

# NOTES ON THE DEVELOPMENT OF MY CONCEPTS

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In the German classical gymnasium in which I was educated, our interest and learning was essentially directed toward the humanities, and so was my reading outside of school. Nevertheless, the young men in the gymnasium generally tended to choose natural science as a profession. When I had to decide between natural science and philosophy before entering the university, I did not know which to choose. In deciding on natural science, I was certain that I would use it only as a basis for becoming a physician. Medicine alone appeared suited to my inclination—to deal with human beings.

The vague knowledge I had of medicine concerned mainly people with mental diseases, who seemed to me particularly in need of help. At that time, these diseases were considered the expression of abnormal brain conditions. Thus study of the nervous system was taken for granted, and I became attracted by professors who were occupied with studies in this field: the anatomist, Professor Schaper, who was interested in the embryonic development of the nervous system; the famous psychiatrist, Professor Karl Wernicke, who tried to understand the symptoms of the patients psychologically and to combine this understanding with the findings on their brains; and Professor Ludwig Edinger, who laid the foundation of comparative anatomy of the nervous system and for whom the study of anatomy was mainly the means of understanding the behavior of different animals and man. In the middle of my university life I had already started work in the laboratory and published two anatomical papers, somewhat neglecting the required lectures, particularly those in surgery and gynecology.

## THE SYMPTOM IN RELATION TO THE WHOLE ORGANISM

Prepared with some knowledge in my favored field, I went to work with neurological patients, using the wonderful detailed method of examination of Wernicke for my model. In 1907 I obtained a position in the psychiatric university clinic in Koenigsberg. There I was extremely disappointed because psychiatric care was at that time mainly custodial; and the clinical approach of Kraepelin, by which he tried to bring order into the somewhat confused field, appeared to me unpromising for therapy.

While concentrating on investigation of organic neurological and psychiatric cases, I became aware that the usual procedure, following the method of natural science, studying carefully the outstanding

symptoms and trying to base therapy on these results, revealed many interesting phenomena but was very unsatisfactory for purposes of therapy. When I began to examine also the other manifestations of pathological behavior of the same patients, which were usually considered simple concomitants and were more or less neglected in the interpretation, the results seemed more promising. Indeed, I was not certain how far one should go in this respect and by what method one could evaluate this increasing amount of material. I felt that we are confronted with a basic problem in our scientific approach to understanding the behavior not only of patients but of living beings in general. I did not yet foresee that the attempt to attack this problem would permanently determine my scientific endeavors (14).

The problem became particularly urgent during and after the First World War, when I was confronted with the task of treating a great number of young soldiers with brain injuries and defects in different mental capacities, particularly language. After surgical treatment, they were generally considered objects of charity and care, because it seemed that a real improvement could never be expected. Only a few neurologists, myself among them, protested that by adequate treatment these patients might be brought to a condition where life would again be worth living, despite some remaining defects. For this purpose, a few special hospitals were established, in opposition to the opinion of most of the leading neurologists of the country (1, 17).

My idea was to build an institution which offered the opportunity to observe the patients' everyday behavior and to study them in all respects. Accordingly I organized in Frankfurt am Main, under the administration of the government, a hospital which consisted of a ward for medical and orthopedic treatment, a physiological and psychological laboratory for special examination of the patients and theoretical interpretation of the observed phenomena, a school for retraining on the basis of the results of this research, and finally workshops in which the patient's aptitude for special occupations was tested and he was taught an occupation suited to his ability. I was assisted in this work by younger neurologists, teachers, and psychologists. Here the cooperation of my late friend, the psychologist A. Gelb, for over ten years proved to be of the greatest significance. This hospital, later called Institute for Research on the After-Effects of Brain Injuries, existed until Hitler came to power. For our purposes it was particularly fortunate that we could keep and observe patients for a long time, even for years (1).

This intensive cooperative work yielded many results of practical and theoretical value for medicine and psychology, as evidenced by a number of publications by my co-workers and myself, particularly the *Psychologische Analysen hirnpathologischer Faelle* (2). The enormous experience gained became the basis for the development of my theoretical concepts.

#### ABSTRACT VERSUS CONCRETE BEHAVIOR

We soon found that one reason for failure in treatment was that we overlooked the fact that similar-appearing symptoms can be of essentially different origins, and that only by knowing the latter can one avoid inadequate treatment and achieve better results (4).

