "must" be reached, to a sum of money one wishes to "sacrifice", all such "sticking to...", is compulsive, and thus a symptom itself. "Learning by rote" (cf. the mechanical "swotting" or "cramming" of neurotic students) is only horizontal expansion, not vertical evolution, and not differentiation.

Many patients have a tendency to watch out in a cramped, tensed way, so that not even a word escapes them ("if I missed the least thing, the treatment would be pointless, it would have been done-for"); and thus they hear and retain less (anxiety spasms by the cerebral vessels with reduction of consciousness-clarity, etc.) than the healthy ("relaxed") listeners, and also misunderstand what is heard (the neurotic is "in principle" a misunderstander), weave it into their false associations, they hear the therapist's nuances of tone quickly, etc., – the ones they can be touchy about. They misuse the words of the therapist as a spell, to be applied exactly, word for word, so far as possible, including the tone, the gestures of the master magician against the symptoms: sickness spirits, and are then "unhappy" when the expected magic effect does not take place. They take the therapy into their demonism, grasp it as veiled demonism, as confirmation of the existence of demons, are sorcerer's apprentices, learn how one deals with demons from the master magician (p. 105), and now play

their game with them, scare them away (suggestive improvement) and confirm that after a while they dare to reappear, to approach again, talk with them, laugh them to scorn: now you cannot do anything more to me.

Other patients "overhear" the words of the therapist, their thoughts are somewhere else completely, woven into their "spiritual" = "spirit-world", concerned with the banishment of their demonic thoughts – and thus cancel out the therapist and his therapy. The enemy-demonism that wants to destroy my all-power (my soap-bubble existence), can also take the form of cognitive therapy, so *I* must "get ready" with it and the therapist. The words of the therapist are also only "tangents of my absoluteness". The enemy-demonism can change itself artfully into the teaching that there is no demonism at all, and if one is deceived by this "fetching theory" the enemy demons finish one off (of course, nobody knows how to say that this "finish" looks like; it also never happens, as His Almighty, the neurotic, always watches out, and what is more, there is in fact no demonism; see p. 114); the magic-therapist is thus the worst (devilish) tempter – also in the way that he tries to tear down the metaphysical-remote-from-the-world person (his absolute purity, etc.) into the worldly, and thus wants to lead him to eternal ruin, and also in the way he wants to divert him from his unique superhuman mission, prevent the act of Salvation, etc. (Mephistopheles-Faust, Devil-Christ, etc.). If the theories are already listened-to, suspicious as they are because of their simplicity, then one must protect oneself strictly against their practical application. And even if one accepts the theory, it is far from confirmed that it would prove itself in practice; but if there is the least danger that they do not do so, one dare not make any use of them, at the least one must mentally reserve a remnant – and thus "all", for the tiniest piece of magic nevertheless remains the whole magic, exactly like the largest, i.e. every magic is a hundred percent and can "make" itself the smallest and the largest. "I look at me interestedly as a sick stranger who happens to have the same name as me, and debate the "case" absolutely objectively", quasi as a student or colleague together with the therapist-master, but I except myself completely, do not let the theory and therapy apply to me" – but *tat tvam asi*! (Sanskrit for "that is you"). Such patients can even be a sort of "expert witness", recite the theory by rote – but still be ill, even if considerably improved; they do not notice the improvement or do not let it apply to them; it is only a withdrawal of the demonic front in the face of the attack by the enemy-therapist, an attempt to let him go astray, neurotic strategy, the remaining symptoms are still the entire illness, the therapist-magician is not allowed to triumph, otherwise His Almighty the neurotic would be "finished", the all-power of demonism is his "life", the therapist who wants to "take the demonism away from him" is his deadly enemy.

Many patients train to the normal, believe in the possibility of thinking and acting healthy mechanistically in their illness, of altering the abnormal to the normal. They "cling on" to the all-powerful norm, which of course rules in a metaphysically-unattainable way, but whose letting go will throw man into eternal ruin. Many patients boast about their numerous symptoms, go into endless symptom descriptions that are naive-diagnostic, but are believed by them to be therapeutic (uttering thoughts, catharsis, confession), they proclaim their endless, doleful laments many thousand-fold, their all-suffering, as a gospel (evangelium = joyful message; kakangelium =

bad message) of world-salvation, and in this way steal away from therapy unknowingly. Some patients worm themselves out of the therapeutic corner with leg-pulling and chaffing. Others withdraw into taciturnity, stuttering, total less of speach, in the "rapture of silence" (speech anxiety), that is into the unattainable and therefore absolutely safe beyond, etc. The neurosis is sophisticated – also in its methods of hiding itself and thus rescuing itself from the therapy; it can even disclose itself, like the demonic Godhead, to conceal its "true being".

All that is misuse of cognitive therapy: it is removed more and more with quiet continuation of the work, i.e. the more it is removed, the more the demonistic *Weltanschauung* differentiates in the direction of realic *Weltanschauung*. The therapist does not get tired of demonstrating the nonsensical interpretations to the patient, and these alone are describing his attitude, experience and behaviour adequately. In this the *anxiety about the application* also becomes milder. The patient is taught that it is not a matter of "grey theory", ill-equipped for life, but therapeutic practice, whose characteristic is only that it is applied appropriately to the sick thinking, explains the symptoms from the world-perceptive aspect, and, consequently, by its nature, with verbal clarification; this is very true to life, is directly valid for the sick person, his sick experience and his behaviour (including description). Finishing off the demonism "in theory", but retaining it in practice will not do, and letting the patient hold the "theory" as valid for others, but with the exclusion of himself also will not do. Anxiety about the application is evidence that the patient still believes in the demonism within his symptomatology and, consequently, has also not yet cognitively given up his belief in description, no matter how much he insists he has, and even amuses himself about his "former superstition". He has kept back at least a very small reserve, a taint perhaps, that in accordance with the law of magic contains the entire faith in demons and "justifies" it for the practice of life. The patient can also behave as *if* there were no demons; in this form or doubt he accepts them, places fiction against fiction; "your teaching is negative demonology", he says, e.g., "comparable to the negative theology of the middle ages. You have drawn a picture of the world free of metaphysics, and that is a magnificent achievement, I am completely convinced of the *logical* truth of this, but your teaching does not provide evidence of the non-existence of the demonistic, it *can* exist after all, and thus it would be foolish if I wanted to give up my demonism, i.e. my symptoms, much as I would like to be rid of them". The patient remains in his magic circle, only lets "the teaching" "pass revue externally", only watches and listens, but remains absolutely locked-up: if he were only to admit the most insignificant trifle he would have been done-for (he would, for example, have to got to work, fulfil the task of love, accept something that had been missing in his allness, and would thus have been a failing of infallibility; if he lets himself be "bound" in one way or another, it would have been done with his all-demonism-absoluteness, etc.), he only learns by rote, and not thoroughly.

