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Photograph by Robert Emde, M.D.

RENÉ A. SPITZ, M.D.

1887-1974

René Spitz died quietly in his sleep on September 14, 1974, leaving on his desk notes of things to be done and manuscripts on which he was working. Despite increasing sickness in his final weeks, he had maintained to a remarkable degree his active curiosity and productivity.

During his eighty-seven years, Spitz had lived, studied, and worked in Vienna, Lausanne, Berlin, Budapest, Trieste, Paris, New York, Geneva, and Denver. In a way, he was a late bloomer. (His father had despaired of his ever amounting to anything since he declined to go into the family business.) In his late forties, he began the four decades of research into the earliest psychic development of infants and young children for which he became famous. He was a pioneer in the direct observation and photography of infants and their interactions with their mothers. At age seventy, he moved to Denver where in addition to his teaching and research, he helped organize the Denver Psychoanalytic Society and was its first President. He was also instrumental in developing the Denver Psychoanalytic Institute and became its first training analyst.

For many of us René Spitz was a direct link to the whole history of psychoanalysis. He was fond of telling that he was born January 29, 1887, in an apartment house owned by his grandfather, near the City Hall in Vienna, and that in this building at 7 Rathausstrasse on April 25, 1886, Sigmund Freud had opened his first office for the practice of medicine. In 1910, carrying a letter of introduction from Sandor Ferenczi with whom he had been working in Budapest, Spitz went to Vienna, met Professor Freud, and began analysis with him. He thought of himself as being the first training analysand since a chief motive, in addition to his personal reasons for seeking analysis, was to learn how to be a psychoanalyst. Although never a member of the inner circle of psychoanalytic pioneers, Spitz knew most of them, and he had many further contacts with Sigmund Freud and in later years with Miss Anna Freud. His recollections of people and events gave us a feeling of intimacy with the entire psychoanalytic movement.

As an investigator and teacher, René Spitz was imaginative, creative, encouraging, and insatiably curious and questioning. He could at times be self-centered and dominating, but these traits were usually tempered with warmth and humor. Narcissism never prevented his giving credit and respect to others. If he did not know something, he tried to find out and then was eager to share with others what he had learned. His opinions were clear, firm and insistent, but to the end of his life, he was always ready to listen and to change his mind when presented with new and convincing data. To colleagues and students he was an inspiring model of scholarship and hard work. His curiosity and knowledge spread into all the humanities, but especially art. During his travels, he enjoyed collecting art, and his home was crowded with objects from ancient, medieval, and modern periods as well as examples from primitive cultures. In late years, he was particularly interested in the culture and art of the Orient.

Spitz liked to be a participating subject in research projects, especially if they gave promise of being a bridge between neurophysiological and psychological processes. In an ongoing study of the relation of electroencephalographic patterns to cognitive development in the life cycle, he had his own E.E.G. recorded several times. His records were unusual and even most recently resembled those of a very young adult. Part of his life style was to be adventuresome and exploratory. He had soloed in an Army balloon in World War I, and recently had thought he would like to run a snowmobile.

René Spitz, you were a man for all seasons; we miss you.

BRANDT F. STEELE

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Affects and Psychic Conflict

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AFFECTS AND PSYCHIC CONFLICT

BY CHARLES BRENNER, M.D. (NEW YORK)

Anxiety is not the only affect which characteristically triggers defenses and psychic conflict; depressive affect does the same. The two affects are defined, compared, and related to the pleasure principle. Precipitants of depressive affect are discussed and compared with precipitants of anxiety. Defenses and other reactions to depressive affect are also discussed. The clinical importance of this expansion of the psychoanalytic theory of conflict and symptom-formation is emphasized, especially with respect to superego functioning and conflicts related to aggression.

Since the publication of Inhibitions, Symptoms and Anxiety (Freud, 1926) anxiety has been the affect most closely associated with psychic conflict. The currently accepted connection between the two can be summarized as follows. Whenever a derivative of a drive or of a self-punitive or self-destructive trend is perceived as dangerous, anxiety develops. In order to eliminate or minimize this anxiety, attempts are made to ward off or defend against the dangerous derivative. The result is characteristically a compromise between derivative and defense, either with no anxiety or with less than would have developed without the defense. Thus the components of conflict are: 1, wishful striving, 2, anticipated danger, 3, defense, and 4, compromise among these. The function of defense is to avoid anxiety in accordance with the pleasure principle. Since current psychoanalytic theory—the structural theory—subsumes drive derivatives under the id, self-punitive trends under the superego, and defenses under the ego, one may say that there are two major classes of conflict, those between ego and id and those between ego and superego. In both, anxiety is understood to occupy a key position. It is the trigger that sets an individual at odds with dangerous id or superego derivatives and that is responsible for the initiation of the defenses that oppose them.

The principal thesis of this paper is that the relation between anxiety and conflict is not as exclusive as has been customarily assumed and that the theory of anxiety and defense outlined in the preceding paragraph must be revised and broadened if it is to account satisfactorily for the facts concerning initiation of defenses which the psychoanalyst can observe in his clinical work. An attempt will be made to demonstrate that anxiety is not the only affect which can trigger defenses and thus lead to conflict. Depressive affect can do the same, and psychoanalytic theory as well as psychoanalytic practice should take account of this fact.

The theoretical revision which seems necessary and which is proposed in this paper is based on a consideration of the role played by the pleasure principle in initiating defense (*cf.*, Freud, 1926; Brenner, 1973, p. 83) and makes use of ideas on affects and affect theory in general that have been recently advanced (*cf.*, Brenner, 1974a, 1974b, 1974c).

It will be useful to start by examining some clinical material from the area of superego analysis. It is of a sort familiar to every analyst from his own clinical experience.

A patient in his mid-twenties, as he lay on the couch, would often pick at a sore on his hands or face, finger an old scar, rub a shoulder which had been injured in an automobile accident some years earlier, or give some other indication of pain or injury. His attention was repeatedly directed to this behavior, and it gradually became apparent that all these gestures were unconsciously intended to gain my sympathy. In each case he had either told me or was about to tell me of actions or wishes which made him feel guilty and of which he believed I too disapproved. His sores and injuries were unconscious evidences that he had already punished himself enough for his misdeeds and that he should be pitied and coddled rather than blamed and hated.

As the unconscious motivation of his behavior on the couch emerged, it became apparent that it was a transference to the

analysis of a pattern of behavior which had been established well before his adolescence. Whenever he was engaged in aggressive or competitive behavior, he tended to injure himself, to make himself fail or lose, or both. When, on the contrary, he had suffered a severe reversal in his life, he could sometimes compete with much less inhibition. Eventually it was possible in the course of his analysis for him to be conscious of daydreams which had previously been unconscious altogether or had been briefly conscious but soon repressed. These daydreams accompanied every ambitious, competitive action which he undertook. In them he imagined himself confronted by an older man who was invariably more powerful than he, whether physically or by virtue of his position in life. The main business of the daydream was a violent conflict between the patient and his opponent, which always ended with the patient being defeated. Sometimes the defeat was physical, sometimes not, but it was invariably complete. There was never any question who had won.

At the same time it became possible to understand the unconscious meaning of a repetitive element of his nocturnal dreams. He remembered only a small fraction of his dreams, but of the ones he did remember many had to do with fighting with other men. These dreams probably began in latency, or at the latest in early adolescence. In them the patient was always inhibited in attacking his opponents and was often unable to defend himself effectively. He could never strike an opponent forcefully, either with his fists or with a weapon. If he had a gun, it wouldn't fire, and often he couldn't even run away.

There was evidence from many sources, therefore,—from his behavior during his analytic sessions, from his past and present difficulties in every competitive situation, from his daydreams and from his nocturnal dreams—that this patient both inhibited and punished himself for his competitive strivings, strivings directed unconsciously toward his powerful father and also, as it turned out, toward a much older brother who was the principal conscious enemy of his childhood.

What part was played by anxiety in all of this and what part by other affects? In those real life situations in which the patient inhibited his competitive strivings, as well as in the dreams in which he could not fight effectively, anxiety clearly played the role that psychoanalytic theory customarily assigns to it. In each such instance a competitive wish was equated unconsciously with a murderous childhood wish to surpass and supplant his father or older brother. This aroused fear of retaliation, of loss of love, and of object loss (in his case, of being sent away forever), and he defended himself against his frightening wishes by a kind of reaction-formation: he demonstrated that he was weak, stupid, ineffectual, and not to be taken seriously as a competitor.

There were other situations, however, which were different from those just described. There were times when he unconsciously felt he had been punished for his bad deeds and wishes, times when he experienced the misery that at other times he anticipated with anxiety, as, for example, when he failed an important examination, when he was refused advancement in his career, or when I left him either to go on a vacation or for some other reason. On such occasions his behavior and associations during his analytic sessions revealed that he was making great efforts to remain unaware of his misery or to counteract it in some other way. What was intolerable was to be conscious of how miserable he was, to know how he really felt. In the case of a check in his career, for example, he would find himself persuaded that he had been wrong to choose the career he had in the first place, that his true interests lay elsewhere, that the thing for him to do was to recognize his basic mistake and to rectify it by pursuing a different career, or a different style of life altogether. Perhaps it was silly to pursue any career. Perhaps the only sensible way of life was the one many of his friends pursued, to despise the conventional ambitions of bourgeois morality and to wander about the world enjoying life as it came. The defensive function of the attitude expressed by this train of thought is obvious. On the several occasions when it occurred, it may be noted that it never succeeded in

dispelling the patient's misery. It merely mitigated it. When its defensive function was interpreted to him, the patient's response was, 'What should I do? Burst into tears?'.

