A. METHODOLOGICAL APPROACH AND PURPOSE OF THE STUDY

The problem of prejudice in general, and of anti-Semitism in particular, has heretofore been approached from many different perspectives. Philosophers, historians, sociologists, psychologists, and others, throughout the history of the Christian era, have contributed a wealth of concepts, theories, and facts on the relationship of the occurrence of mass prejudice to other events in society.

In offering this study, based on the psychodynamic approach, as an additional contribution toward the development of a comprehensive theory of anti-Semitism, we are fully aware of the scope of knowledge which is already available. The claim of psychodynamic science, that it can amplify existing knowledge of such behavior and refute erroneous hypotheses, rests upon a specific interpretation of social processes.

Cultural traditions and social forces do not exist as abstractions. Although they have been profitably studied in isolation, they actually exist only in so far as they express themselves dynamically in the behavior of human beings. Ultimately, therefore, a completely meaningful conception of social processes depends on an understanding of the expression of such forces through the behavior of persons singly and in groups. To achieve such understanding it is necessary to study the continuous and intricate interaction of intrapsychic tendencies and environmental forces as they shape and develop each other.

The acquisition of such expanded understanding has been made possible through the evolution of the science of psychodynamics, and the development of specific methods for exploring the interaction between psychic forces in the individual and the social environment.

The relative newness of psychodynamic studies of prejudice is, how-
ever, not entirely due to the short history of psychodynamic science. After all, such concepts have been in use for some fifty years, and during the last thirty years, particularly, the methods of psychodynamics have found increasing application in the field of psychotherapy. The reason for the failure of emphasis on the psychological aspect of anti-Semitism up to now lies rather in the nature of the phenomenon itself. Whenever and wherever prejudice arises in its full force, supported by mass movements, its destructive impact is most conspicuous on the social structure and it is, therefore, viewed—by no means incorrectly—as being largely a social phenomenon.

It manifests itself as a form of intergroup behavior; it expresses itself in stereotyped accusations which are part of the socially transmitted cultural pattern; and it produces social consequences of disastrous dimensions, as the world has witnessed during the last decade.

It is with reference to these social manifestations that the psychodynamic approach to the study of prejudice is even now brushed aside by some as irrelevant. In view of the magnitude and the social urgency of the problem of prejudice, such efforts at "microscopic" investigations are regarded at times as valueless, and even as dangerous. Certain people argue that this emphasis might serve to detract from the social, political, and economic concomitants of anti-Semitism, and diminish the demand for decisive social action against them.

The answer to such arguments is simply our conviction that intelligent counteraction against organized or sporadic anti-Semitism must be based on the fullest possible knowledge of its character, and that psychodynamic insight adds to such knowledge.

More specifically, the psychodynamic view itself is based on the consideration of the specific place of anti-Semitism in American culture. Psychologically, morally, and legally, anti-Semitism is neither outlawed nor imposed in this country. Under the same historical, social, and economic circumstances some people, even within the same family, adhere to such an ideology while others do not. Where social compulsions to anti-Semitism are not overpowering, the question arises: What determines this seemingly free choice of an individual, to be or not to be anti-Semitic? Formulated in a deceptively simple way: Why is a person anti-Semitic? It is the purpose of this study to seek an answer to this question.

As in all motivational studies, three types of behavior determinants are to be distinguished:

1. The functional determination or the purpose of the attitude;
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2. The genetic determination or the history of the attitude; and
3. The circumstantial or external determination, or the impact of external factors on the formation of the attitude.

While we shall treat each of these determinants consecutively, their constant interaction will be pointed out at every step.

A more precise definition of the scope of this study will be possible only after the specific nature of our data has been described.

B. DATA COLLECTION

With the broad aim of this study in mind, a small number of psychoanalysts were first approached, and about a dozen preliminary case histories of patients manifesting anti-Semitic attitudes were collected. There was, at that stage, no attempt to obtain the same kind of information on every case. The psychoanalyst was completely at liberty to include any fact that seemed relevant to the patient's anti-Semitism. These informal and undirected preliminary interviews revealed many different aspects in the psychodynamic approach to the study of prejudice, and they served chiefly to direct the expansion of the investigators' original concepts. The ideas that emerged were condensed into the final recording schedule, which served as a methodological guide for the systematic collection of comparable data.