Therapeutic clarification: psychobiology is neither negation nor affirmation of the demons, the demonistic *Weltanschauung* exists throughout a long period of man's thinking, as is acknowledged, cognitive *Weltanschauung* takes its place, and the demonistic *interpretation* disappears; recovery is the vertical evolution to cognitive *Weltanschauung*, and one cannot become well – and remain ill. The patient is

still demonistic to the extent that he still has symptoms, and to the extent that he is still demonistic, he still has symptoms. The differentiation of the sick experience completes itself according to the differentiation of description, the symptoms become milder in the direction of the norm, the patient must understand that he can neither accelerate nor inhibit this biologic process (with "will", etc.), and that he makes progress *nolens volens*. We aim for the result that even the slightest "hiding place of demonism", the slightest "but what if...?" is found and cleaned out. The patient has become well as soon as he has the complete (theoretical and practical) conviction that the entire demon world is only an interpretation, and in reality, truthfully, does not exist. In practice, he can therefore no longer behave as if it existed in quite the same way.

It becomes clear from this that the patient is not served well by extension of his fictional thinking, with an accumulation of lots of knowledge within his *Weltanschauung*. Not, the patient must depart radically from his demonisitic *Weltanschauung*, he must learn vertically. He must, to the extent that he digests the cognitive therapeutic information into his demonism, be given clarification that he is doing so (naturally not "willingly", or knowlingly, etc., but according to his existing biologic structure at the time). There has to be diagnosis of misuse of the therapy, e.g. in a too rapid ("immediate") success, in recitation by rote of "what has been learned", in cramped adherence to wording (magical ceremonial), in superstitious worship of the therapist and his teaching, in reports such as "I had awful pains again yesterday, then I carried out the therapy, and it helped at once" (word magic), etc.

The therapeutic work of the patient dare not become a neurosis itself, i.e. be placed in the service of the neurosis. Some patients are "not to be got rid of", would prefer to continue the therapy "forever", the therapist "talks so well", "it is so interesting", "I still cannot put the therapy together so well as you", etc. (anxiety about the "end", about independence, one has to manage without a guide then, is "betrayed and sold"). The therapist takes care that the patient gradually becomes independent of him, as the mother makes the child less accustomed to her hand; this "taking care" takes place in the form of clarification of the demonistic sense = nonsense of anxiety about the "final step": one is delivered up to "destiny", lost without the therapist – magic, etc. Many patients are so "enthusiastic" that, like Wagner in "Faust", they "want to know everything"; it is made clear to them that we have to concentrate on the therapy, and only apply psychobiology to the extent that is needed for this purpose, and that it is impossible to discuss "everything". But the therapist does not avoid questions. Every patient comes with *his* doubts, *his* examples, *his* experiences, the therapist must go into these, but also make it understood that the basic laws of psychobiology and cognitive *Weltanschauung* are valid once and for all, that the "endless presentation of details" is superfluous, that the patient does not want to become an expert, but only well.

Further, some patients are of the opinion that they must carry out therapy 25 hours a day, continuously pick away at the illness, conjure-up fancies, and reconsider them "exactly as you say"; they delude themselves that they can ban the illness with their thoughts and must train this sort of magic thoroughly. The therapist makes it clear to the patient that he is demonizing "the thoughts", and that there are really no

demons, that the thoughts are not "spirits", but functional properties of the conceptual cells, and "come and go" according to specific functional periodicity, and also do not let themselves be commanded as compulsive thinking (conceptual hypertrophy), or command themselves, etc. In addition, the patient is at first not so familiar with therapeutic thinking that he can apply it on his own; he "should" apply it, of course, but under the leadership of the therapist, who he informs of them, and who examines, corrects and expands them. It is sufficient that the patient works with the therapist in the sessions; he thinks about what he has heard outside the therapy in any case, i.e. the reflex systems concerned keep on coming into actual function time and again – perhaps intercurrent with daily work or in leisure time, but therapeutic compulsive thinking must be discussed and removed, like the other symptoms. The patient is to be instructed that all diagnostic, case history, etc. (often hypochondriac overgrowth) thinking of and about his symptoms is not therapeutic thinking, and that only the world-perceptive clarification that brings out the sense-nonsense of the symptoms, by setting cognitive reality against them, free of interpretation or (sive) fiction, is therapeutic. This instruction about the facts of life is not magic against the illness-magic, but a special description of the symptoms. The patient learns to know and apply this description, and acquaintance and application take place completely without compulsion, "on their own", namely according to the commencement and progression of the differentiation of the sick functions (in the direction of the norm), and only *this* concern of the patient with his symptoms is healing. All compulsive concern of the patient with recovery is non-therapeutic, and requires world-perceptive explanation again: the patient deludes himself that he can use compulsion as a magic method to deprive the compulsion of the sickness demonism of power, but in reality the "therapeutic compulsion" is also a symptom. Too much reflecting is also just as much a symptom as too little reflecting (thought anxiety, anxiety about "exorcizing the demons", only the therapist-master-magician can do that, or: I do not need to reflect at all, I know everything already, my knowledge is all-knowledge, including the knowledge of the therapist, etc.). The patient can write notes for himself at home and bring them with him to the therapist, but he should not put together any "novels" and perceive "the entire therapy" in simple mechanical records. We do not make any notes in the therapy sessions, the therapy is not paper, but experience. Some patients take a list of their symptoms out of their pockets; "therapist must know everything", "don't forget anything", "memory too poor", "leaving something out is also a lie, and one does not want to lie", etc.; it is explained to them that a dozen symptoms make no difference, the doctor is not a father confessor, so these "reminders" are superfluous, a sign of neurotic anxiety and self-torture.

The patient can read books on psychobiology (depending on his or her level of education); in this way he saves himself and the therapist many an hour, but the therapy is living teaching, the dialogue, where all doubts can be examined and resolved at the time they present themselves, and it cannot be replaced completely by studying books and literature. But there are neurotics who read themselves well through busy and precise working-through and thinking-through my books. In every case the patient must be aware that *he* is meant, and must cease to exclude himself and his neurosis, or to hide in generality.