His characteristic response to my leaving him was more successful in avoiding any awareness of his misery. With great enthusiasm he would make vacation plans himself, plans which expressed the idea that, far from feeling lonely and unhappy at my absence, he was eager to get away and glad of the opportunity to do so, either to visit a friend or to take a trip with one. In other words, his reaction to my absence was his way of assuring himself that he was happy, not unhappy, that he did not wish to accompany me, that he had his own place to go to, his own trip to take. That it was also unconsciously a way of taking revenge on me by being the active rather than the passive one of the two of us was indicated by the fact that he regularly arranged to leave before I did or to return on a later date.

What is one to conclude from all of this? First of all, as has already been noted, some of the patient's reactions to his unconsciously murderous, consciously competitive wishes are readily understandable as defenses triggered by anxiety. In other instances, however, the psychological determinants and motives of his defenses are not understandable on that basis. In those cases the patient was not unconsciously afraid of what *would* happen as a result of his wish to supplant his father and brother; he was convinced that he had indeed been punished for wishing to supplant them and for other bad wishes. His defenses were motivated not by a need to avoid or to minimize anxiety, but by a need to deny or to put an end to his misery and his unhappiness. It appears therefore that while anxiety played the role which is customarily assigned to it in some ego-superego conflicts, in this patient it was also a variety of depressive affect—misery, unhappiness—which gave rise to defense and conflict in other of his ego-superego conflicts.

Since the material of this case is commonplace, rather than unique or even unusual, the conclusions just drawn from it represent a substantial change in the psychoanalytic theory of

conflict. In order to understand the significance of this change more clearly, it is necessary to turn at this point to a comparison of depressive affect and anxiety, a comparison which will be based on recent considerations concerning affect theory in general (*cf.*, Brenner, 1974b). In addition, the role of the pleasure principle in initiating defenses will be reviewed. By defining depressive affect and anxiety in the light of current knowledge of affects, by comparing the two, and by keeping clearly in mind the role of the pleasure principle, it should be possible to obtain a more accurate appreciation than is otherwise available at present of the relation of both affects to defense and conflict and to answer at least some of the questions that arise from the changes in the theory of conflict that necessarily ensue.

In a recent paper (Brenner, 1974b), I stated that affects are complex mental phenomena consisting essentially of two parts: 1, an experience or sensation of pleasure, unpleasure, or a mixture of the two, and 2, associated ideas. Thus affects can be defined or distinguished from one another only on the basis of the amount and intensity of pleasure, unpleasure, or both, and of the nature of the related ideas.

If these conclusions concerning affects in general are followed in defining the specific affect of depression, one is led to the following formulation: depressive affect is unpleasure associated with the idea that something bad has happened (*cf.*, Abraham, 1911). In the discussion to follow this is the definition that will be adhered to. Any affect which meets these two criteria will be called a depressive affect; no affect will be included under that heading unless it does conform to these criteria. It is, of course, unnecessary to add that either the ideas or the unpleasure constituting a depressive affect may be partly or wholly unconscious.

The reader will note that within these broad limits a wide range of individual variations is possible. The 'something bad' that has happened may be oral, anal, or phallic; it may be a narcissistic injury or humiliation; it may be a person or other object one has lost; it may be a bad deed one has committed or

a brutal punishment one is suffering; it may involve physical pain, mental anguish, or both, and so on. In addition, it must be borne in mind that whichever of such ideas are involved, in each individual case they will refer to that individual's particular memories and experiences, to *his* objects, *his* body, *his* knowledge of pain and suffering. In this sense every affect is unique. To group them under a heading—in this case, the heading of depression—it is necessary, to be sure, to focus on the general at the expense of the individual. But it is important, especially in clinical work, to remember that in doing so one neglects what is individual, what is most important to the person himself about his affective experience, in order to demonstrate what that experience has in common with affective experiences in other persons.

To repeat, then, depressive affect is defined as unpleasure associated with an idea that something bad has happened. Both the unpleasure and the idea(s) may be conscious, unconscious, or both. This definition includes a wide range of affects which cover a spectrum from sadness to despair. For example, if the 'something bad' that has happened is a variety of object loss, the affect is likely to be called loneliness. If it is a public defeat or failure, it may be called shame. If the unpleasure associated with the failure is mild, the affect is likely to be called embarassment or discomfort; if it is intense, humiliation. 'Despair' implies the idea, conscious or unconscious, that the 'something bad' that has happened will never change. When the same idea is present, but with a milder degree of unpleasure, the affect may be called pessimism. Many more examples could be offered but these should suffice to indicate what is meant by the range or spectrum of depressive affect. A more extensive discussion of varieties of affect and their relation to ego development is found in my previous paper (*cf.*, Brenner, 1974b).

Turning now to anxiety, we shall define it as was proposed in previous papers (Brenner, 1953, 1974b), namely, that anxiety is unpleasure associated with the idea that something bad *is about*

to happen. This definition differs somewhat from that of Freud (1926) in that it does not include under the heading of anxiety unpleasure without ideational content, i.e., unpleasure which is the result simply of an excessive influx of stimuli, an influx which exceeds the capacity of the mental apparatus to discharge or to bind.

The justification for thus revising the definition of anxiety was presented at length in the two papers referred to above. Here it will suffice to observe that the definition which is offered reflects rather accurately the approach of most analysts to the subject at the present time. When a patient complains of anxiety, but has no conscious knowledge of what it is that he fears, analysts assume that the nature of his fear, the 'something bad' that is about to happen, as well as all the other associated ideas are unconscious. They assume that it is repression and other defenses that are responsible for the fact that the patient himself is unable to say what it is he fears, to give any 'content' to his anxiety. The data of psychoanalysis speak unequivocally in favor of the conclusion that 'free floating' or 'contentless' anxiety are contradictions in terms. In such cases the ideas, the content are indeed present, but they are unconscious rather than conscious. In fact, psychoanalytic data permit us to go even farther. They permit the assertion that even when a patient *is* able to say what he fears, cancer, syphilis, an airplane crash, etc., many other ideas are *un*conscious parts of his anxiety and that these *un*conscious ideas, deriving from experiences of early childhood, are of principal importance in most, perhaps in all, instances of anxiety in later childhood or adult life.

It is clear that according to the definitions just given, depressive affect and anxiety are closely related. Each is characterized by unpleasure which is more or less intense as well as by ideas having to do with something bad. In the case of anxiety, 'something bad' is in prospect—the familiar concept of anxiety as a reaction to danger—while in the case of depressive affect, 'something bad' has already happened.

It seems likely that the close relationship that anxiety and depressive affect bear to one another will explain the observa-

tion that either can initiate defense and psychic conflict and this, in fact, turns out to be the case. The explanation hinges on the important role of the pleasure principle in initiating defense. The following quotations from Freud (1926) are to the point:

> . . . when [the ego] is opposed to an instinctual process in the id it has only to give a *'signal of unpleasure'* [= anxiety] in order to attain its object with the aid of that almost omnipotent institution, the pleasure principle (p. 92).
>
> . . . as soon as the ego recognizes the danger of castration it gives the signal of anxiety and inhibits through the pleasure-unpleasure agency . . . the impending cathectic process in the id (p. 125).
>
> . . . anxiety sets symptom-formation [on p. 145 'symptom-formation' is emended to 'defensive process'] going and is, indeed, a necessary prerequisite of it. For if the ego did not arouse the pleasure-unpleasure agency by generating anxiety, it would not obtain the power to arrest the process which is preparing in the id and which threatens danger (pp. 144-145).

The sense of these quotations is that what is basic to the currently accepted psychoanalytic theory of the role of anxiety in initiating defenses is the idea that unpleasure is to be avoided or minimized at all costs; that is, the role of the pleasure principle is crucial (*cf.*, Brenner, 1973, p. 83). The reason why anxiety triggers defense is that anxiety is a form of unpleasure: unpleasure plus ideas of 'something bad' about to happen, i.e., unpleasure plus an anticipation of danger. But, as we have seen, anxiety is not the only source of unpleasure in mental life. The broad range of reactions subsumed under the heading of depressive affect is also a frequent and important form of unpleasure. As such they may be expected to give rise to mental activity which is analogous to the familiar defenses initiated by anxiety, activity which, like those defenses, would result in cessation or diminution of unpleasure. The clinical vignette that opened this discussion contained instances of just such mental activity which was initiated not by anxiety, but by depressive affect.

What is involved, it seems, is a somewhat new way of looking at conflict. Instead of concentrating exclusively on anxiety, defense, and their familiar consequences, one broadens one's perspective if one focuses rather on the more inclusive phenomena of *unpleasure,* defense, and their consequences. Such a shift in focus enables us to include depressive affect and its psychic consequences along with anxiety and the defenses consequent to it.

A similar change in focus followed the publication of Inhibitions, Symptoms and Anxiety (Freud, 1926). Before that time analysts set themselves the goal of discovering their patients' libidinal fixation points and regressions in order to undo them by making conscious the repressed infantile wishes associated with them. After the new understanding furnished by Inhibitions, Symptoms and Anxiety had been assimilated into psychoanalytic practice, however, this was no longer enough. Analysts then realized that they had also to discover what anxieties were aroused by a patient's pathogenic wishes, what defenses he used against them, and what were the origins and developments of both his anxieties and his defenses (Brenner, 1957, p. 245; Waelder, 1966). Now it appears that still another addition is in order: one must discover the depressive affects associated with childhood instinctual conflicts, their ideas (content), their history, and their consequences in mental development and in current mental functioning. To analyze psychic conflict, it appears, is to analyze all these elements.