FORM FOR THE COLLECTION OF CLINICAL DATA ON ANTI-MINORITY AND ANTI-SEMITIC ATTITUDES

I. Characterization of the Patient's Anti-Semitism
1. Patient's statements about Jews (quotations)
2. Dreams about Jews and other minority groups
3. Verbal or behavioral anti-Semitism: i.e., Does the patient act out his anti-Semitism as well as verbalize it? Under what conditions and in what ways does he do either one or both?
4. Threshold of anti-Semitism: What stimulus is required to activate it? Is the patient anti-Semitic (a) only in analysis, (b) in his ingroup, or (c) before Jews themselves? If only (b), are there any ingroups to which the patient belongs in which he would not express his anti-Semitism? Does he originate, respond to, or acquiesce to anti-Semitic remarks in his ingroup? If only (c), are there any Jews before whom he would not express his anti-Semitism?
5. Fixity of anti-Semitic pattern: When did the patient first become anti-Semitic? In what ways, if any, has the pattern of the patient's anti-Semitism changed? What caused the change?
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6. Specific or nonspecific anti-Semitism: Is the patient anti-Semitic toward individual Jews or the Jewish group as a whole?

7. Diffuseness of anti-Semitism: Is the patient against the Jewish group alone or against other minority groups as well? Which other minorities? Quote remarks made about them. In what ways are the patient's other anti-minority feelings similar to, or different from, his anti-Semitic attitudes? Is there any displacement of hostility toward a non-Jewish minority onto the Jews? What motivates this displacement?

8. Relative novelty of anti-Semitism in analysis:
   a. Transference manifestations—meaning and origin? Difference in anti-Semitic reactions reported by Jewish and non-Jewish analysts?
   b. Periodicity?
   c. Intensity?
   d. Restricted to analytic relationship or acted out?
   e. Method of resolution?
   f. Residue, if any?
   g. How are such transference reactions related to the patient's previous attitudes toward Jews?
   h. What is the basis for the displacement of the patient's hostility?

9. Does the patient attribute his anti-Semitism to real causes; e.g., disagreeable personal experiences with Jews? In the analyst's opinion, to what extent is this anti-Semitism rational, i.e., based on really objectionable features in some Jews?

10. Does the patient attribute his anti-Semitism to socioeconomic or religious influences—to competition, propaganda, education, etc.? Does the analyst concur? What is the analyst's explanation of the patient's anti-Semitism? Does the patient have any insight into the psychological functions, if any, of his anti-Semitism?

11. Specificity of anti-Semitic symbols: Is there anything peculiar or idiosyncratic about the patient's attitude toward Jews? That is, in what ways does it differ from the culturally prevalent stereotypes regarding Jews?

12. Hierarchy of anti-Semitic symbols: Which of all the actual or alleged qualities of the Jews is most important to the patient? How does the analyst interpret this?

13. Which of the following alleged or actual qualities of Jews does the patient consciously or unconsciously attribute to them: Inferiority, superiority, weakness, oppression, enslavement? Invulnerable individual integrity or vulnerability? A solid sense of identity? Femininity or passivity? Castration or circumcision? The agency of oppressive social forces? The cruel destructive side of humanity? Loudness, demandingness, or vocalness? Aggressiveness? Moral or intellectual superiority? Insatiable, unbridled appetites? Exaggerated
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or passive oral needs? Success or failure? Isolatedness? Specify whether the patient attributes the above qualities to the Jews consciously or unconsciously.

14. Which of all the above qualities does the patient identify with? Consciously or unconsciously? Which does he attempt to deny? Why?

II. General Clinical Data

1. Dates when treatment began and duration
2. Patient's presenting complaints
4. Patterns manifested by patient's attitudes toward: (a) home, (b) school, (c) college, (d) work, (e) authority, (f) equals, (g) inferiors.
5. Physiological and neurological diagnosis, if any
6. The patient's idiosyncratic habits
7. His sense of humor
8. Appearance type, for example, short, fat, dark, etc. Does he look or think he looks "Jewish"?
9. Attention to personal appearance, for example, fussy, neat, well dressed, etc.