2.3.7 *Prognosis*

All prognosis is an estimate of probabilities based on experience, but not a promise of healing. In cognitive therapy, neurotics become well to the extent of the biologic differentiation capacity of their sick reflex systems. In general, the prognosis is good. Here, too, the patient receives clear information. No therapist can afford a "guarantee" that he will conjure the sick person into health. The mountain guide also does not promise the mountaineer that he will reach the summit, he only promises to guide him, and from his experience, he can say that, as a rule, the mountaineers reach the peak, and in the present case, depending on what is found, this may be possible or probable, or not. A promise of healing would be, moreover, a suggestion, and this is to be avoided methodically. "Trust"? The cognitive therapist only makes one conviction a presupposition with his patient, that he is a specialist, rather as the teacher is a specialist in a foreign language. "Trust" as a "credulous submission" is a suggestive state, in which the patient leaves "everything" (including all responsibility) to the therapist and does not carry out the self-work, without which he cannot recover. Do not believe, but know! The student can also only make progress to the extent that he learns productively (hears, evaluates, understands), not to the extent that he believes and echoes, even if he piles up "dead knowledge" and becomes a walking encyclopedia (p. 75).

The intensity and extensity of the symptoms does not decide the prognosis; very intensive and extensive symptoms usually regress quickly, while lesser symptoms, also as remnant symptoms, are more stubborn (anxiety about the "final step", dogged striving after the retention of a "remnant", the magic being still the "whole", i.e. being "the whole magic", "demonic life"). The further the neurosis from the norm, the poorer the prognosis. The degree of distance from the norm cannot be measured by its intensity and extensity, but from the total type and biologic individuality of the symptoms. Borderline phrenosis cases should only be taken into treatment with express advice about the poor prognosis; one says to the relatives: I will make the attempt, but with the reservation that I will break off the treatment (protectively) as soon as its hopelessness is apparent. One says to the patient: your case is difficult, but we want to start work and see how far we get. Do not throw in the towel too soon! In many cases the healing differentiation only begins after a long delay, and then often critically ("the spell is broken"). Many patients say at first: I have no idea what you want from me – or he thinks this, and it is the job of the therapist to notice this and clarify it; the patient then says: Aha, now the penny drops! (Aha experience according to *Karl Bühler*, a joy stage).

The "strong interest" of the patient can only be turned to account prognostically to the extent that it is just the first stage of the healing process (the recovery hunger); but it is not a guarantee of success, it is not or has not any magic power, it is often to be discussed specially, be it hypertrophic, be it not directed towards recovery at all, but, for example, to scientific orientation (the patient "understands" it), or to "opposition to as such" and "teaching the teacher a lesson", or to a naive getting to know the methods (curious), etc. Many a patient follows a secondary purpose as the main purpose, e.g., "I'm only here out of

professional interest" – or "only because of my husband, he wanted the treatment"; prognosis is poor if the secondary purpose cannot be dethroned. Many patients make a headstrong demand for treatment, but have such an intensive anxiety about leaving the house or the flat or the bed that they cannot come to the therapist. One can attempt to relieve this anxiety in the patient to the extent that he can come to the therapist, but the prognosis is mostly poor: the patient already has the upper hand because he has "compelled" the therapist to come to him, and defends this position stubbornly. If the patient comes without (for him necessary) accompaniment, the prognosis is better than when he is "brought", "dragged along". It is wrong to persuade the patient that he should come on his own or to threaten him that he will come to nothing otherwise, etc.; one must enter the therapy quietly, and may expect that with progressive improvement this symptom of anxiety will also become milder to the extent that the patient does not need the accompaniment any more. I say: as far as I'm concerned, you can hire yourself a bodyguard, I do not compel you to come alone, I hope you will soon learn that the demonic dangers that seem to be hovering before you in your sick anxiety do not exist, so that the need for a "guard" vanishes on its own.

Every neurosis is as old as the neurotic. The patient's statement that he has been "suffering for 20 years already" only means that he had previously not known about his neurosis (it was still latent *for him*), the "duration" of the illness cannot be used prognostically; in this, this patient is neither better nor worse off than any other who says he has only been ill for 5 years or 3 months.

For the individual case, the *duration of the treatment* cannot be given precisely; how the individual patient "responds" cannot be foreseen, i.e. his rate of differentiation is just as unlikely to be foreseen as the level of differentiation he is able to reach, namely the level to which the vertical recovery progresses. One can only give the average, with the comment that the prognosis in individual cases has to remain open as regards time, but the expectation exists that the patient is within the average (about 12 to 16 weeks with 1- to 2-hour consultations three times a week). This has the advantage that the patient does not "fix" himself to a certain date and becomes more and more anxious the nearer the approach of the date ("Will I manage it or not? If I don't manage it, I'm incurable and therefore lost, and if I pass the big exam I will have to satisfy the major demands of life, and if I cannot master destiny, I am still lost"; furthermore, the date as demonistic compulsion, etc.).

The same holds true for the *fee*; it has to be adjusted to the social position of the patient in such a way that a certain excess over an agreed amount sum is possible, so that the patient does not start to worry, and does not "fix" himself to a certain amount. If the fee is to be paid by a third party (health insurance, etc.), it is established according to the limits and a request for the continuation of the therapy is made with adequate notice. It is wrong to treat without a fee. Some sort of bill has to be presented, no matter how modest. Nothing is given as a present in professional life, and love has nothing to do with the profession; the patient certainly takes unfair advantage of the therapist, and also devalues work that costs nothing.

In sorrow neuroses the prognosis is not as good as in the other forms of neurosis. Joy neurotics hardly ever come to the therapist. Mixed neuroses have to be approached from the schizoid side. In neuropathies, namely cerebral anomalies and the concomitant symptoms of other hadroses, the prognosis is influenced from the hadroses side.

2.3.8 *Therapeutic mobilization*

No matter what attitude the patient adopts to the healing work, and how he behaves according to his neurosis, if he wants to be well, he has no alternative other than to leave his previous *Weltanschauung* and to grow into realic *Weltanschauung*. Every vertical teaching brings something new from the biologically higher level (in contrast to horizontal expansion in which the patient does not give up his previous demonistic thinking, but finds it to be confirmed). But everything new is doubted at first. Thus, therapeutic doubts also occur in cognitive therapy; they interweave themselves with the already existing neurotic doubts, so that the patient at first says he is now all the more confused. It is however the first task of the patient to become uneasy about his previous *Weltanschauung*. This brings the sick areas into a functional mobilization; without it a higher differentiation is impossible. One must become uneasy about the previous belief-systems if one wants to resettle in a new level. One must understand (clarify) a misunderstanding in order to leave it. The morbid doubts resolve themselves according to the resolution of the therapeutic ones. So, the patient must fight it out. The tumult (with intensivation of the symptoms) is the beginning of recovery, the storm before the calm. One explains this to the patient in the horizontal healing process, e.g. the gout modules can only disappear if the deposited uric acid is mobilized, chronic (e.g. tuberculous) inflammation can only become latent in the event that it alters from the torpid course to the acute form. So the leptotic area also has to come into functional stimulation if it is to differentiate itself out of its stagnation and its habits into the normal. The "tool" for this vertically-directed mobilization is cognitive therapy teaching: the therapeutic doubts are healing in its true sense. The patient is to be prepared in time for these excitations with adequate announcement, and also for the critical moods and reflections, he then lives through – prepared for them – with less intensity, and will not be confused about the therapy.