Since analyzing these elements is a part of the task of analysis, let us consider each of them in turn, trying to maintain as close a relationship as possible between theory and observable clinical phenomena. We shall begin with the history of depressive affects and of the ideas or content which are characteristic for them.

As is the case for anxiety, depressive affect is something which is an inborn potential of the normal human mental apparatus.

As with anxiety, it is not possible to say what *causes* depressive affect unless it be understood that 'cause' here means 'precipitate' or 'trigger'. Every individual must experience unpleasure at times during the course of his development. After a certain level of ego functioning has been attained there will inevitably be times when this unpleasure is, by definition, depressive affect, i.e., when it is associated with the idea that 'something bad' has happened. Thus the question of history resolves itself principally into the question of specifying the precipitants of depressive affect, if this can be done.

It seems likely that two questions are crucial here. First, are there typical precipitants of depressive affect, especially in very early childhood, as Freud (1926) was able to show there are for anxiety? Second, if there are, are they the same as those for anxiety or are they different?

On first thought one would assume that the similarities at least outweigh the differences, that object loss, loss of love, castration (genital absence or injury) and punishment (superego condemnation)—the typical dangers of infancy and early childhood—are as decisive with respect to depressive affect as they are with respect to anxiety. In fact, however, most analysts at present would not agree that this is the case. The generally accepted current view is that real or fantasied object loss is of primary importance with respect to depressive affect, at least with respect to depressive affect which is both prominent and severe as a clinical symptom (*cf.*, Fenichel, 1945, p. 396; Zetzel, 1960, p. 477). The origin of this view is doubtless to be found in Mourning and Melancholia (Freud, 1917). Lewin (1950) carried it so far as to suggest that even such a mild degree of depressive affect as sadness must also originate in a fantasy of object loss. Not all authors agree with the prevalent view (e.g., Abraham, 1924; Beres, 1966; Jacobson, 1971), but dissidents are very much in the minority. Since this is a matter that has important clinical and technical implications (*cf.*, Brenner, 1974c) it is essential that it be submitted to reappraisal. Is ob-

ject loss the catastrophe, the 'something bad', that is regularly connected in unconscious fantasy with depressive affect, whether mild or severe? The present author's clinical experience to date suggests that it is not, that on the contrary a fantasy that castration has occurred, whatever the basis for such a fantasy may be, is of prime importance with respect to depressive affect, just as the expectation that castration will occur, whatever the basis of the expectation may be, is of prime importance with respect to anxiety. As noted previously (Brenner, 1974c), a number of cases cited in the literature conform to this conclusion (*cf.* especially, Jacobson, 1971). Only careful observation in the psychoanalytic situation, i.e., with the psychoanalytic method, can decide this point, a matter that will necessarily take time. Until it is decided, it would seem to be unwise to approach patients in whose clinical symptomatology depressive affect occupies a prominent position with the assumption that object loss and oral conflicts must be of prime importance.

One further observation may be of interest in this connection. To the extent that a little girl conceives of castration as a catastrophe, as 'something bad', it is a catastrophe that, to her way of thinking, has actually happened to her. One would predict, therefore, that in later life women should be more subject to severe depressive affect than are men and that troublesome episodes of depressive affect in women will be associated with events which symbolize castration. That the former prediction is true has been known for many years on the basis of hospital admission statistics (*cf.* for example, Cohen, 1967, p. 677, col. 2). Among patients labeled 'psychotic depression' (or some variant of that term) women outnumber men by almost two to one in most samples. As for the second prediction, the two most common precipitants of depressive affect in women are menstruation and childbirth, both of which are, par excellence, reminders of femininity and symbols of castration. For what this evidence is worth, therefore, it supports the view that the topic of castration occupies a principal position with respect to depressive affects, as it does with respect to anxiety.

What about the consequences of depressive affect? What are the reactions to it which, in accordance with the pleasure principle, serve to reduce or eliminate it? Are they the same as the defenses against dangerous instinctual and superego derivatives? Are they, in other words, the same as the consequences of anxiety, or do they differ from them in significant ways?

One can say in the first place that any answer to these questions must be a tentative one. It will be subject to revision as informed clinical observation results in the accumulation of data which are more extensive and more reliable than those available at present. In addition the following reservation should be kept in mind. The definitions given here for anxiety and depressive affect respectively are based on the major difference between the two in ideational content: the former is to be applied to 'something bad' in the future, the latter, to 'something bad' that has already happened. Consequently, if a schematic formulation may be permitted for economy of expression, one may say that the general form, the 'formula', for a defense to minimize or prevent anxiety is, 'If I do "A" (the defense), then "B" (the danger) will not happen. I'll not have to be afraid of it.' The corresponding formula for minimizing or eliminating depressive affect is necessarily different. It would read, 'If I do "A", then "B" will change. It will stop happening, or it will stop making me suffer so, or both.'

The difference between the two 'formulae' is obvious, yet it is important to bear in mind the fact that to a child there is often much less difference between 'now' and 'soon', between 'is' and 'maybe' than there is to an adult. This is one aspect of the phenomenon in mental life which is called the omnipotence of thought. To a child's mind, and often enough to an adult's mind too, especially unconsciously, what is strongly wished or greatly feared seems already to have happened, so that anxiety and depressive affect can be coexistent and, for practical purposes, indistinguishable. This is of special importance, for example, in the case of guilt (superego anxiety). When a person, whether consciously or unconsciously, fears punishment for wishes he feels are bad or wrong, we say he is

guilty. We also say he is guilty when he feels that he is being punished for his bad wishes and deeds and that he must do penance or make amends in order to be forgiven. The two affects are clearly distinguishable despite the fact that both are called by the same name, guilt. The first is a variety of anxiety, the second, a variety of depressive affect. Yet in many instances they are indistinguishable for the reason mentioned above, namely, that bad wishes and bad deeds may be felt to be the same and that a future danger—punishment in this case—may become, psychologically, a present ill. The distinction between the two affects is clinically important to make when it can be made, for reasons that will become clearer below, but it is equally important that it be a real distinction, not an artificial or a schematic one.

With these reservations, then, it may be said that one can point to two major trends which are observable in reactions to depressive affect. The first of these includes derivatives of aggression and their consequences. The second has to do with efforts to eliminate or to diminish the unpleasure of the affect itself. Let us consider each of them in turn.

That derivatives of aggression become manifest in (are activated by) situations of unpleasure is so well known as to require no special documentation. Children, especially very young children, to whom something highly unpleasurable has happened are likely to become angry at whomever they blame for having caused them unpleasure. The fact that they always blame *someone* is attested both by direct observation of young children and by psychoanalytic observation of the unconscious reactions of adults. The idea that no one, not even some god, is to blame is a very sophisticated one that comes quite late in life if it comes at all. At any rate, it is clear that the aggressive reactions which are of obvious clinical importance in later life are those in which aggression is directed in the first instance at objects of importance in a child's life: parents, siblings, and other members of his immediate family.

One example of the consequences of such an aggressive reaction to depressive affect in early childhood is afforded by persons who correspond to the character type which Freud (1916) called 'the exception'. It will be recalled that Freud illustrated his observation by reference to Shakespeare's portrayal of Richard III, a man born with a physical deformity. The rage, resentment, and desire for revenge of a person like Richard can be understood as his aggressive reaction to the depressive affect caused by his awareness in early childhood of his physical deformity. A lifelong persistence of rage in reaction to depressive affect is the constant element to be found in all such 'exceptions', however much they may differ from one another, as indeed they do in other respects.

A fateful and clinically familiar consequence of intense and persistent aggressive wishes arising from any source in early childhood is that they may give rise to anxiety—to fear of object loss, of loss of love, of retaliatory castration, and of punishment, depending on the circumstances and on the nature of the child's own aggressive wishes. This is as true of aggressive derivatives caused by depressive affect as it is of those from any other source. They are, therefore, warded off (defended against) in many different ways, and the resulting compromises between defense and drive derivatives show the greatest variety.

There are, however, two defenses which deserve special mention because of the frequency with which they are encountered clinically. The first is identification with the aggressor. The second, closely related to the first, is a type of reaction-formation in which submissive and ingratiating, or even masochistic libidinal wishes are intensified in order to ward off aggressive ones. These two defenses, operating together, play a major role in the institution of the restrictive and self-punitive trends, which is such an important aspect of superego formation. They account for what is clinically a very significant part of that agency, since their joint action often plays a considerable role in turning aggression against oneself, a vicissitude of aggression that has serious consequences in many cases.

It will be understood that these remarks on the vicissitudes of aggressive derivatives appearing in reaction to depressive affect are by no means exhaustive. They are merely illustrative. Reference has been made to only a few of the varieties which are commonly encountered in clinical practice. The examples which have been offered, however, will hopefully serve both to substantiate the fact that aggressive derivatives are caused by depressive affect and to illustrate the potential value in clinical work of recognizing the relationship between aggression and depressive affect.

We turn now to reactions to depressive affect which serve the function of eliminating or diminishing the unpleasure of the affect. Many, if not all, of the familiar mechanisms of defense can be used or, better, can be observed to play a part in serving this function. The affect may be repressed, wholly or in part; it may be isolated more or less completely; it may be projected onto others, handled with the help of identifications, etc., in ways which will become clearer, perhaps, in the course of the discussion to follow. What serves to distinguish all of these defensive reactions to depressive affect from defenses which are instituted in order to eliminate or reduce anxiety is that they aim, in general, at changing something that has already happened, some aspect of current experience, rather than at saying 'No' to an instinctual derivative which is either a wish or a self-punitive trend that is felt to be dangerous (*cf.*, Brenner, 1973, p. 99). Perhaps it is this which accounts for the impression that denial and undoing are especially prominent among defenses appearing in response to depressive affect. We shall, at any rate, pay special attention to these two defense mechanisms. As the following discussion will show, the two terms have in the present context approximately the same meanings that are familiar from the study of defenses initiated by anxiety.