III. Brief Description of Patient's Character

1. Describe the patient's moral structure; his attitude toward moral obligation, authority, conventionality. Rigid perfectionist, compulsive, etc.
2. What is the patient's concept of self? What appearance or facade does he wish to present? How stable is his feeling of identity as an individual? Define specific weaknesses and confusions in sense of self, if such are present. What are their origins?
3. What are the patient's major drives? Does he manifest a neurotic need for affection, or neurotic drives for wealth, prestige, and power? What is their origin? What are the symptoms of this? How are these major drives related to the individual's basic conflicts? In what ways and to what extent does the patient manifest a sadomasochistic syndrome?
4. The patient's sexual adjustment: When did he have his first sexual experience? Describe his marital sexual experiences. Describe any perverse experiences he may have had.
5. How does he satisfy his other appetites—eating, drinking, smoking, etc.
6. What major patterns of defense does the patient rely on?
7. Other features in the patient's character structure which are important.
IV. Outline for the Life History

Environment into which Patient was Born
1. The patient's siblings, their age and sex
2. Family relationships: Mother-father, sibling-parents, father-patient, mother-patient, siblings-patient. Analyst's characterization and interpretation of these relationships.
3. Data on father: Age at patient's birth; occupational status and history; social status; religious affiliation; degree of religiosity; political ideology; attitudes toward Jews and other minorities; education; special interest; place of birth. Brief description of father's personality.
4. Data on mother: (same as for father)
5. Persons other than mother, father, and siblings in household (nurses, grandparents, etc.) Their relationship to patient.
6. Other persons frequently interacting with members of the patient's household. Their relationship with patient.

Infancy to Adolesence
1. Patient's infant rearing experiences: Nursing, weaning, sphincter training, enuresis, infantile masturbation. Is there evidence that any of the above were culturally atypical?
2. Childhood: Friendships; first sexual knowledge—age at which this was acquired; circumstances, patient's reaction if known; type and intensity of patient's religious education. Outstanding events.
3. Group adaptation in adolescence: Shift in identity; control of sexual and aggressive drives; displacement of hostility.

Adulthood
1. Education; present religion; changes in religion, if any, and degree of religiosity. Occupational history; social status; patient's political views; degree to which patient is interested in politics; special personal interests; attitude toward money.
2. Group activity: Social, civic, recreational, political, etc., groups to which patient belongs; major group activities. The approximate amount of time patient chooses to spend with other people. The intensity of his relationships with these other people; the approximate number of people the patient chooses to spend time with. Does he originate group activity more or less often than he responds to it?
3. Own family experiences: Present marital status and marital history; concrete description of own family relationships—number and age of children, patient-child relationships, wife-child relationships, patient-wife relationship, and analyst's characterization and interpretation of these relationships.
4. Data on patient's spouse: Older or younger than the patient; religion; religiosity; occupational history and social status; education;
political ideology; attitudes toward Jews and other minorities; special interests. Brief description of spouse's personality.

V. Summary and Interpretation

1. Is anti-Semitism an expression of the patient's conflict patterns? If so, which patterns, and how is anti-Semitism interrelated with these? What is the genesis of these conflicts and of the anti-Semitic attitude?
2. What functions does the patient's anti-Semitism fulfill in his character structure?
3. What is the relationship between the patient's other anti-minority sentiments and his anti-Semitic attitudes, and how, if at all, does either one develop from the other?

VI. General Background Data

1. Patient's age; sex; and place of birth (if foreign-born, age at immigration)
2. Case number
3. Analyst
4. Dates of interviews with analyst

This recording schedule was intentionally designed to be as comprehensive as possible. For example, Part I, Characterization of the Patient's Anti-Semitism, includes conceptual items which go far beyond the type of data usually obtained in the average case study. Even though complete information on all items was not obtained in any single case, the comprehensiveness of the schedule proved to be an advantage because it demanded a systematic approach to each case, with consideration of every possible feature.