We discovered further that we are dealing with two different groups of symptoms. In the one group, the symptoms are due to damage of a special mental capacity, which we could characterize on the basis of the defects of behavior of these patients and which we later called the abstract attitude; while in the other group, the symptoms represent a damage of another form of human behavior, the concrete behavior to which the learned activities belong particularly (5, 16).

Because observation revealed that the characteristic modification of behavior in the first group concerned more or less all performance fields, it was possible to explain through a differentiation of one and the same function many different symptoms which before were considered the result of more accidental damage of different performance fields. This gave a deeper insight to our concept of brain functioning in general (6, 10).

Among the symptoms consisting of modifications of concrete behavior, we could distinguish (1) those which were the direct effect of the lesion in one field, and (2) those which became understandable from the change of the functioning of the field concerned due to its isolation (14, p. 133) from the influence of the abstract capacity. When we then saw that the modification of function through isolation follows definite laws, we pondered whether isolation might not play a decisive role in the development of many pathological phenomena in general. The increasing verification of this idea became the basis for a new approach to study the functioning of the brain, the so-called *holistic approach*, which assumes that every phenomenon — normal as well as pathological — is an activity of the whole organism, in a particular organization of the organism (14).

By application of this methodical procedure, a number of much discussed phenomena became more easily explained. Regarding the

problem of brain localization, the usual assumption of isolated functions in isolated regions of the cortex proved untenable (14, p. 249). The so-called psychosomatic relationship (14, p. 335) found a new interpretation which resolved many of the former difficulties in this field. The experiences with aphasic patients led to repudiation of the concept, at that time predominant, that different types of aphasia, related to lesions in different centers of the brain, can be distinguished (12). The various forms of aphasia could be explained in a unitary way, which gave rise to a new concept of language, with consequences for the theory of language in general (9, 18). Similarly, new explanations were suggested for the problems of the reflexes (14, p. 159), of anxiety (14, p. 291), of the so-called unconscious (14, p. 307), and the phenomena of the tonus (3, 6, 8).

#### HEALTH, DISEASE AND THERAPY

The most general result of our studies in the field of medicine was a definite concept of health, disease and therapy which originated from observation of brain-injured patients, but gained general significance after it proved to be useful in application to all diseases which cannot be cured totally.

The brain-injured patient presents not only failures of a greater or lesser degree, but a frequent occurrence of what I called *catastrophic condition* (14, p. 35), i.e., symptoms of disordered functioning of the whole organism, which shows all the characteristics of severe *anxiety*. By considering the patient's mental condition in its totality, we concluded that this anxiety cannot be a reaction to the experience of failure (14, p. 295). The catastrophic condition and anxiety can be understood only as a reaction of the personality to the danger to which he is exposed by the impossibility of realizing his essential capacities, due to the failure. The observations brought us to characterize anxiety in general is the *subjective experience of being in danger of losing "existence"* (21).

It is this danger to existence which the individual experiences in all conditions we call sickness (14, p. 247; 19). In contrast to this, health appears to be the condition of order by which the realization of the organism's nature, its "existence," is guaranteed. But health is, in cases in which *restitutio ad integrum* cannot take place, characterized by another phenomenon, which we also first studied in these brain-injured patients.

If the patient has achieved a state of order, after we have arranged an environment where no demands are made on him which he cannot

fulfill and which would lead him to catastrophe, then, he feels healthy; and one could say he is in a state of health. But observation shows that even then, when he is in principle able to use undamaged capacities, he seems not to use those which may bring him—under some conditions—in spite of the protection, into catastrophe. In other words, for maintenance of order as well as existence in an objectively not totally restituted condition, *some restrictions are necessary to guarantee the order, and thus the existence corresponding to his nature* (19).

What we observed in the brain-injured patient proved also to fit patients with sicknesses of different kinds, as long as the sickness cannot be wholly eliminated. In such cases order, or health, can be achieved only if some restrictions are maintained. But even then health can be maintained only if the patient does not encounter catastrophe due to these restrictions. Such catastrophe is avoided in the brain-injured, when we arrange their environment so that they get as much as they can appreciate of the personal satisfaction which they need so badly. Due to the impairment of their abstract capacity, they do not realize under these conditions the shrinkage of their world and their personalities by the restrictions. When mentally normal individuals with severe bodily diseases, neurotics, and psychotics become aware of restrictions of performances which they feel able to execute, they are confronted with a dilemma. The solution of this dilemma is necessary for their becoming "healthy," else they may come into catastrophe, and their health will be diminished. They must bear restrictions, and with them some suffering and anxiety. Only then will such patients be in an ordered state where they can "exist." So we come from our "organismic approach"—which takes the whole nature of the individual (his *Wesen*, his existence) into account—to a concept of sickness and health which must consider the phenomenon of accepting some restrictions as a prerequisite of health (19).