A depressive affect—unpleasure plus 'something bad' has happened—can be denied in either or both of two ways. One

way is to deny the unpleasure, to replace it with pleasure, as though to say and to demonstrate by action as well that what has happened is pleasurable, not unpleasurable. The other way is to deny what has happened. That is, one may deny the unpleasure, the event, or both. In either case the denial usually involves some gratifying fantasy.

To deny that 'something bad' has happened by pretending that it is really 'something good', to insist that one feels pleasure rather than unpleasure, is one of the basic mechanisms of pathological elation (mania, hypomania, etc.). The relation of this syndrome to denial has been noted by many psychoanalysts, most extensively perhaps by Lewin (1950), and the reader is referred to Lewin's work for a fuller discussion of the topic. It is also interesting to note that such denial of the unpleasure of depressive affect is closely related to what Fenichel (1939) called the counterphobic attitude, a phenomenon whose importance in character structure has been increasingly appreciated during the years since it was first described. This is because the counterphobic attitude, like the reaction to depressive affect just described, is a defensive reaction to the unpleasure of anxiety itself, rather than a defense which is directed against id and superego derivatives that would give rise to anxiety were they not warded off. In adopting a counterphobic attitude, as its name indicates, an individual attempts to deny that he is frightened, rather than to ward off a frightening instinctual wish or self-punitive trend. The degree of success attained will obviously vary, but regardless of how successful it may be the resemblance of a counterphobic reaction to denial of the unpleasure of depressive affect is an evident one.

In other instances of the use of denial to eliminate or minimize depressive affect the emphasis, as noted above, may be on denial of the event, of the fact that 'something bad' has happened. One sees this kind of denial frequently in connection with penis envy, usually buttressed by one or several wish-fulfilling fantasies. It has been observed long since that in many little girls the depressive affect which results from their belief

that they are inferior and castrated is mitigated or eliminated by a denial of the obvious fact that they do not have a penis. They convince themselves that they really do have a penis, that it is not true that they are without one (*cf.*, Rado, 1933).

Such 'illusory penis' fantasies may coexist with others that are likewise attempts to minimize the unpleasure of the depressive affect involved, fantasies to the effect that it is 'better' to be a girl than a boy. For example, an adult female homosexual will not infrequently cherish a fantasy which is conscious or nearly so during sexual intercourse with a female partner that she has a penis, represented by her finger or tongue, with which she is better able to gratify women sexually than is a man. Psychologically such women appear to be the counterparts of male fetishists: both have reacted with denial to the depressive affect consequent to their discovery that, as they believe, there *are* people who have been castrated—a denial buttressed by the fantasy that women really do have a penis, that it is not true that they either have been born without one or have had it removed.

Burial customs and a belief in immortality are other common examples of denial with the help of a wish-fulfilling fantasy as a reaction to depressive affect. Since time immemorial dead bodies, often arranged in a fetal posture, have been placed in the earth, man's 'universal mother', to be born again. This practice, like a shared belief in immortality, serves to deny the permanence of loss by death and to mitigate the unpleasure of the affect associated with it.

Wish-fulfilling fantasies like those just described, which buttress denial, can as well be considered under the heading of *undoing*: a fantasy that a woman really does have a penis 'undoes' her 'castration', immortality 'undoes' death. There are other examples of undoing as a reaction to depressive affect, however, which are unrelated to denial. For example, the entire range of penitential and propitiatory behavior, which is such an important part of superego functioning, can be understood as a form of undoing. Much of what M. Klein (1948) and

others have called reparation would belong to this category. A child who is, or feels himself to be, abandoned may make himself sick, pitiable, or suffering in order to bring mother or father back. One who feels himself to be unloved may do the same to be forgiven and loved again; one who feels castrated, in order to be rewarded with a penis. Thus undoing, like identification with the aggressor, is one of the mechanisms that is intimately involved in the process of turning aggression on oneself and that participates in a major way in superego formation.

In addition to resulting in aggression being directed toward oneself, penitential and propitiatory reactions are prospective. They look to the future, in contrast to the type of denial mentioned earlier which concerns not the future but the present. Not all prospective reactions to depressive affect involve predominantly self-directed aggression, however. For example, a desire for revenge is a reaction to depressive affect that is certainly prospective, yet it need not necessarily be connected with self-injury or self-abasement. Likewise, fantasies of magical omnipotence such as one finds in fairy tales, many versions of the family romance, and other similar phenomena are all prospective reactions which often serve the function, consciously or unconsciously, of eliminating or diminishing depressive affects in children or in adults. 'Hope', says the poet, 'is the remedy for despair'. Making believe that things will be 'better' in the future is as much an antidote for depressive affect as is making believe that they are 'better' or not so bad now. Whether one calls the one undoing and the other denial, or whether one uses a single name for both is less important than is the realization that what is at issue in both cases is a reaction not to anxiety but to depressive affect.

Something should be said at this point about traditional psychoanalytic views concerning the connection between identification or introjection and depressive affect. Since Freud's (1917) first discussion of this connection, the view has prevailed

that identification and introjection lead to depressive affect. One may summarize the presumed sequence of psychic events very schematically in the following way. Murderous, angry wishes toward an object give rise to fears of loss of love and loss of object. These in turn give rise to what some call identification and others call introjection in order to preserve and retain the object. As a result, the aggression that was originally directed at the object becomes self-directed, thus giving rise to depression, which is characterized by hating oneself, by despising oneself, by making oneself suffer, and even by injuring or destroying oneself rather than by hating, despising, injuring, or destroying the object. In brief, identification with or introjection of an (ambivalently) hated object is presumed to precede and to cause depression by substituting self for object as the target of aggression.

The understanding of the connection between identification and depression which is based on the considerations advanced in this paper differs in important respects from the currently accepted view just outlined. According to the view advanced here identification is primarily a defensive reaction to depressive affect rather than a precursor of it. It is not the cause of depressive affect, but an unconscious attempt to minimize or to eliminate it. As such, it may be more or less successful. The more successful it is, the less evidence there is of depressive affect. The less successful it is, the more evidence of depressive affect remains. In addition, according to the view advanced here, the depressive affect which has triggered defensive identification, or introjection, is not necessarily a consequence of object loss. The 'something bad' that has happened may be object loss or it may not. In some cases it is, in other cases it is not.

In accordance with this view, when depressive affect occupies a major position among a patient's symptoms, it is because his defenses have been only slightly or partly successful. In those cases in which one of the major defenses caused by depressive affect is identification, identification plays its part in the conflicts and other consequences of depressive affect.

Sometimes the consequences are severely disruptive of psychic functioning—'full blown' depression or mania—, sometimes they are only mildly disruptive, and sometimes they are, as far as one can judge, wholesome and constructive in their final effects, i.e., they lead to normal superego formation. Thus, in some instances identification with the aggressor is part of a seriously pathological psychic process which may have a fatal outcome, in others it is part of a process which is properly called normal, while in others, the result lies somewhere between these two extremes.

Lest such considerations be thought of as merely academic and theoretical, it should be explicitly stated that they are, on the contrary, of direct practical importance in everyday analytic work with patients in whose conflicts reactions to depressive affect in general and superego problems in particular play a major role. One is reminded here of the practical consequences of the recognition that repression and other defenses are not the precursors and causes of anxiety but are instead a reaction to it (*cf.*, Freud, 1926). One cannot understand and analyze correctly the defenses which are triggered by anxiety and the conflicts of which they are a part without a correct appreciation of the fact that they serve the function of avoiding anxiety, of guarding against real or imaginary dangers. Nor can one correctly understand and analyze the aggressive and defensive reactions to depressive affect and the psychic consequences to which they give rise unless one appreciates the functions they serve in lessening or eliminating that affect in accordance with the pleasure principle.

In this connection it is worth noting that while the term 'depressive affect' has the advantage of being usefully descriptive, it has some disadvantages as well. In addition to being cumbersomely long, it connotes a familiar diagnostic label—'depression'. As many authors have pointed out (*cf.*, Brenner, 1974a, 1974c), whether 'depression' be considered a syndrome or a true diagnostic entity the psychological phenomena which it designates are unquestionably more complex than what is

here called depressive affect, as Beres (1966), for example, has emphasized. One must, therefore, beware of equating depressive affect with depression as a diagnosis, or vice versa. It is the author's opinion (Brenner, 1974c), that patients who are commonly included under the diagnostic label of depression, or any of its many synonyms, are a very varied and psychologically heterogeneous group. They range from nearly normal to fatally ill, from relatively mature to extremely infantile or regressed, from those whose traumata and conflicts are largely œdipal to those in whom anal and oral elements predominate, from those whose contact with their environment is within normal limits to those whose object ties and whose ability to test reality are seriously impaired.

In order to understand satisfactorily the melange of symptoms a severely depressed patient presents, in order to reconstruct the origins and the development of those symptoms in any substantial degree, and in order to interpret them in analysis to the patient himself in those cases in which such a procedure is possible, it is necessary to approach them within the framework outlined above. One must discover what part is played by anxiety and what part by depressive affect in initiating the various reactions which have given rise to the symptoms and characterological problems from which the patient suffers. One must reconstruct, as far as possible, not only what dangers were, and unconsciously still are, a part of the patient's anxiety, but also what calamities were, and unconsciously still are, a part of his depressive affect. As much as one can, one must learn of the vicissitudes of the aggressive derivatives that are activated by his depressive affect, of his attempts to deal with his depressive affect by denial, by undoing, or by any of the other defense mechanisms he may use for the purpose, and one must discover his penitential, self-punitive reactions, along with the fantasies associated with them and the anxieties and defenses to which they in turn have given rise.