The cooperation of psychoanalysts was then enlisted on a larger scale. Accredited psychoanalysts in New York were first approached by a letter in which the research plan was outlined. Those who expressed interest were then visited by a member of the research team. During the prolonged period of data collection, the authors were assisted by a trained psychiatric social worker, also previously psychoanalyzed, and a sociologist.

After some initial experimentation, it was found to be essential that interviews with the psychoanalysts should be conducted only by those members of the team who had been psychoanalyzed. This helped to establish quickly an atmosphere of confidence between the psychoanalysts and the research personnel. In the first interview, the form of cooperation was discussed, and the collection of relevant data begun,
with full assurance given the psychoanalyst that all customary precau-
tions to preserve the anonymity of each case would be taken. The inter-
view procedure was essentially as follows:

The psychoanalyst was first asked to describe a case of anti-Semitism
in a consecutive manner so that the interviewer would become familiar
with the anti-Semite's life history. The interviewer then started to dis-
cuss the case with the psychoanalyst in terms of the items included in
the recording schedule. As a rule, these were prolonged discussions re-
quiring two or three meetings. During interim periods, each psycho-
analyst's case was recorded in detail and discussed further by the
research team under the guidance of its psychoanalyst member. A tenta-
tive interpretation of the dynamic and the genetic aspect of every cas-
was formulated by the research team and resubmitted to the psycho-
analyst in the following interview for agreement or modification.

The research team discussed each case again and again in terms of any
divergences of interpretation which might have emerged, and in term
of its place within the general frame of the investigation.

In addition to practicing psychoanalysts, another source of data was
tapped: two social-welfare agencies. In their case work, such agencie
employ trained psychiatric social workers, usually under the supervisio-
of a psychoanalytically trained psychiatrist. The hope of getting from
this source additional data on the environmental determination of anti-
Semitism was fulfilled at least in some cases. Data approximately com-
parable to the psychoanalytic material were actually obtained. The de-
velopment of concepts leading to a psychodynamic interpretation of the
evidence, however, was based exclusively on the material obtained from
psychoanalysts about their patients. Case histories from social-servic
agencies, where appropriate, are used in the text as illustrations.

The procedure in gathering case material from agencies was essentially
the same as that used in obtaining psychoanalytic material. The case
worker, when aware of the incidence of prejudice in one of her cient
discussed the case with a member of the research team who afterward
studied the written record in full detail. When all relevant informatio
had been extracted, another discussion with the case worker complete
the data collection for that case.

After discarding cases containing insufficient or contradictory informa-
tion, the material for this study consisted of twenty-seven cases obtained
from psychoanalysts and thirteen cases obtained from social servic
agencies. A summary of the relevant information covering each case will be found in the appendix.

C. SPECIFIC METHODOLOGICAL CONSIDERATIONS

The specific methodological problems which this study had to face arose out of the fact that the cooperation of practicing psychoanalysts was enlisted not for the study of psychotherapeutic theory or practice, but for that of a sociopsychological phenomenon. This means that material originally gathered in the process of therapy, and thus geared to that purpose, was to be used for another purpose, that of research. Such procedure is gaining increasing favor with the growing awareness by both psychoanalysts and social scientists of the need for coordinating scientific results which are obtained by the application of different methods. This awareness grows in proportion to the demand for investigations which are problem-centered rather than method-centered.

1. THE SELECTIVE CHARACTER OF THE MATERIAL. Despite the ever-widening range of people receiving therapeutic help from psychoanalysts, such people compared to the population as a whole constitute, in many respects, a special group. First, they are emotionally disturbed personalities, and—to make this a characteristic truly distinctive from the rest of the population—they are aware of their disturbances to a degree that makes them voluntarily seek help. Furthermore, they are aware that psychoanalysis may provide this help. It is impossible to determine how this selective factor influences the study of the psychological mechanisms of anti-Semitism. It may well be that the “lunatic fringe” type of anti-Semite, who acts out his violent feelings with little restraint, will hardly ever seek psychoanalytic treatment. More important, however, than the infrequent representation of the extreme type, is the possibility that less extreme forms of anti-Semitism are excluded because of the peculiarity of the source of our material. Some studies on prejudice have suggested that a certain rigidity and unwillingness to engage in introspection are frequently found in the prejudiced personality. It is not impossible that those persons undergoing psychoanalytic treatment present marginal cases of even the mildly prejudiced population.