The patient has to make up for the differentiation of the sick reflex systems out of the early childhood period into the differentiation level of the healthy reflexes. He has to live through the early childhood world catastrophe subsequently (loss of aloneness, disuniting of the world), as well as all later evolutionary steps and crises in his sick areas until the homogeneous evolutionary front is produced. Now, the neurotic functions with their demonistic interpretations are to be compared with the primitive-phylic puberty battles to life or death with the "daimon", the patient deludes himself continuously ("eternally") in the demonic battle for all-oneness, all-power, in being or not being, life or death, in the course of which, structurally, the raw brachial violence is usually not commited any more. In contrast, the maturation process is *the therapeutic puberty experience:* the patient leaves his primitivism with

its demonistic interpretations and moves into cognitive *Weltanschauung*. But this process takes place, first of all, as mobilization of the sick areas, namely with excitements that once again are analogous to those of the primitive puberty crisis, so that the patient at first also misunderstands the therapy as the general attack on his all-oneness, etc. The clarification of the patient-therapist relationship (the therapist does not fight with the patient, he is not an enemy, but a guide, he is not the father, but a [health] teacher, he is not pro or contra, but neutral) soon results in the removal of this misunderstanding on principle.

With progressive recovery the sick excitements ease off, like the therapeutic ones, the symptoms vanish, and thus also the raw interpretations, and only in crisis-type waves "the devil seems to be on the loose again", but already in diluted demonism, which is of course still "the whole demonism". The patient still affirms himself in his residual symptoms, i.e. his demonism, and no matter how diluted it is, in this way it remains the all-power, "life" and "death", also termed soul, spirit, energy, etc. The patient is entirely recovered only after he has completely given up the demonistic way of thinking.

The therapeutic puberty experience is much more difficult than normal maturing with its passing through puberty. The child matures over about fourteen years, and gradually lives through the degrees of dilution of the demonism, and this world-perceptive differentiation process continues in youth, etc. But "in old age", the patient, no matter how young or old, must get to know, and also learn, the things that the healthy person of the same age has long since left behind, and in a few weeks. Naturally, every detail that the healthy person lives through cannot become actual in this; for example, in the recovery process the forty year-old cannot subsequently re-experience everything that he might have experienced in the event of healthy differentiation in these years, he does not have the time for supplementary re-differentiation of the "spoiled" forty years. The recovery process takes place summarily in major lines, in express-train tempo (the express-train also does not stop at every station), and there is certainly a disadvantage in this: the healthy-organic evolution is missing, the constant series of evolutionary steps with all the details, comparable to the grains of a mountain of rice that the healthy person eats his way through. Thus, the neurotic can never become so healthy that it is as if he had never been ill; the neurosis also heals "with a genetic scar".

2.3.9 *Conclusion*

As a rule the patients reach the recovery target; they will be completely competent in the autonomic, sensory and idealic functions of the trophic and genic areas, the "almost", the morbid nuance also disappears from the up-to-now almost-healthy parts. A differentiation that has been reached cannot regress, "relapses" are therefore impossible in true recovery, they are always a sign that the intensity of the symptoms had sunk down suggestively or in their periodic course, that true healing has not taken place, and for this reason exact attention has to be paid to this in cognitive therapy.

The patient cannot of course differentiate over the biologic boundaries of his personality, and thus not over his age. The healing of the neurosis enables many people to carry out higher tasks, to take over higher positions than before, but this elevation of the biological niveau also remains within the boundaries of personality and individual specificity. Furthermore, the 20 year old cannot reach the maturity of the 30 year old. Young children are not really suitable for cognitive therapy treatment, and older children also have to wait till at least the beginning of puberty (about age 11 or 12), and be left to conventional rearing supplemented with child-guidance methods; on the other hand, clarification about ghosts, fairytales, myths, mind-spirit, etc., namely, world-perceptive introductory explanation, can prepare for cognitive *Weltanschauung* and lead to early interference thinking (with improvement of the symptoms). Children at the beginning of puberty can already be taught cognitive-therapeutically; the teaching has to be attuned to the age, just as the symptoms are age-specific, so for the younger patients understandable facts are discussed (man: reflex being, sickness: infantilism, etc.) to elucidate the demonistic thinking up to the level of interference thinking.

It would be best if *Weltanschauung* instruction were a part of the school syllabus from the upper school onwards; this would provide the healthy schoolchildren with a highly desirable explanatory clarification, and the neurotic children with an advancement in health that would certainly make actual treatment superfluous in many cases. Furthermore, interference thinking elevates itself to the cognitive, and in this way the symptoms that still have not been completely disposed-of in childhood and youth remove themselves. The therapist checks the status from time to time (about once a year) and continues the treatment for some time (depending on the situation, for one or two weeks). If the children are not yet capable of accepting treatment, then the parents should receive cognitive therapy. If the parents are set right, then their attitude to the child is also right, the child finds no further confirmation for its interpretations and behaviour in such proper representatives, and under such circumstances his or her health can only benefit (p. 149f).

The differentiation reached in cognitive therapy usually continues further on its own. Mostly, the patient is free from the therapist. In the other cases, where full recovery could not be reached at one go, it is correct to help further with a short repeat course in due time. This applies particularly to treated children and adolescents: they cannot and should not be spared the tasks that the healthy person completes, and cognitive therapy assistance may be necessary in the resolving of higher tasks in profession and love. Sick structures that were still latent during treatment can happen to become manifest later on. Some patients only have a short holiday, the therapy can then be continued and completed at the next opportunity. Some patients "dose" the therapy out of anxiety about its ending; they want to make a pause and then come again, and for that purpose they put in all sorts of pretexts and excuses that are pseudo-logic, but whose pseudo-logic the patient often does not see through. The therapist should not accept such pretexts – they are as cheap and numerous as grains of sand at the seaside, but he does not exhort, he explains that the illness also has its logic, but a sick, a pathologic logic, and that the pseudologic is fond of using normal logic arguments for its false justification (e.g. "my sister is coming on a visit, I have

to devote myself to her and cannot come for treatment, it is also a good thing to consider what I've heard for a while", etc.), and naturally the therapist explains the world-perceptive sense of the interruption: anxiety about the "loss of all-oneness", about the recovery with its "monstrous" duties, anxiety about an "innermost secret", triumph over the therapist-demon, etc. Some patients achieve insight and stay, others come again, others are never seen again (interruption = breaking off, delayed is removed). The therapist should not "send the patient away" (perhaps out of regard for other patients who are marked down for treatment, etc.), the treatment should "run down on its own", namely, succeed to a point where the therapist and patient are convinced that they have finished. The case is different when the prognosis is definitely poor.