Our result concerns the condition of health not only in patients without *restitutio ad integrum*, but also in normal individuals, since life always demands some restrictions. Each performance, pathological or normal, can be correctly evaluated only if one takes its relation to the individuals' "existence" into consideration. The relation to the existence is so important a factor for the interpretation of each performance of an individual that it is essential to any attempt to understand human behavior in general.

I want to mention here shortly some consequences of this viewpoint for *therapy*. Becoming healthy demands a transformation of

the individual's personality which enables him to bear restrictions. That is the presupposition to acquiring an adequacy between his remaining capacities and the world, i.e., an ordered state—and thereby the possibility of using the undamaged capacities to such a degree that life remains worth living in spite of restriction. It is our task in therapy to help the patient realize the necessity of restrictions in becoming healthy. I would like to stress again that this concerns all kinds of sickness.

We shall be successful in therapy only when we always have the aforementioned goal in mind. From this point of view we have to decide, for instance, which symptoms can be eliminated and which should remain undisturbed, and shall have to evaluate the many procedures which have been recommended in the different schools of psychotherapy.

A particular part of therapy consists in making the patient understand the problem as much as possible in all of its details. It will help him to take restrictions, particularly if he becomes aware that his situation is in principle not so very different from that in which normal human beings "exist."

In all the mentioned respects, adequate organization of the relationship between physician and patient will be of the greatest importance. Its development is according to our experience a prerequisite for success, not only in so-called functional diseases but in "organic" patients as well. Of course, it will be organized somewhat differently in the various conditions. Our organization is based on the organismic approach and differs somewhat from the transference of other schools of psychotherapy, particularly that of psychoanalysis (20).

#### EPISTEMOLOGY AND THE NATURE OF MAN

In stressing that the interpretation of any symptom and the organization of therapy must be based on knowledge of the total organism, that we always have to consider the individual personality in its functioning and the way in which its existence is guaranteed, we are faced with a serious epistemological problem (14, p. 399), which indeed concerns all biological knowledge in the same way. This problem becomes apparent in the further consideration of our concept of "accepting some restrictions as a prerequisite of health," in that becoming "healthy" demands a choice from the individual. Health thus acquires the character of a value—the value of existence (22)—whereby existence does not mean simply survival of the individual in his

psycho-physical organization, but *the preservation of the nature of his being*. Knowledge of this "nature" of the individual cannot be gained by the methods of natural science alone. The data obtained through the method of natural science, which till now have been almost wholly in the foreground in medical and biological theory, are not at all considered useless. It is only that they hold another place within the totality of our knowledge concerning organismic existence—a place by which many wrong interpretations may be avoided, and the theory becomes grounded on a more realistic basis. The knowledge we need, can be comprehended only by a special mental procedure which I have characterized as a creative activity, based on empirical data, by which the "nature" comes, as a Gestalt, increasingly within the reach of our experience (14, p. 402). This procedure will no longer seem so strange when one realizes that it is essentially akin to the activity of the organism itself, by which, in achieving adequacy with its environment, the organism's existence is guaranteed (14, p. 403). The application of this cognitive procedure is subject to difficulties similar to those of the procedure of the organism itself in finding the condition in which it can exist. From this viewpoint results a definite concept of human nature which I tried to develop on the basis of the experiences gained with pathological cases (15).

It became understandable that our cognition can never be complete and definite. All our knowledge in human biology is based on some freedom of choice, and thus always runs some risk. Therefore any action on this basis demands responsibility and courage. This is true also of every kind of therapy, particularly psychotherapy. Therapy is not simply an objective procedure. The physician must not only be aware of the nature of the total personality of the patient he is dealing with, but must also be aware of his own responsibility for the effect of any action he undertakes. Therapy is a joint enterprise of the physician and the patient, based on a kind of communion between them (20), in which the physician leads because he has learned how to handle difficult problems. Therapy will be successful only if the patient participates in this enterprise adequately and is more or less aware of its complexity.