This does not, however, impair the findings of this study, which is essentially exploratory in character. The demonstration of the patterns

of interaction between intrapsychic needs and social forces is independent of any such considerations as frequency. This is also the answer to those who might question the value of the material because it is derived exclusively from emotionally disturbed persons in need of help. They assume that anti-Semitism in a “sick” personality is different in its motivation and functioning from anti-Semitism in a “healthy” person. As has been pointed out earlier, modern psychiatry assumes that the difference between the “sick” and the “healthy” personality is one of degree and quantity rather than one of quality.

Similarly, the geographical limitation of this study does not interfere with its purpose. The material stems almost exclusively from psychoanalysts practicing in New York City and refers mostly to patients residing in the metropolitan area. Many of these patients, however, were brought up in other parts of the country so that the early development of a predisposition to anti-Semitism is not limited to social conditioning in an area with an exceptionally large Jewish population. Nevertheless, the manifestations of current anti-Semitism as they emerge from the case studies must be regarded as being influenced by the social climate of New York.

The cases collected from psychoanalysts are further defined in economic terms, since most such patients belong to the upper economic income stratum. The selectivity of the cases in this respect was offset by cases from social-service agencies.

Of obvious importance for the validity of the material are those differences which were found in the accounts of Jewish and non-Jewish psychoanalysts who cooperated in this study. As far as the content of anti-Semitic accusations and the underlying psychodynamic mechanisms are concerned, no such differences were found. However, the patient's knowledge as to whether his psychoanalyst was Jewish or not influenced the timing and the intensity of his anti-Semitic utterances in analysis, especially in the “negative transference” phase. Following the resolution of the “transference hostility,” no significant differences could be discerned. Finally, the preference of the psychoanalyst for describing patient A rather than patient B must be mentioned. To a certain extent his freedom of choice was limited by our insistence on a current case that was well enough advanced to allow an interpretation of the basic conflicts. This condition, however, was occasionally waived. Although it is possible that some accidental selective principle was at work here, the case studies themselves are so varied that there is no reason to believe
that the choice of the various psychoanalysts was made according to any one universal principle.

In view of these selective factors the scope of this study can now be defined with greater precision: It investigates those forms of interaction between intrapsychic and social forces which result in anti-Semitism, in persons suffering from an emotional disturbance, who are aware of the disturbance and seek psychoanalytic treatment for its relief, who live at present in the New York area, and whose cases have been arbitrarily selected for contribution to this study by the cooperating psychoanalysts.

2. THE DEVELOPMENT OF CONCEPTUAL TOOLS. Very early in the study it became clear that some working definition of anti-Semitism was needed in order to determine whether or not a particular case was to be included. The following operational definition was adopted: Anti-Semitism is any expression of hostility, verbal or behavioral, mild or violent, against the Jews as a group, or against an individual Jew because of his belonging to that group. This definition includes, of course, anti-Semitism that may become manifest only in the temporary "negative transference" phase to a Jewish psychoanalyst. It also includes the self-hatred type of anti-Semitism that some Jews display.

It will be noted that this definition is much wider than the definition of prejudice given previously. The study was begun with this broader definition for a good reason: to discover whether or not anti-Semitism is a prejudice in the psychological sense, that is, irrationally motivated, we had to extend our inquiry beyond the scope of this more limited definition.

Several psychoanalysts, mainly those who had had personal experience with Nazi anti-Semitism in Europe, felt that the broad scope of this definition was unacceptable. They refused to regard the "polite" anti-Semitism (the Gentleman's Agreement type) and the violent acts of the Nazis as expressions of the same phenomenon. Since they had not treated any anti-Semites of the latter type, they felt themselves unable to cooperate, assuming that these different forms of anti-Semitism represented distinct psychological entities which were not comparable.