As a rule, cognitive therapy arrives at a good end. The recovered person accustoms himself to healthy living; he soon believes it was never anything else, he also forgets many details concerning the therapy – as adults forget many details about their rearing, school lessons, etc., the master, the countless manipulations that they carried out while learning. The recovered person has worked himself through the details of the therapy and has reached a differentiation level whose details are fused and integrated into the higher entirety, he has grown into cognitive *Weltanschauung* and can now no longer know the individual stages, the path he has gone through, and he does not need to know them any more, he is not an expert and cannot give information about "everything that was discussed and happened in those weeks". Of course, the expert must be well informed and able to give precise answers.

If the task is completed, it has done its genetic duty, and the recovery task is only completely performed when it no longer appears or can appear actual, and is in this sense over and forgotten.

3. Appendix

3.1 What is Psychobiology?

Psychobiology: Empirical biological science founded by *Lungwitz* in 1923 and developed in decades of fruitful work. Founded on exact science, this is a purely biologically centered psychological-anthropological theory which is based on the stipulation that knowledge of the (healthy and ill) person should adhere exclusively to facts which can be checked and has to dispense with all psychological or psychopathological considerations based on magic, myth, or mysticism. Psychobiology is thus the "science of the healthy and the diseased person based on the insight that the human being is a purely biological organism, i.e. that even the 'mental processes' and phenomena are biological". The starting point of his epistemological considerations is for L. the question as to the nature of perception (according to L., this is both "antitheticality" and "polar simultaneity": subject:object, mind:body, I:You, content:form, negative: positive, nothing:something, female:male, etc.) and the development of consciousness and thus the nature of things. L. contrasts the "demonistic" (interpreting, fictional) pattern of thinking (e.g., spiritual faith, but also "motivism", i.e. causalism, conditionalism and finalism in psychology) with "realic" thinking: faith in the existence of the metaphysical (e.g., of souls or forces resembling souls) is the content of a demonistic (fictional) view of the world; by means of realic thinking, on the other hand, metaphysics can be seen to be a fiction and one can develop a realic-biological view of the world. The epistemological clarification of the nature of consciousness and the medical elucidation of the biological structure and function of the nervous system including the cerebral cortex as the organ of consciousness enables L. to recognize the human being as a purely biological entity consisting entirely of reflex systems. The experiences of the human being are also biological in nature and can hence only be explored psychologically on a biological basis. With the insight that all mental processes are functions of the nervous system or the brain, any methaphysical speculation becomes a dispensable fiction from the "demonistic" assumption of a "soul" up to the aberrations of Freudianism. For example, the dualist body-soul problem as well as the (metaphysical) problem of causality prove to be a fictitious matter of no concern. The solution of the problem of causality without metaphysical implications (purposive causes) is found by L. in the restriction to description of the factual situation without metaphysical interpretation, i.e. in a "biological determinism" in consequence of which the human being is as he/she is and behaves according to his/her proper nature. Of particular anthropological-medical importance is the theory of neurosis developed by L. in the context of psychobiology as well as the adequate medical-philosophical method of treatment he inaugurated, the cognitive therapy (*Erkenntnistherapie*) (only the way of knowledge leads to cure!). In his theory of disease, according to which psychological diseases are also only physical, L. distinguishes hadroses (organic diseases) and leptoses (functional disorders). The leptoses include the neuroses, which, depending

on whether the genic (oriented to reproduction by love and procreation) or the trophic (oriented to preservation of life by nutrition and work) part of the personality falls ill, are either genoses (neuroses of platonics and sexuality) or trophoses (neuroses in the field of nutrition and work). Like Freud, L. sees the neuroses (and going farther than Freud, diseases in general) as infantile disorders and inhibitions of development, which are manifested in childish exaggerations, exaltations, overestimations and underestimations, etc. Besides the object neuroses (neuroses of sensory perception) and the conceptual neuroses (thought neuroses in the narrower sense), L. distinguishes the following five types of feeling neuroses or neuroses in general, since objects and terms are also a matter of "feeling": hunger, anxiety, pain, sorrow and joy neuroses. Whereas these five basic feelings have a harmonic relationship to each other in healthy persons and they regularly follow each other with roughly equivalent intensity, in the basic experience series of the hunger-anxiety-pain-sorrow-joy scheme according to which all experience occurs, this harmony is disturbed in the neurotic person. Besides the basic feelings, L. also distinguishes mixed feelings (e.g., envy) and congestive feelings (e.g., hatred). The complex structure of neurotic disease is illustrated by an example: a pain neurosis can for example be trophically or genically centered and may be actively or passively accentuated in each of the two cases; in the case of trophic pain-pleasure, a distinction is hence to be made between active and passive dolorism, in the case of sensual pain-pleasure between (active) sadism and (passive) masochism, mixed forms being common (e.g., sadomasochism). Finally, L. has extended his psychobiological theory, i.e. his (a very highly differentiated theory accordingly permitting profound human knowledge) biological-psychological-anthropological-medical theory of the human nature (in the form of a minute description of the healthy and the diseased person and his world in all stages of biological development) to a philosophy of life, indeed to a comprehensive philosophical system. Within this system, he comments on all ideologically relevant questions from sociology, biogenetics, educational science, philology, law and politics, ethics and esthetics, evolutionary theory, cosmology and philosophy of religion in a highly original way. He measures his psychobiological theory constantly by the facts, in order to verify the "realic" (based on realic thinking) view of the world of the "realic" (healthy, mature, i.e. cognitive) person and to safeguard it against possible objections from all sides and in its final consequences. "Psychobiology" in this widest sense is thus a "biological philosophy", which encompasses all fields of life and science.

From Austeda, F.: Lexikon der Philosophie [Lexicon of Philosophy]. Verlag Brüder Hollinek, Vienna 1979, pp. 287-288 (preparation of the text for translation into English, R. Becker). Used by permission.

3.2 The Terminology of Psychobiology

This book contains a number of psychobiology terms. They are explained below. There are neologisms like "genosis" that precisely describe previously vaguely defined states. On the other hand, there are familiar expressions like "*Weltanschauung*", with

different meanings, so how they are meant here has to be stated. Other key words are defined in the text of the book, and can be found in the subject index.