Any new, unfamiliar approach to clinical problems is bound to seem at first to be more difficult than the old, familiar one

that has served for many years. It will be neither an easy nor a simple task to expand the psychoanalytic theory of anxiety, defense, and conflict so as to include depressive affect and its consequences for symptom formation. Yet the effort is worth making. In the long run the advantages will far outweigh the disadvantages which unfamiliarity will initially impose. Defenses and resultant psychic conflict are *not* related exclusively to anxiety, i.e., to unpleasure associated with danger, to 'something bad' which is anticipated in the future. Depressive affect—unpleasure plus idea(s) that 'something bad' has already happened—gives rise to similar, often identical psychic consequences. It is the facts themselves that require that we pay attention to depressive affect and to its psychic consequences in our clinical work as psychoanalysts. It is of particular importance that we do so if we wish to deal effectively with many of the manifestations of superego functioning and with conflicts related to aggressive derivatives in general.

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EGO SYNTHESIS AND COGNITION IN A BORDERLINE CASE

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Clinical investigation of a borderline patient elicits distortions of the autonomous functions of thought, cognition, and the semantic aspects of language as well as an integrative 'disjunction' manifested by simultaneous but nonconflictual strivings toward contradictory goals. The primary etiological importance of a constitutional defect in the synthetic functions of the ego in the formation of a borderline personality are described. Technical innovations in handling the transference of borderline patients and criteria for diagnosing borderline personalities are given.

INTRODUCTION

Exclusive preoccupation with one case as clinical psychoanalytic research enables the analyst to rely chiefly on the material obtained from the patient, with minimal recourse to imposed theory. An ongoing psychoanalysis that is at the same time a clinical investigation offers a continuing opportunity for verification, modification, or refutation of tentative hypotheses. One may ask whether psychoanalysis at its best can be anything but a study of one case—a study in which the special properties of the particular person are observed directly within the framework of the psychoanalytic situation. Both in clinical practice and theory formation, psychoanalysis can best claim scientific status within such a context. Much of the generalization and

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I am indebted to my colleagues in the Study Group on Aggression (Psychoanalytic Research and Development Fund), Drs. Samuel Abrams, Sidney S. Furst, George Gero, Irving Kaufman, Francis McLaughlin, Werner Muensterberger, William G. Niederland, Mortimer Ostow, Richard F. Sterba, Arthur F. Valenstein, to whom I presented some of the clinical material.

theory formation extrapolated from data on groups of analytic cases belong more properly in the field of general psychology or psychiatry, or in the humanities.

The psychoanalyst, equipped with a method and a body of empirical psychological data, strives for an objective appraisal of his patient. His main point of reference, however, is inevitably himself: the vantage point of his own life experience and the integrated inner world he has attained in arriving at maturity. In that process the analyst has attained knowledge (conscious, preconscious, and unconscious) of biological, psychic, and social reality, of values, of how things are and how things are supposed to be. It is within this emotionally cathected universe, presumably shared by analyst and patient, that the analyst exercises his empathy and comprehends his patient.

A basic working assumption, psychologically and philosophically well grounded, is the concept of the total organism, manifested psychologically in the total ego. Gitelson's (1958) hypothesis that where the ego is immature, it is nonetheless intact at its level of development helps the analyst in his study of immature and widely deviant personalities.

Psychic process may be viewed as a ceaseless integrative activity, oriented toward unity and synthesizing the human experience into a harmonious whole—the inner representation of the world as one feels it and knows it.[1] This formidable result

[1] Nunberg's (1930) concept of ego synthesis is that 'it is derived from the binding and productive power of Eros'. Erikson, as quoted by Apfelbaum (1966), concurs when he writes of 'a need for synthesis and a pressing urge for growth, development and mastery'—the achievement of identity. I use the term 'ego synthesis' in the sense that synthesis is a function of the total psyche.

In the course of its executive and defensive work, the relatively developed ego performs a synthetic function, the 'organizing function' of which Hartmann (1959) speaks. This valid concept, quite distinct from the ego synthesis of Nunberg and Erikson, we shall term the 'synthetic function of the ego'. For Hartmann it has the balancing function of a 'regulatory principle'—homeostasis.

The integrative and synthetic force can be viewed as an intrinsic developmental drive that leads to the maturation and autonomy of the individual (individuation) which enables the infant to leave the symbiotic stage (*cf.*, Mahler, 1963).

can be achieved only by the synergistic activity of psychic defenses, such as repression, isolation, and rationalization. Most of these defenses come into being at advanced stages of mental growth. A retardation in their development has the effect of interfering, secondarily, with the end product of the synthetic process.

The case to be presented offers strong evidence of the primary etiological importance of a constitutional defect in the integrative and synthetic functions in the formation of a borderline personality. At the same time, evidence of pathogenic dynamic influences that clearly derive from early mental conflict will be offered. My study is far from determining which is primary, or whether both factors are concurrent and interacting, but I hope that the objective evidence presented will help the reader arrive at his own critical judgment.

CASE STUDY

The patient, a thirty-six-year-old interior designer, is a handsome woman who dresses in 'mod' fashion. She is the mother of two children, aged eleven and fourteen. She entered analysis four years ago in the midst of frenetic sexual promiscuity following a recent divorce. Her reason for seeking analysis was that she wanted to 'settle down' and remarry.

Ostensibly the patient had terminated her marriage when her husband became involved in an affair with her friend, an affair that the patient herself had set up. However, her real reason for divorcing her husband was that he had become depressed and paranoid. She saw nothing inappropriate in leaving him when he was ill. Although her husband earned an adequate living as an accountant, throughout her marriage she had recognized her wealthy father as the real provider.

Consciously the patient wants to find and marry a rich man. However, whenever she meets a suitable prospect, he bores her and 'smells bad' to her, particularly if he shows any serious interest in her. When the patient entered analysis she

was, and intermittently still is, sexually involved with Bob, a divorced man of forty whom she describes as 'black and evil' and whose primary relationship is with another woman. In essence, this affair is a *ménage à trois* with the patient searching for sexual clues of the other woman's presence. The affair is 'timeless' with no discernible course; there is neither a real union nor a parting and mourning.

Another of her symptoms is the delivery of her stool manually. Although she is not constipated or impacted, she does this because she is afraid of possible pain in defecating and of being ripped. She gave a history of colitis but during her analysis her gastrointestinal symptoms were more indicative of a hyperkinesis of the gastrointestinal tract with some pylorospasm or colonic spasm when she is tense, anxious, or angry.

The patient's family are well-to-do but have meager educational and cultural attainments. She professes to hate her family. From her description, her father, a 'self-made man', is phobic, hypochondriacal, irascible, garrulous, and boastful. He is always critical of the patient and her mother and is given to violent outbursts of anger, especially during meals. The patient recalled her terror as a child of eight when her father brandished a gun and threatened to kill the family and himself.

The mother is described as rather detached, neglectful and over-protective in turn; according to the patient, several of the mother's siblings are pathological recluses and misers. Early in the analysis, the patient reported that from age three or four her parents would leave her and her brother, who was two years older, in care of a 'nanny' while they went south for the entire winter. Later in the analysis, she said she had learned they were actually away only several months and always returned to the city during the children's winter vacations.

Her dependence on her father's support and her 'Jewish mother's' endless supply of 'goodies'—special cuts of beef, freshly squeezed orange juice, specially baked cakes—is abso-

lute; it persisted throughout her marriage and has continued since her divorce. She still 'finagles' small amounts of money from merchants by using her father's credit cards.

The patient has few recollections of her brother. She does not recall their eating or playing together, or the brother showing any interest in her. Her most intense feelings about him are persistent envy and rivalry, feelings which he reciprocates. In an hour in which she expressed her great envy of her brother, she said:

> Lately I've been looking at everybody's crotches, even women's crotches. Men and women are the same, except the crotch. What makes men so horrible, so different, so demanding, so restricting? I hate them. Why do men and women get together altogether? Is it just sex? Why do women take all that junk that men hand out? . . .They come home and speak to each other between their teeth, spewing out all this hatred that they feel for each other.

Relatively little is known of the patient's early years. At the age of one, she suffered a severe throat infection which lasted many months and from which she almost died. There was also a period of blinking when she was about five years old, and she has been a nail-biter since childhood. She always had trouble at school, particularly with the other children who she says harassed her. At the same time she was very aggressive toward other children; she would bite their foreheads and faces: they were 'nasty children' and deserved it.

The patient's first sexual experience occurred when she was fourteen; the man was twenty-one. They had frequent sexual relations, which she initiated and controlled. Although the affair had all the trappings of an earnest love affair, with talk of marriage and the future, at no time did she consider him her fiancé. This affair was a prototype of her later sexual involvements: she would become 'engaged', then break off the engagement presumably because of her parents' disapproval, but with no regret on her part. At sixteen she became pregnant

and had an abortion. She recalls no anxiety. The affair was terminated, again with no sense of loss on her part.

At nineteen she married a young accountant. She tried to keep the marriage 'part-time' by spending as much time as possible away from her husband. After the birth of her first child, she was operated on for a premalignant thyroid tumor and warned against further pregnancies. Nonetheless, she deliberately had another child. This was followed by a tubal ligation. She recalls no anxiety about any of these experiences. She was frigid during her marriage and suffered from dyspareunia. During the last two years of her marriage there were no sexual relations except toward the very end when she told her husband, at his insistence, of her premarital affairs, which excited him sexually. He pleaded against the divorce.