In some cases, even though our definition of anti-Semitism was accepted, a preliminary discussion disclosed disagreement on the value of such an investigation from a strategic point of view, and this deprived us of the cooperation of a few more psychoanalysts. Two arguments were advanced in this connection: Some psychoanalysts, both Jews and non-
Jews, adhered to the idea that the less said about anti-Semitism, the better for its victims, and precisely because they had strong sympathies with the Jewish cause, they preferred not to cooperate in a study which in their opinion might antagonize Gentiles. The second argument concerned the question of the psychological approach to the phenomenon. Some analysts, as much concerned with the problem as those advocating a policy of silence, feared that our investigation might detract attention from the more fundamental social and economic causes of anti-Semitism.

Such discussions were important in the development of concepts. The rejection of our definition as well as the rejection of the psychodynamic approach to anti-Semitism appeared to us, in a few cases, as rationalizations for the wish not to be concerned with anti-Semitism at too close a range, as an attempt to keep away from its horror and to avoid identification with its victims—in short, it seemed to be an expression of self-preservation. The fervor of feelings of this sort expressed by some psychoanalysts gave us a dramatic demonstration of the intensely emotionalized nature of the subject of anti-Semitism.

Conceptual clarification became both more difficult and more important once the readiness for cooperation had been established. The need for it was convincingly demonstrated by the great range of views among psychoanalysts concerning the frequency of anti-Semitism. While some psychoanalysts said that they had not encountered a single case of anti-Semitism in all their practice, others declared that every patient they had ever treated, whether Gentile or Jewish, showed some traces of it. Admittedly, many subjective factors enter into a psychoanalyst's selection of patients. More than one psychoanalyst, for instance, stated that he had refused treatment of violent anti-Semites. But these subjective factors in the selection of patients can hardly be regarded as the sole cause for the variety of views on the estimate of incidence.

The amount of data on anti-Semitism that a prejudiced patient produces in analysis obviously depends on several factors. When anti-Semitism is very near to the central personality problems or when the social conditions that go into the formation of that attitude are obvious, the amount of data will, of course, be considerable. But the amount of data depends also on the psychoanalyst's interest and incentive for analyzing the motivation of this attitude. As the operation of this subjective factor must be assumed to have influenced the psychoanalyst's judgment, his estimate cannot be taken as an objective indication of the incidence of anti-Semitic attitudes among his patients.
From the outset, it had been our hope that the specificity of the anti-Semitic reaction would be pursued in analysis—that its onset would be noted, its history traced, its symbolic role in the patient's development and its current psychological function investigated. While this was so in many cases, several psychoanalysts did not accord it such detailed attention. In many instances what seemed to be a "neglect" in terms of our research project was the only justifiable course of treatment when other, more urgent, symptoms needed to be taken up first. It is conceivable, furthermore, that a successful analysis of a prejudiced person might make the prejudice disappear without ever involving a direct discussion of it. In some case histories, however, anti-Semitism may have received no attention in analysis for a different reason: peripheral anti-Semitism may have escaped the close, systematic attention of the psychoanalyst because he might have unconsciously assumed an accepting, matter-of-fact attitude toward this part of his patient's reactions. The same social conformity trend in psychoanalyst and patient might have induced both to regard some amount of anti-Semitism as "normal" in our culture, and not as a symptom needing special clarification. A few cases, consequently, were reported with such a paucity of relevant facts that it was necessary to exclude them from consideration.

Among some psychoanalysts there was the tendency to present interpretations rather than facts. Such interpretations were given in analytic terms. At present it appears that psychoanalytic terminology is not sufficiently standardized to make such short interpretations meaningful. "Ego weakness," or other diagnostic terms were used with more or less divergent meaning by different psychoanalysts, so that it was impossible to compare any two cases on the basis of interpretative terminology. Even classical concepts like "Oedipal conflict" proved to be a handicap rather than a help. The statement, by some psychoanalysts, that anti-Semitism in a given case was the result of an "Oedipal conflict," or "penis envy," represented a level of abstraction unsuited to the purposes of this research.

This difficulty became especially clear in connection with our probing for the motivation of anti-Semitism. Psychoanalysts are professionally interested mainly in the discovery of primary motivations. To them, the origin of anti-Semitism in a patient is often satisfactorily dealt with by describing it as the outcome of the Oedipal conflict. But from the point of view of this study, it is important to trace the path from primary motivation to the actual manifestation of the attitude. There are sub-
stantial reasons for the difficulty encountered in obtaining this type of information.