Cognitive Therapy. Synonym: psychobiological analysis. The psychobiological treatment methods, or the functional therapy of the neuroses inaugurated by *Hans Lungwitz.* A verbal process of revealing and structuring. Its aim is the adjustment of functional development differences in the neurotic, with correction of infantilistic personality components concerning cerebral function, to the benefit of the higher and more mature development level and, with this, the elimination of morbid manifestations in the internal and external organs. Cognitive therapy fastens on the infantilistic experience of the patient and informs him about the substance and essence of his symptoms, without attacking the symptoms as such. Misinterpretation due to morbid experience and behaviour is demonstrated to the patient in a way he can verify. Maturing, he learns to recognize the nature and sense of the neurotic uniqueness (absoluteness and all-oneness) of his neurotic standpoint, and to renounce it. The morbid symptoms finally disappear with the changed behaviour that follows from altered insight in the evolutive process of rethinking.

→ Neurosis, Psychobiology, *Weltanschauung.*

Concept. One of the three types of object: feeling, sensory perception (the object perceived by the senses), and concept. Concept is memory. Concept is a manifestation of consciousness lying on the reflex pathway leading over the idealic (conceptual) sphere. This is the cortical centre of the idealic nervous system (limited to the cerebral cortex) and is the organ of concept perception. The concepts (memories, ideas, thoughts, etc.) are actuality series of certain cortical brain cells, the idealic thinking cells (concept cells). There is no direct expression of concept. The connections between the idealic system and the motor system are indirect; consider "circumspect" movements, "well-considered" actions, "prudent" behaviour, etc.

Psychobiology differentiates between three types of concept: individual, collective, and final. Example: the memory of the optically perceived (certain) object "house" is the individual optical concept "this house". It fuses with other individual concepts of "house" into the uniform collective concept "house", which includes all individually conceived houses as a uniform type ("farmhouse" type, "skyscraper" type, etc.). The final concept is "a building" or "a house as such"; the general idea of a house.

The objects of conceptual perception are described according to their "feeling tone", influenced by such feelings as hunger or anxiety. The feeling quality, or tone, of the concepts is not the same as the feelings themselves, with which the concepts, or memories, are associated.

Concept Neuroses: see text.

→ Object perceived by the senses, Reflex System, Thought Cells, Feeling.

Feeling. One of the three types of object: feeling, object perceived by the senses, and concept. Feeling is a manifestation of consciousness, lying on the reflex pathway leading over the sensile (feeling) sphere. This is the cortical centre of the sympathetic-parasympathetic nervous system and the organ of perception of feeling. Feelings (moods, humour, affect, etc.) are actuality series of certain cerebral cortex cells, the sensile thinking cells (feeling cells). Feeling expression manifests itself in a specific motor-secretory way at its organ of expression (for example, a certain feeling of hunger corresponds specifically to the innervation of certain muscle fibres and digestive glands in the mouth, intestine, etc., i.e. the organs where the feeling is localized).

Psychobiology differentiates five so-called basic feelings: hunger, anxiety, pain, sorrow, and joy; in addition, there are congested and mixed feelings. For example, hate is a congested feeling, congested hunger, and solace is a mixed feeling: joyful sorrow, or sorrowful joy, depending on the preponderance of the one or the other of the component feelings.

Hunger, anxiety, etc. are understood in the summarized description of the hungry, anxious, etc. experience as uniform collective concepts. In this way the various individual concepts of hunger and its nuances (such as a desire for love, hunger for food, thirst for knowledge, want, demand, covetousness, intention, addiction) are covered by the collective concept "hunger", to which the individual feelings correspond as well as the "feeling tone" belonging to the associated sensory perception and concept perception. As a result, the concept of "hunger" is not identical to the feeling with the same name.

Feeling Neuroses: see text.

→ *Concept, Object perceived by the senses, Reflex System, Thought cells.*

Genosis, adjective*:* genotic (Greek: genan, to breed). The vital functions are all to be grouped together into the two classes of nutrition (trophic) and reproduction (genic). The genoses are the neuroses of sensuality (sexuality) and the platonic. The platonic is non-sensual, non-sexual love. It includes child-parent love, friendship, love of humanity, religious love, hobbies and favourite leisure activities, and love of art and the sciences.

→ Neurosis, Trophosis.

Hadrosis, adjective: hadrotic (from the Greek: hadros, gross, swollen; vide hadrons in physics). The hadroses are the illnesses known up to now as organic diseases. However, as the purely functional diseases are also organic, always taking place in the body tissues, it is wrong to reserve the term "organic disease" for the anatomical diseases that can be diagnosed by gross tissue alterations. Vice-versa: the organic disturbances are always also functional; in the hadroses, the functional findings are in the background of the anatomic.

→ Leptosis.

Leptosis, adjective leptotic (from the Greek leptos: thin, tender, fine; vide leptomenix, leptospirosis, leptons in physics, etc.). The leptoses are the purely functional illnesses. As nerve-brain diseases, the neuroses and phrenoses are leptotic (purely functional), or the so-called psychic disturbances without organic findings, as they have been designated up to now. There are only gradual differences between the functional and the "organic", or the "psychic" and the physical processes. These processes are both physical and organic. Change in function accompanies organic change; however, in the leptoses, no gross tissue anatomical evidence is found.

→ Hadrosis, Neurosis, Phrenosis.

Modal Cells. Cerebral cortex cells whose peak function is consciousness of the objects perceived by the senses.

→ Object perceived by the senses (sensory perception).

Neurosis. Collective term for the purely functional illnesses situated between the normal and the phrenoses ("psychoses"). Neurosis is neither psychic nor psychogenic; it is a pathobiological fact. The expression of neurosis in the internal and external organs is a phase in the course of correspondingly morbid nerve-brain functions that focus as disturbances of consciousness or (sive) of thinking. Neurosis is therefore to be defined as morbidity of thinking. Since there are no anatomic findings, it is "pure" morbid thinking. The way the neurotic comprehends the world, according to the structure and function of his cerebral cortex, is his *Weltanschauung*. Neurosis is a disease of *Weltanschauung*. The symptoms of neurosis are situated in the (early) infantile development area. Neurosis is infantilistic ideology.

→ Cognitive Therapy, Genosis, Leptosis, Phrenosis, Thinking, Trophosis, *Weltanschauung*.

Object perceived by the senses (sensory perception). One of the three types of object: feeling, object perceived by the senses, and concept. The object of sensory perception. The objects the senses perceive are manifestations of consciousness, lying on the reflex pathway leading over the modal (object perceived by the senses) sphere. This is the cortical centre of the sensory nervous system and the organ of sensory perception. Objects perceived by the senses are actuality series of certain cerebral cortex cells, called modal thought cells (sensory perception cells). The modal expression occurs kinetically in a specific way at the corresponding organs of expression (for example, as specific arm-bending, torso-twisting, larynx movement/type of speech, etc.).