After her divorce, the patient became very promiscuous, nearly always with men she could not marry and usually in a triangular situation. Her dyspareunia and orgastic frigidity persisted during her post-divorce promiscuity. She experienced her first orgasm with her divorce lawyer in a relationship that had for her a 'prostitution fantasy' component. Since then, except for Bob whom she describes as her most gratifying lover even though his phallus is 'broad' and she suffers pain on penetration, she experiences orgasm only if there is no object relationship. For her, seeking orgasm became an end in itself, overriding all other considerations. Masturbation is usually unaccompanied by fantasies.

In the beginning, her sexual acting out was so extensive that it threatened the analysis; however, after a few months the nymphomania ended. The patient is free of shame or modesty and will reveal the most intimate details of her life freely and without inhibition. However, I later learned of her extreme modesty about noises connected with urination and defecation; she goes to another floor to urinate or defecate so that her lover will not hear her. The importance of anal erotism in the transference was revealed in her resistance to disclosing this behavior.

PERSONALITY TRAITS

An assessment of some of the patient's character traits and ego functions demonstrates the level of maturity she has attained. But it must be evaluated against a background model of fully attained maturity. Metaphorically, if the model were a cone, we would see a clearcut truncation of the cone at the two to three year level of ego maturation. The headings used below are descriptive rather than scientific designations of character traits and ego functions.

The patient is lively, spontaneous, and articulate. She is quite popular and gives the impression of warmth, although this is at variance with much that is reported here. She seduces people by an active show of interest in them, which proves at bottom to be narcissistic. A one day's acquaintance sounds like a lifelong friendship. Except for a mild polyarthritis, her health is good.

Aggressiveness:

The patient feels angry much of the time and expresses her hostility freely against her children, family, friends, merchants, strangers. Indeed, anger is the only clearcut affect she manifests. Her stance is generally an attacking one since she expects people to take advantage of her. She enters into social contacts in an aggressive, pugnacious way; she is calculating, manipulative, and exploitative. If her interests are involved, she is never in doubt about her rightness and never hesitates to strike out. She is litigious, recognizes no rules of fair play, and is quick to seek revenge. When a policeman gave her a traffic ticket, she wanted to go to court to fight him. On one occasion when her mother invited the patient and her brother to a 'chicken dinner', she refused to go because her brother likes chicken but she prefers beef. She said, 'I am furious. I want to rip his neck off. I want to karate him.'

In one session, late in the analysis, she said, 'Fury and anger are the only feelings I can feel. Calmness does not move—I can't feel it move. I can't stand it when it is peaceful.' When

things become calm with one lover, she begins to think of the next. If the children cause her any inconvenience, she strikes out at them and issues peremptory orders: 'No TV for two weeks—Go to bed immediately.' She reports such behavior with relish. On the other hand, if the children complain about a teacher or classmate, she invariably blames and attacks the 'enemy'.

Ambivalence without Conflict:

The patient attributes the basest of motives and acts to other people, even when she esteems them. Such contradictory evaluations may be expressed during the same hour: her positive and negative feelings and statements do not clash, nor does she have a need to harmonize them.

This seems to be connected with an inability to differentiate self from object, or to organize adequately an internalized object that can be externalized for interpersonal relationships. She perceives only her own needs, pain, and frustration; to apprehend the needs of others would require an empathy beyond her capacity. When frustrated she projects her aggression. The result is a misapprehension of the intentions of others, which constitutes a cognitive distortion. For instance:

1. She is hit in the eye during a tennis match. Acknowledging that she was out of position on the court, she is nonetheless sure that her opponent meant to hurt her.

2. She blandly reports that she fears an employe will kill her and her children because she did not respond to some interest she thought he showed in her, although she readily admits that there was no real basis for this idea. In her associations, she recalled that she had a similar fear of her husband and that it prompted the divorce. She also recalled her father's threats to kill his family and himself. On questioning, however, one finds that she had no real belief that any of these people were a danger to her.

3. When the children's governess asked for an eight dollar monthly raise, the patient protested violently although only a

short time before she had said that as the governess had had a raise in her rent she would need this modest raise in salary. The patient reported the governess's need quite naturally but a half hour later, described her as 'my enemy who is out to ruin me'.

Self-Centeredness:

Any intrusion into her comfort infuriates the patient. She shuts off her phone to guard her sleep no matter what urgent matter may be going on in her life. Recently after being up part of the night with her son who had a fever and stomachache, she told the maid to call the doctor in the morning and then went to bed. It is as though she thought: 'I've taken care of Johnny, now I'll take care of me'. She was astonished when I pointed out the lapse in her care of her son. When it turned out that the boy had appendicitis, she felt no anxiety, only guilt that she had not made the diagnosis herself. The morning following this episode, she delivered her stool manually; otherwise she was sure the stool would rip her intestine.

Lack of Kindness:

The patient is completely lacking in kindness. Although she maintains that she loves her daughter, in the illustrations she gives of her love, it is obvious that it is the little girl who is comforting and saying loving things to the patient. Another manifestation of what sounds like tender love toward her children is something akin to pity. She will say: 'How cute he is with his front tooth missing' or gleefully, 'There he goes, limping along on his sore foot'.

Lack of Sentiment:

Any allusion by the analyst to considerations of romantic or parental love, justice, fairness, decency, is greeted by the patient with expressions of contempt: 'hearts and flowers', she labels it. At the same time, the realization that she is unable to share feelings appropriate to an adult fills her with genuine alarm.

Defect in Empathic Function:

The patient can describe situations almost identical with her own in the most judgmental terms and with righteous indignation, yet not recognize herself in the stories. During one session she reported that her ex-husband became 'hysterical' when their daughter failed a subject in school, and that she had demanded that he control his hysteria as it was harmful to the child. Yet in the previous session she had reported her own violent reaction to the girl's failing mark: she had 'given hell' to the teacher and principal. She saw no connection between her ex-husband's behavior and her own. One is reminded here of M. Klein's (1955) description of projective identification.

Another example of the patient's defective empathic function, which affects her cognition and insight, was revealed during a session in which she attacked her mother for deserting the children every winter when she went south. I reminded the patient that she had done the same with her children. I knew she would experience this as criticism but hoped it might give her pause for thought. It did not; she could see no connection between her mother's action and hers. She left her children for good reason: she had been upset at the time by her divorce and resented the children. There was no indication of empathy with the mother, nor was there any guilt.

The patient shows little awareness or concern for the needs of other people. For instance, she unwittingly exposes her twelve-year-old daughter to precocious sexuality; to the patient her daughter is herself, an adult. Similarly, in her relationships with men the patient ignores the other person's wishes. If the man makes clear that to him the relationship is just an affair, she feels injured and deceived although all she wants of the man is the penis—an 'affair'.

Unrealistic Expectations:

The patient's peremptory wishes ignore reality. For example, she sued her ex-husband without any consideration of his economic resources; at every fashionable bar she expects to

meet a millionaire whom she will marry; if a lover frustrates her wishes, she is sure he will 'change', particularly with psychoanalysis. A cognitive defect is evident here.

Homosexuality:

The closest the patient comes to mature object relations is in her friendships with women, some of which have endured for years. When she is in trouble or must make an important decision about an emotional matter, she most often seeks a woman friend's opinion; her advice will carry great weight with the patient. During analytic sessions, she frequently quotes the opinions of her women friends, relegating the analyst to limbo. Because of her paranoid sensitivity, her friendships may turn into enmities for slight or imagined offenses; but they are soon re-established. Her paranoid sensitivity defends her against the breakthrough of her homosexual strivings but her compulsive erotomania plays an even more important role in her relationships with women. Her erotomania is invariably directed toward narcissistic, rejecting men (primeval bad mothers) who are involved with other women and bound to disappoint her.

During an hour in which she fought off falling asleep, she told of her adolescent daughter's attachment to a 'dykish' friend. She then reported a recent dream:

> A big dykish girl wants me to kiss her . . . the lesbians that work for me!

The patient then fell asleep on the couch and on awakening, reported this dream:

> I'm not sleeping next to you. You are not a good sleeper. I'm trying to escape you.

Ongoing Fantasy, Daydreams, and Acting Out:

Her fantasy life is very limited. There are a few sadomasochistic fantasies accompanying masturbation which is indulged

in without any particular erotic tension or desire. Much in her relationship to men is an acting out of an adolescent fantasy of 'keeping steady company' and of 'being married some day', while remaining home forever.

With Bob, there are some positive elements: the occasional exchange of love and even promises. But she wishes to be the exclusive object not only of Bob but of other men, and simultaneously. The prolonged love affair is the prolonged daydreaming reverie, largely acted out in her affairs (*cf.*, Arlow, 1969). Part of this fantasy is the unrealistic pursuit of a millionaire who will marry her. She tells of going to a bar in a large hotel and expecting several millionaires to approach her and begin a great 'romance'. Then, in anger, she says: 'This is like the end of me. I'll get my way. I hate men, they all stink. I win because I disdain them and that makes me superior. Shit on them before they shit on me. Business is good.' She then tells me of her new business.

Pseudo-Adaptation of Social Roles:

The adult world and its social institutions are poorly apprehended and she assumes social roles by way of imitation. Classical rules of business practice do not exist for her; all she wants is huge profits without any capital outlay. Money is something to be acquired in large 'gobs' and to be spent for her sensual pleasure. She manipulates economic reality in order to retain the pleasure in unsublimated form. For example, she claimed to have lost money, in a year in which she had actually made a large profit, by withholding information about accounts receivable since this asset was not immediately and concretely available to her. In her resistance, she must defy and outwit the analyst; he might introduce economic reality and rob her of immediate libidinal satisfaction.