A patient who undergoes psychoanalytic treatment usually presents more data than a psychoanalyst can remember or put into notes. Short of a phonographic or stenographic record of analytic sessions (a procedure not used), nothing, not even the most painstaking note-taking, could guarantee completeness. The selective perception of a psychoanalyst while a patient is producing material is neither accidental nor arbitrary, but is influenced both by his theoretical frame of reference and his own emotional reactions. Apart from factors inherent in his personality, the selectivity in the psychoanalyst's attention is partly the expression of the vicissitudes of his professional training. This implies his acceptance of a specific theoretical system of personality dynamics, genesis, and motivation as evolved in his psychoanalytic education. Doubtless this selectivity is in itself an essential part of the therapeutic process, since the avoidance of the two opposed dangers—getting lost in details or making interpretations prematurely and thus losing the meaning of contradictory clues—is an essential part of the psychoanalyst's therapeutic skill. Here, however, attention has been focused on the training-conditioned selectivity of the analyst's memory as one of the factors bearing upon the development of this research study.

With the exception of those patients committed to an ideology of political liberalism, who before analysis were painfully puzzled by their anti-Semitic prejudice, and of Jewish anti-Semites who were obviously involved in severe emotional cross-pressure, it was the psychoanalyst and not the patient who accorded the prejudice special attention. The patients, as a rule, were quite unaware that this attitude received special scrutiny. The psychoanalyst's purpose, however, was restricted to linking anti-Semitism to prime motivations. Thus he gathered data on the intrapsychic nature of the patient's conflicts, and in doing so was able to discern the predisposing mechanisms for placement of hostility onto outside groups. In most of our cases the evidence for the intrapsychic determination of this particular hostility is, therefore, ample and satisfactory. This is not always the case, however, with group pressures and external stimuli which function as secondary motivation in channeling the hostility pattern into group hostility, and more specifically, into anti-Semitism.

This was especially noticeable with respect to the genetic aspect. A serious handicap in tracing the development of anti-Semitism in some of
the cases is the lack of information on the history of external life circumstances. Often little is known about ideological influences during various stages of the patient's life: neighborhood contacts and circles of friends; the accepted norm in daily behavior that the patient shared with those around him; the first contacts with Jews, and the atmosphere of such contacts, at home or at school; books and newspapers read; group affiliations of the patient in various stages of his life; work conditions, economic problems and adjustments. In short, little is known about the daily experience of life unless it was conflict-laden and a significant expression of the patient's intrapsychic life. The task of the psychoanalyst is to reveal to the patient where attitudes and early acquired behavior patterns have shaped his life. But the direction and coercion, overt or silent, that a person experiences under the conditions of modern civilization are too much taken for granted, and the individual slants they take in each case frequently do not receive special attention.

As has been pointed out, this was one of the reasons for including cases from social-service agencies which are, by definition, more concerned with external life circumstances.

The extent of this "neglect" varies considerably in individual histories. Well-advanced current cases proved to be more useful than those already terminated. Those for which notes had been taken were more useful than those in which the psychoanalyst had relied on memory alone. It is almost superfluous to add that those psychoanalysts who considered anti-Semitism "normal" had less data on the history of its development than those who regarded it as having irrational roots both in society and in the psyche.

Hence, each individual case was in some way incomplete. But every one which was finally included had demonstrated at least some aspects of the psychodynamics of prejudice.

This brings us to the last, and most difficult, methodological problem, that of the interpretation of the necessarily uneven data.

It lies in the nature of case history material that the elaboration of common basic elements is fraught with difficulties. The more detailed the information available, the more the unique qualities of each case stand out. That is why the attempt to emphasize some basic common elements for the purpose of comparison always implies the potential danger of a violation of facts. There is, furthermore, the dilemma of fixing the level of common denominators neither too low nor too high; for if fixed too low, the material becomes meaningless because it includes features com-
mon to every psychological conflict, and if fixed too high, no case could be compared with another. The guiding principle for the following formulations has been the attempt to evolve a meaningful syndrome of personality reactions even at the risk of not accounting in detail for those cases which do not manifest all elements of the syndrome.