Psychobiology differentiates nine senses: the optic (visual), acoustic (hearing), tactile (touch), thermic (temperature), olfactory (smelling) and gustatory (taste) senses, and the kinesthetic (position), static (strength) and topical (direction) senses. The last three senses cover coordinative perception.

The objects perceived by the senses are described according to the "feeling tone" they present (for example, as influenced by feelings of being hungry, anxious, etc.). Note: the feeling quality of the objects the senses perceive (the "feeling tone") is not the same as the feelings themselves, with which the objects the senses perceive are associated.

Sensory Perception Neuroses (Neuroses of objects perceived by the senses): see text.

→ Concept, Feeling, Reflex System, Thought Cells.

Perception: see *Weltanschauung*.

Phrenosis, adjective phrenotic (from the Greek phren: the diaphragm, the seat of the soul, according to the ancient Greeks). The phrenoses are the functional brain diseases that lie between the neuroses and anatomic brain diseases (encephalosis and encephalitis), or the previously so-called psychoses without organic findings. In psychobiology, the word "psyche" is used exclusively in the cognitive theory sense. It is not suitable for the description of physical and organic processes – including the purely functional.

→ Hadrosis, Leptosis, Neurosis.

Psychobiology. The science founded and developed by Hans Lungwitz (not to be confused with Adolf Meyer's teaching with the same name in the United States of America).

Basically, it poses and answers the question: how do human thinking, human consciousness and *Weltanschauung* come about? Psychobiology proceeds, on the one hand, with cognitive theory, and on the other, medically.

As cognitive theory it deals with the question according to the substance of the matter, the triad: what is the recognized (the object, perceived, thought of, etc.), what is the recognizing (the subject, perceiving, thinking etc.), and in what manner, and how does the recognition take place?

Medically, it investigates the healthy and the sick person according to the special structure and function of his organ of thought and its expressions.

With the overcoming of the body-mind problem, the results of both these investigations lead psychobiology to a consistent understanding of the human being. In this way, it is the theory of *Weltanschauung* and is also medical science.

In particular, psychobiology investigates and describes the development of the way of human thinking, and records its laws and regularity, including deviations from the norm.

As cognitive criticism, it deals in depth with the causal way of thinking and its scientific statements.

Psychobiology itself adopts a non-causal standpoint, and thinks in exclusively genetic and associative connections in time and space. It holds that causal thinking is capable of being overcome by evolution. It describes its own way of thinking as realic, or cognitive.

The so-called spiritual-mental processes in the organism are described by psychobiology as exclusively biological nerve-brain processes. With the method of cognitive therapy of the neuroses, it is applied science.
→ Cognitive Therapy, Neurosis, Reflex System, *Weltanschauung*.

Reflex System. Synonym: part of the personality. A reflex system consists of the peripheral receptor (the sensing nerve ending), the centrally-leading (afferent) nerve pathway, the central nerve cell complex, the peripherally-leading (efferent) nerve pathway, and the organ of expression.

The complete nervous system is composed of the sympathetic-parasympathetic system, the sensory system, and the idealic system (limited to the cerebral cortex). A complete reflex system therefore has sympathetic-parasympathetic, sensory and idealic parts (for further differentiation of the reflex systems, refer to the text). The function of the reflex system is the reflex. Psychobiology defines reflex actions as exclusively temporal (acausal) and biological events. The cerebral cortex is the organ of consciousness. The conscious, the actuality, the object, is a manifestation sited on the reflex arc leading over the cerebral cortex. If a reflex runs over the cerebral cortex it remains a reflex, nothing else, but it is called thinking, and not reflex. According to the reflex, the internal and external reflex expressions correspond to the *Weltanschauung* of the individual. In the human organism there are only reflexes, and their actual functions. The human organism is a homogeneous, biological combination of reflex systems.

→ Concept, Feeling, Object perceived by the senses, Thinking, *Weltanschauung*.

Thinking. Thinking is a physical, biological function of the brain cortex; in its functional course, perception, actuality, consciousness arise. In general terms, thinking describes the function of the cerebral cortex, be it unconscious and non-actual, or conscious and actual (i.e. with consciousness and actuality). In the narrower sense, thinking means the conceptual function of the cerebral cortex.

→ Reflex System, Thought Cells, *Weltanschauung*.

*Thought Cells.*Cerebral cortex cells in whose biological function the formation of consciousness arises.

Trophosis, adjective: trophotic (from the Greek trophe: nutrition; vide trophoneurosis, trophic, etc.). The vital functions are grouped collectively into the two classes of nutrition (trophic) and reproduction (genic). The trophoses are the neuroses of nutrition, work and profession.

→ Genosis, Neurosis.

Weltanschauung. How a person perceives. The leading fact for generally designating perception as *Weltanschauung* is that the sense of sight (*anschauen* – to look at) is

preponderant in human perception. *Weltanschauung* embraces the sensations, as well as the feeling and understanding ("spiritual-mental") adjustment to the environment. It can be recognized in expression and behaviour, including speech behaviour and description. *Weltanschauung* corresponds to the constitution and activity of the organism and to the personality of the individual. It corresponds in particular to the structure and function of the cerebral cortex as the organ of consciousness. it is specific to the individual; it has a development history (ontogenesis and phylogenesis).

The science of *Weltanschauung* and its development is the theory of *Weltanschauung*. It belongs to philosophy, and is close to cognitive theory and to medicine, where it is the science of the structure and function of the organ of consciousness. In this sense, the term *"Weltanschauung* theory" is scientifically defined, and generally valid. In lay terms, *"Weltanschauung"* is often understood as purely private opinion, and the theory of *Weltanschauung* as "subjective" (prescientific) ideology, or a political or religious system of belief.

→ Neurosis, Psychobiology, Reflex System.

3.3 Chronological Table of the History of Lungwitz's Cognitive Therapy

1924 Hans Lungwitz (1881 to 1967), a physician in Berlin, introduces the term "Cognitive Therapy" (Erkenntnistherapie) to the literature.
Lungwitz, H. (1924): Über Psychoanalyse [On psychoanalysis]. Leipzig, Wien: Oldenburg, p. 10.
He disassociates himself from psychoanalysis after Sigmund Freud refuses cooperation with his proposals to correct psychoanalytic theory.

1925 Lungwitz introduces the term "cognitive thinking" (kognitive Denkweise) for what he also calls "realic or highly mature way of thinking", and assigns it to cognitive therapy.
Lungwitz, H. (1925/1947): Die Entdeckung der Seele. Allgemeine Psychobiologie [The discovery of the mind. General Psychobiology] 3rd–5th ed. Berlin: de Gruyter, p. 182 (lst ed. Leipzig: Oldenburg).
Initation of courses in cognitive therapy for physicians.