She tries to laugh off such social institutions as marriage, parenthood, and family as 'phony', 'hearts and flowers'; however, she recognizes that they have real meaning to other people. She has an 'as if' relationship to social institutions.

Primitive Superego:

The patient seldom weighs a matter according to any moral or ethical judgment. Instead, she uses a friend's experience as a 'guidepost' which serves her as a criterion for judgment or reality testing.

Amorality:

For most of us the need for laws is implicit; whether or not we abide by them, we identify ourselves with the laws inherent in the operation of our social institutions (*cf.,* Atkin, 1971). For my patient, however, social reality is an entity outside herself, a foreign sanction alien to her; indeed, she has not even reached that stage of ego development at which she could become 'alienated'. Such a person helps us comprehend amorality as we encounter it in the psychopathic personality.

LANGUAGE, THOUGHT, AND COGNITION

Even as we probe unconscious processes in the psychoanalytic situation, the communication process, of which language is the most important medium, forces itself into our consciousness and brings into focus the language and cognitive features that are characteristic of the patient *(cf.,* Atkin, 1969). Since language plays such a predominant role in human psychic activity, one would expect that a defect in the integrating function would be revealed in the language function. The cleavage in the functions of cognition, thought, and language found in my patient can best be understood, in my opinion, as a developmental arrest. In the early part of the treatment, no anxiety was aroused by the analysis of her disjunction, an indication that it was not a defense. Where no integration into a whole takes place, there can be no 'split' in the sense that Kernberg uses the term.[2] Only after some maturity of the ego took place as a

[2] Kernberg (1966) bases his diagnosis of borderline personality organization on the presence of a 'split', much as described here. He regards the 'split' as being due to early mental conflict. The mechanism, he feels, is used actively for keeping 'good' and 'bad' self and object images apart (*cf.,* p. 245). This mechanism is retained in consciousness at later stages as a defense against anxiety; the analysis of the 'split' generates anxiety.

result of the psychoanalysis did my patient use disjunction as a defense.

Although my patient presents no formal defect in language and thought, certain aspects of her language and cognitive functions pointed early to some basic ego immaturity, the full significance of which I came to comprehend only much later in the analysis.

Glaring inconsistencies and contradictions present no problem to her; she bothers little about cause and effect in her observations or conduct. For example, as already described, in her sexual relationships she has two contradictory expectations.[3] Her affairs are generally purely sexual encounters, verging on the perverse, with unsuitable men who tell her 'the score' from the beginning. At the same time, she expects the man to establish her at once as his exclusive love object, with marriage in the offing, and she becomes angry and demanding when this does not happen. Interpretations have no effect on the course of the next affair. It took me a long time to realize that the need for consistency was only in *my* mind, not hers; she felt no need for it.

Corollary to this lack, I believe, is an inability to form an introjected object of constancy. There is inner discontinuity both in the organization of her introjects and in the relationship between them of the sort that takes place in more mature object relations. If the object disappoints her, it disappears. This is not a case of 'sour grapes' or revenge; the person simply no longer exists for her; he has been extinguished. And it is not amnesia due to repression; rather it is a case of 'out of sight, out of mind'. I believe that primary repression operates here

[3] It is necessary to differentiate this from obsessional doubt, in which the person usually has feasible alternatives, one of which must be given up. With my patient, the alternatives never quite present themselves in this way. In so far as she wants the perverse relationship, she wants it completely. But in addition she insists on marriage with the man, even though it is not attainable. In terms of her inner life, her several needs are addressed toward 'part objects' which in personal relations are embodied in the same individual. The internalized imagoes have not been integrated into 'one person'.

since, with the need withdrawn, it is as though the object never existed. A weakly cathected nonperemptory idea leaves the dynamic field, sometimes through forgetting.[4]

In typical primitive, narcissistic manner of eliminating painful stimuli, my patient seeks to suppress, to 'wipe out', the disagreeable. But she does so in her own special manner. For some time I thought she was resorting to trickiness or prevarication but then I realized that, to save herself pain, she has to alter what she has said only a moment before. It is not that she simply substitutes a pleasant idea for a painful one, as in denial or delusion. Since contradictions are no problem to her, she can easily supplant something unacceptable, which she forgets the next moment, with verbalization of something acceptable. This verbalization is a magical linguistic instrument, a sign or symbolic representation of fulfilled desire; it is, in a way, like visual dream images, and it shares the character of dream formation. As we know, signs are a primitive component in the composition and evolution of language. Her secondary process thinking also contains excessive features of primary process. Semantically lucid observations proved, on analysis, to contain large masked increments of primary process thinking.

A semantic insight that illuminated her communication with me may have some theoretical interest. I realized that what masked the veridical meaning of her verbal communication was the fact that she used the same language that mature people use to express phallic and genital ideas, but in an idiosyncratic way. Not having advanced in her development beyond a pregenital or even a preverbal level of drives or wishes, she uses linguistic images and metaphors ordinarily semantically expressive of phallic and genital aims as verbal vehicles in the pursuit of primitive, pregenital, aggressive, and narcissistic aims. Thus a variety of linguistic themes, some more, some less drive cathected, are pursued simultaneously, unhampered by their

[4] This is in contrast to repression which is an active hypercathexis due to anxiety or guilt against a powerfully cathected, peremptory idea (*cf.*, G. Klein, 1967).

ambiguities. A musical analogy of what eventuated from these themes would be a linguistic fugue.

The patient's tolerance of contradictions and inconsistencies in the cognitive sphere had another consequence. In articulating the unsynthesized 'part-universes',[5] her language and speech, formally unremarkable, assumed special features. The semantic aspect of language is, as we know, anchored in the mutually shared concepts and meanings of the social group; in my patient's case, however, it often has reference only to her private world of reality. Since it is not readily recognizable as idiosyncratic, it is subject to misunderstanding; to the listener her statements are misperceived as prevarications or misapprehended as quasi-parapraxes. This cognitive gap occurs frequently.

Language is socially shared, but there is also a private language. Perception is an autonomous function and, within limits, there is a common response in the perception of outer reality (*cf.*, G. Klein, 1970, p. 319). Omitting consideration of personal style, percepts enter into thought and cognition differently, both quantitatively and qualitatively, since they are differently cathected by wish and motivation. For instance, 1, they may be cathected; 2, in mental conflict, they may be decathected, as in repression; or 3, for the person having no interest in them, they may be uncathected, as in primary repression. What is not cathected is less likely to be remembered, another factor in disturbing cognition.

An example of this latter factor in my patient was her report of receiving a letter from her ex-husband's lawyer protesting, because of the children, her having her lover live in her house. She did not remember that until shortly before she had kept her lover's sleeping overnight a secret from her children, for the same reason.

Special features of her language and thought functions re-

[5] Reality is organized around separate needs with instinctual aims directed toward part objects. These clusters remain discrete and unsynthesized into one universe—they are 'part-universes'.

flect the basic fact that her world of objects and reality is strangely fragmented, with the parts unintegrated and unrelated to each other. To illustrate an effect on her cognitive capacity, let me cite some consecutive statements of hers. She is speaking about her ex-husband. Angrily, 'I should have him pay more alimony.' 'I had my father's money.' 'He [ex-husband] had no money.' She makes no attempt to reconcile the three statements. Each is cathected separately by her oral-sadistic needs and each remains distinct and separated in her thinking. When I point out the discrepancies, she cannot comprehend them and answers with a *non sequitur,* 'I should have included an escalation clause'. This is an on-the-spot invention, a 'daydream' that will keep the money coming in.

Thought and cognition, in the service of adaptation, should subserve the reality principle. In this instance, to conform to necessity, the three statements should have been organized into something like this: 'I hate the s.o.b. I want his money. But he hasn't got any. So what's the use of suing him? I'll get it instead from my father.' But she sues and sues, at the same time exploiting her father.

To ward off pain she creates through her special verbal usages—magical incantations—a new 'reality'. If some wrong she has done is uncovered, this is immediately counteracted by a statement out of context, but quite sincere, that is meant to blot out or negate the effect of the misdeed. When the analyst points out the reality, she complains that he is 'picking' on her.

She also uses verbal acrobatics to strike bargains for herself. She will complain, 'How can Bob be so promiscuous?' and then speak of how good she has been to him and to his children, how constant and abstinent she has been, even though this may well be completely at variance with the facts. The verbalizations are again like the visual images in the dream.

As we know, language can obscure rather than reveal meaning. What follows is an example of how I learned to listen to the patient's linguistic 'signals'.

I have mentioned that throughout the analysis the patient

has been involved intermittently in a love affair with Bob, whom she describes as 'handsome, perverted, narcissistic, brilliant, black as the devil, and very mod'. When she thinks nothing will really change in their relationship, she leaves him but immediately shifts to a similar lover; at such times she firmly states that she has 'finally left Bob'. In one hour, she talked about a new lover, Joe, 'the spitting image of Bob'. She is afraid he will die; she is afraid that a more mature and 'marriageable kind of man' will steal her business. Her brother will steal her business. In their relation to women, men are 'all yelling and insisting on their way. . . . Who the hell needs them? . . . Bob too.' Is this to put off the forbidding analyst? I realized she did not mean 'Bob too' but 'about Bob it is different' or 'with Bob it would be different'—the unspoken thought to clear the path back to Bob. It was a *signal* that she was going back to him. While I had no direct evidence, this was my 'hunch' and it turned out to be correct. With her criticism of Joe, she was derogating the analyst and at the same time 'angling in the magician's pool' for Bob, whom she was supposed to stop seeing for therapeutic reasons.