#### RELATIONS TO OTHER THEORIES

I should like to say some words concerning the relation of my concepts to the views of others in the field. It is hardly necessary to say that I am influenced from various sides. Indeed, I was more influenced by contemporary views in general than by the theoretical explana-

tions of specific men or schools. I have always thought that it is not possible simply to take over facts or concepts from one field of knowledge to another. This is often even detrimental to progress. While one should never neglect the facts described by others, one has to make them understandable in the light of one's own theory.

In accordance with the spirit of the times in medicine, I was attracted to the idea that sickness should not be considered something which befalls the individual from the outside, but that one should rather treat the sick personality, a concept which had gained wide consideration in Germany already at the beginning of the century (13).

I was impressed by the demonstrations of Wertheimer and the Gestaltpsychologists which proved that many performances can be understood only from the Gestalt aspect. I tried to apply this principle to the study of the behavior of my patients, because I felt it was similar to my approach which was based on the analysis of normal and abnormal behavior. Needless to say, this helped us to understand a number of phenomena. But later I became increasingly aware of the difference between the Gestalt theory and my own organismic concept. So I think it is not justified that I am often considered a "Gestaltist" (14, p. 369).

Most of the leading psychiatrists and neurologists did not agree with my theoretical ideas when I first presented them. There were only a few who were thinking along similar lines. The one with whom I had most in common, the late Hughlings Jackson, was very little known in Germany or in England at that time. Thus he could scarcely have influenced the development of my ideas, much as I learned later from his writings. Yet there have always remained some not unimportant differences between his views and mine.

The ideas of Freud and his followers were not only not accepted in Germany at that time, except by small esoteric circles, but were so little known for a considerable time after the publication of his most famous books, that—incredible as it may be—I learned about his theory only a little before 1920. I was impressed but not attracted, particularly because of the exclusive application of the method of natural science to the attempt to understand human behavior, and the mechanistic interpretation resulting from that. I recognized similarity between the psychoanalytic and my biologic mechanisms, but after careful consideration realized the difference between them in respect to their significance for normal and pathological behavior. I would like to stress that I was encouraged in my interpretation of the

“symptoms” by Freud’s assumption that they should not be considered simple facts, but become understandable only in relation to their meaning for the individual (II). I was further influenced in respect to my interest in many problems which Freud had put in the foreground. I have always admired Freud’s genius and tried to do justice to him, but never have I concealed my opposition, grounded on careful consideration of his own description of phenomena.

In my general, more optimistic, attitude I felt closer to Adler. I found a number of similarities between my concepts and his, which I unfortunately got to know only quite late. But I see the problem of interpersonal relationships somewhat differently from the way he does. I realize some similarities also with the ideas of Fromm, Karen Horney, and Sullivan.

I should say that the main difference between these writers and myself is that, much as they put personality in the foreground, they do not give enough consideration to the phenomenon of existence. An explanation for this may be that my approach originated in anatomy and physiology and clinical observation, not only of neurotics and psychotics, but particularly of organic patients. In such patients many phenomena which are essential for therapy can be more clearly seen than in those with functional nervous diseases.

Finally I should like to mention the influence of philosophic ideas, particularly those of Kant, Ernst Cassirer, and Edmund Husserl. My introduction of the concept of “existence” in the interpretation of human behavior—much as it developed from observations—ultimately goes back to Kant’s transcendental theory of knowledge.

Because my concept seems to have similarity with that underlying “existential psychiatry,” I should like to stress that it did not develop in relation to the latter and that there are essential differences between the two. I agree with the existentialistic concept in so far as I also deny that biological phenomena, particularly human existence, can be understood by application of the method of natural science. But I differ in the meaning of the term existence. It means for me an epistemological concept based on phenomenological observations, which enables us to describe normal and pathological behavior and to give a definite orientation for therapy. It is a kind of philosophical anthropology. Existential analysis and psychiatry, on the other hand, intend mainly an ontological interpretation of “man as a being” in normal and pathological situations.

From this difference results a different attitude toward psycho-

analysis. Taking the inapplicability of the natural science method seriously, I do not see any possibility of coming to an agreement with psychoanalysis which is based on this method. Without denying that some results of psychoanalysis can be made useful for the new concept—of course, only if they are given a new interpretation from the existential point of view (11)—I cannot accept the belief that both disciplines can be coordinated and harmonized. I think such an attempt must confuse the issue.

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<sup>1</sup>All references being to Kurt Goldstein, the author's name has been omitted.—Ed. note.