1926 The first comprehensive scientific magazine article, with the title "Erkenntnistherapie" (cognitive therapy) appears in the "Zeitschrift für die gesamte Neurologie und Psychiatrie" (Springer: Berlin).
Founding of the "School of Cognition – International Psychobiological Society" in Berlin.
Berliner Börsenzeitung No. 471, 9th Oct. 1926.
First secondary literature in Latvian and Russian.

1932 After many publications about cognitive therapy in various specialist journals, Lungwitz's book "Erkenntnistherapie für Nervöse" [Cognitive Therapy for the Nervous] appears, for the popular science market. The eighth edition appeared in 1977.

1933 First secondary literature in book form as a Socratic dialogue: "Heilen durch Erkenntnis" [Healing by Cognition] by L. Kopelowitsch, Lungwitz's student from the Baltic.

Increasing international acceptance of cognitive therapy. First review of cognitive therapy in the USA (Staatszeitung und Herold, New York, 25th July 1933).

Lungwitz refuses a request by Adolf Hitler's adjutant to take over the treatment of "Der Führer". He justifies his refusal "with reference to the fact that I had already sufficiently diagnosed the incurability of Hitler". The consequence is the denunciation of Lungwitz by the later Reich Minister of Health, L. Conti, to the Reich Propaganda Minister, Josef Goebbels, regarding his "serious insult to the Führer".

Lungwitz narrowly escapes personal persecution.

Schenck, E. G. (1989): Patient Hitler. Eine medizinische Biographie [Patient Hitler. A medical biography]. Düsseldorf: Droste Verlag, pp. 513–514.

Banning of the "School of Cognition – International Psychobiological Society". Removal of Lungwitz's books from public libraries.

1936 At the 4th European Meeting for Mental Hygiene in London, Lungwitz makes a public appeal to the League of Nations under his life motto: "One thing is necessary – cognition". In it he forecasts the outbreak of the abnormality of war, and its disastrous consequences. He demands: "The freeing of the people from neurosis is the highest task of a League of Nations ... by the use of cognitive therapy". (Psychiatr.-Neurolog. Wochenschr. 38, No. 40 [1936]).

to 1945 The National Socialists bring politically-adjusted non-Jewish psychoanalysts according to Freud, Jung and Adler to Berlin, into a "Reich Institute" to evolve a "New German Science of Mental Healing" including psychonalysts who regained dominant positions after the war in Berlin and West Germany, who radically reject cognitive therapy, and are at loggerheads with Lungwitz.

Lungwitz, now aged about 60, does not dare to expose himself to political risks any more, but develops his philosophical and medical anthropology, namely psychobiology, further.

1947 De Gruyter, scientific publishers in Berlin, put the entire scientific works of Lungwitz into their programme.

1952 Refoundation of the Psychobiological Society.

1955 Lungwitz's presents his complete, systematized psychiobiological neurosis teaching and cognitive therapy in two volumes totalling almost 1,000 pages.

1967 Lungwitz dies in Berlin, aged 86.

1968 Foundation of the Hans-Lungwitz-Stiftung in Berlin.

1975 Foundation of the Medical Psychobiology Association in the Federal Republic of Germany with the aims of cultivating Lungwitz's psychobiology and making it known.

1980 The nucleus of Lungwitz's neurosis teaching and cognitive therapy is published as a university pocket book.

1981 W. Machleidt demonstrates EEG characteristics that correspond to the five basic feelings detected by Lungwitz.

1983 For the first time since the World War II, cognitive therapy is presented to an international public at the 7th World Congress of Psychiatry in Vienna. Further international contacts follow, and the first publications in English about Lungwitz's cognitive therapy.

1987 Founding of the "Institute for Psychobiological Analysis and Cognitive Therapy" in the Federal Republic of Germany.

1988 At the XIV International Congress of Medical Pychotherapy, personnel from the institute carry out training in cognitive therapy on the international level. *(Becker, R. (1991): Zur Geschichte der kognitiven Therapie [On the history of cognitive therapy]. Psychobiologie 39, pp. 5–13).*

3.4 Literature

Basic information for a critical study of the theory of psychobiology and cognitive therapy can be found in the following.

Hans Lungwitz: Lehrbuch der Psychobiologie [Textbook of Psychobiology]

Part 1 Die Welt ohne Rätsel [The World without riddles]
Volume I: Das Wesen der Anschauung – Der Mensch als Reflexwesen – Von den Eigenschaften und Funktionen [The nature of perception – The human being as a reflex being – On characteristics and functions]
2nd revised edition, Hans Lungwitz Foundation: Berlin 1970.
Volume II: Die neun Sinne [The nine senses]
Brücke Verlag K. Schmersow: Kirchhain N.-L. 1933.
Volume III: Die Psychobiologie der Sprache [The psychobiology of language]
2nd edition, Hans Lungwitz Foundation: Berlin 1979.
Part 2 Die Psychobiologie der Entwicklung [The psychobiology of development]
Volume IV: Der Mench als Organismus – Die Kultur [The human being as on organism – culture]
Brücke Verlag K. Schmersow: Kirchhain N.-L. 1941.
Volume V: Die Weltanschauung – Der Charatker [Weltanschauung – character]
2nd revised edition, Hans Lungwitz Foundation: Berlin 1969.
Part 3 Die Psychobiologie der Krankheit [The psychobiology of illness]
Volume VI: Das Wesen der Krankheit und der Genesung [The nature of illness and recovery]
2nd revised edition, de Gruyter: Berlin 1953.
Volume VII: Die Neurosenlehre – Die Erkenntnistherapie [Neurosis theory – cognitive therapy]
First part. De Gruyter: Berlin 1955
Second Part. De Gruyter: Berlin 1955.
Part 4 Das Buch der Beispiele [The book of examples]
Volume VIII: Aus der Weltanschauungskunde – Aus der Neurosenkunde [From the science of weltanschauung – From the science of neurosis]
First part. De Gruyter: Berlin 1956
Second part. De Gruyter: Berlin 1956.

Psychobiology and cognitive therapy literature up to 1973 was from Schweckendiek, A. and R. Hesse: Bibliographie der Psychobiologischen Literatur 1924–1973 [Bibliography of Psychobiology Literature 1924–1973].
Psychobiologie – Zeitschrift der Psychobiologischen Gesellschaft [Psychobiology – Magazine of the Psychobiology Society] *22* (1974), 189–218.

3.5 Sources of figures and illustrations

Figures 1-3, 5, 6, 9, 11, 17: editor.
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Figures 8, 12, 13: diagrams from Lungwitz, amended by the editor.
Figure 10: from Lungwitz, H.: Lehrbuch der Psychobiologie. Volume I. 2nd revised edition Hans-Lungwitz-Stiftung: Berlin 1970, p. 534. New illustration. Printed by permission.
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3.6 Subject index