In the following hour, for the first time she came forty-five minutes late. She was destroying the analytic situation and the interfering analyst. She said: 'Father's clock is an hour off', as was the governess's clock. In the five minutes remaining of the hour, she reported that her daughter got bad grades in all subjects; she seemed to feel some guilt about deserting her for Bob.

The next day she reported a dream: Bob was with a beautiful blond. His former mistress, Mrs. X, was also there but looked insignificant, 'nobody to worry about'. In the dream the mistress was humbled and replaced by the blond (the patient). She had got rid of Mrs. X as she was a person of 'no significance'. In her associations, she said that she had written Bob a letter but had torn it up. (She frequently avails herself of such magical gestures. For instance, if 'the phone rings and someone breathes into it', she assumes that Bob is the caller and is 'responding' to her thoughts of him.)

In one dream, intense rivalry toward her brother with regard to her business was evidenced. During this same period, she reported this dream:

> My father and I tried to get somewhere. A truck traveled over rough ground and all of a sudden it tumbles down a hill. My father is very mad.

Her associations were: 'After I spoke with Joe, I had a bad taste in my mouth all day, like dry wood, and I wanted to speak to you'.

Her compulsion to act out her impulse to return to Bob was accompanied by anxiety and fear of the analyst, expressed by the bad taste and dryness in her mouth and her desire to call me so that I would prohibit the acting out. Two days later she was back with Bob, but continued to worry that her ex-husband would take away her daughter.

SENSE OF TIME

The patient's distorted sense of time is intimately connected with her urgent impulses. Thus the analytic schedule will disintegrate and be forgotten as soon as she is gripped with some new prospect of pleasure or gain. Typically, she will abruptly announce a trip planned for the following day too late to rearrange the schedule. Internalized objects are abandoned or destroyed. This is not amnesia, but more like primary repression—that is, 'out of mind', perhaps another instance of the clustering of aims and ideas around part objects, the 'part universes'.

To accommodate a variety of planned actions into a pattern requires the ability to anticipate, to manage time, a mental faculty that in this patient seems to be impaired. Although her impulsiveness is manifested in her inability to endure tension and delay action, it may also indicate her inability to organize experience within a context of extended time involving the capacity to postpone and delay.

DYNAMIC FORMULATION

There is little anamnesis for a firm genetic and dynamic formulation in this case. An early trauma seems to play an important part in her neurosis. At age one, she had a severe and prolonged throat infection and her characteristic aggressiveness may be a reaction of her helplessness and threat of death at that time. A 'choking' symptom has appeared several times during the analysis within the context of traumatic threat. For instance, on one occasion she responded to an intervention, 'I feel nauseous, like being choked' and later said, 'My illness in my throat—a strep throat'; on another occasion she experienced choking, migraine, and great tension.

Though the recalled history of prolonged separations from her parents begins at age three or four, maternal deprivation went back earlier. Recently her mother 'boasted' that when the patient was a little girl she managed to spend only ten minutes a day with her. This lack of maternal nourishment has resulted in her characteristic state of impoverished narcissism: her self-hatred and profound inferiority feelings are accompanied by a never-ceasing preoccupation with herself.[6] An individual with such deep inferiority feelings and narcissistic mortification

[6] I am indebted to Mme. Janice de Saussure for this insight. In her discussion of the case at the meeting of the International Psycho-Analytical Association in 1973, she stated:

'As this patient is so blatantly narcissistic I think it is important to examine closely the nature of her instinctual investment in both her self and her objects. Personally I would say that in spite of her preoccupation with sexuality, her aggressive rather than her libidinal drive is predominant. Dr. Atkin has not mentioned a single object toward whom her feelings could accurately be described as loving. Likewise, he has not presented to us a picture of a woman who loves herself. What he has shown is a woman who is anxiously preoccupied with herself, who desperately and continuously demands love from her objects, but who cannot hold on to love when it is offered and integrate it into herself. It is in exactly this respect that she is so typically narcissistic. In spite of our traditional concept of narcissism, I believe that this patient does not fail to love others because she loves herself so much but rather that she is unable to love others because she does not love herself. In fact, I would say that both the failure to love herself and to love others is the result of an inability to utilize her libidinal potential.'

would tend to project in order to save herself from the aggression that is otherwise turned inward in self-criticism and self-punishment. This may be a factor in retarded superego development. The poverty of my patient's affective life which may hypothetically be attributed to her integrative defect, may also stem from a primitive anaclitic depression which she may have suffered (*cf.*, Spitz, 1946).

A genetic question may be interposed here. Is the paucity of the integrative and synthetic work resulting from an arrest in development due to a constitutional factor—a retardation in the maturational synthetic process? Or is the failure of the synthetic function of the ego due to the pathological effect of early traumatic emotional crises?[7] What is the relative quantitative contribution of each?

Clinical investigation of my patient is made more difficult by the complication that many of her aims and behavior are spurious: they are imitative in a primary identification sense. Like the 'as if' character, rather than manifesting the psychic activity of an authentic person, she mirrors the personalities around her. (*Cf.*, Panel on Clinical and Theoretical Aspects of 'As If' Characters, 1966.)

The patient functions largely on the pregenital level and falls short of maturity in her object relationships. The primitive level of her ego functions and the defect in their synthesis, as well as the manifestations of her narcissistic neurosis, are ego-syntonic. But her lack of insight is qualified by a vague uneasiness about her general lack of appropriate feelings together with apprehension about her vulnerability and threatened integrity. This awareness, however, does not apply to her detachment from moral and ethical considerations which are socially determined: her superego is poorly developed.

[7] This poses an interesting question of etiology since there is reason to think that the need to synthesize, integrate, and unify the input of experience is an autonomous ego function (*cf.*, G. Klein, 1970, p. 319). There is a compulsive drive toward a unified gestalt of the world which is attained with the aid of the psychic defenses. The efficiency of the cognitive faculty depends upon these integrative drives, as does the faculty of self-observation or self-criticism.

There has been a stratification in many of her symptoms, both in their level of derivation and in their defensive function. This corresponds to a striking clinical feature: the coincidence of anaclitic-narcissistic and transference-neurotic aspects. The same symptoms—such as blushing, the 'men stinking' complaint, or exhibitionism—simultaneously or at different times serve different libidinal aims, being derived from different developmental levels and libidinal phases. Thus, in the extraordinary self-delivery of her stool,[8] one can see a schizophrenic fantasy of a pregenital, symbiotic mother ministering to her child and an anally overdetermined hysterical fantasy of the stool penetrating and ripping her, a fantasy she freely verbalizes. Anal penetration is sought in foreplay and in coitus. Her avoiding being observed on the toilet is a defense against exhibitionism.

Late in the analysis she had a recollection of an incident at the age of eight. She was in a closed car with her family. Her father was talking angrily, threatening and boasting. He was

[8] In a personal communication, Dr. Mortimer Ostow (1973) states: 'Although I do not see her as psychotic, nevertheless the basic dynamic mechanism by which she lives seems to me to be basically the mechanism of schizophrenia . . . one of the rejection of the disappointing real world. Her aggression is a kind of schizophrenic reason for rejection of the world. "I wish everybody would go away and die because mother left me. I can't tolerate that. She sent me substitutes that were not the same thing and she must be destroyed; the world must be destroyed and I must be destroyed." This is followed by the restitutive phase, the fantasy of reconstruction. She will give birth to herself. Here is where the stool delivery comes in. She is giving birth to herself by delivering her own stool and by determining to have two babies. The rebirth fantasy by which she lives is, "I don't need mother; I don't need the millionaire; I can do it all myself". In other words, she is turning her back on the disappointing mother and the men who always disappoint her because she always looks for disappointing men. This is a repetition compulsion that forces her to act out the rejection continuously.'

There is clinical confirmation of Dr. Ostow's interpretation. My patient tests almost any anxiety situation with some allusion to her bowels. She believes that giving up the practice of delivering her stool would spell her cure. She has epitomized the perverse relationship with Bob in the most literal, concrete, anal terms. The sexual union is an anal penetration; what she does with her hand in the stool delivery is what occurs in the sexual act.

smoking 'stinking' cigars; the stink was terrible. She wanted to get out of the car but could not. As mentioned, men who approach her for marriage 'stink' and 'bore' her, a narcissistic flight from hysterical anxiety. When a threat becomes traumatically intense, she chokes.

THE TRANSFERENCE AND ITS MANAGEMENT

The analysis of this case has had several phases starting with the anaclitic-narcissistic period and going on to a newly manifested transference neurosis. This may be seen as a reliving of consecutive developmental stages with activation of the innate maturational psychological process in response to the psychoanalysis. Without intending to, in the first phase the analyst served as the pregenital parent; only after this was he permitted, in the second or transference phase, to enter as a working partner in the therapeutic situation.

The core of the transference is the patient's anaclitic, implicit dependency, and her greatest resistance is derived from the need to maintain it. Side by side with this primitive, anaclitic transference, in which the analyst serves as an auxiliary ego and a model, is the object-related transference to the analyst as a parent.

At first the analyst was the perfect person, indispensable to her. He was beyond questioning. In the transference, the patient waits for him to give her what she wants. If she is 'good', or can convince him that she is, the omnipotent analyst will gratify all her wishes, no matter how contradictory they may be. This accounts for much of her coöperativeness in the analysis (*cf.,* A. Reich, 1953). Yet much of the time, the patient is also on guard against the irascible, scolding, violent father who 'told her off'. The sharp splitting of her transference, with adoration of the analyst on the one hand and hatred of the parents on the other, has succeeded in saving the analyst from her destructive aggression.

The patient, aggressive, self-righteous, and stubborn, never really stands up to the analyst in affirming her own opinions.

When she complains, it is only because she has not received sufficient praise or approval. On the other hand, she is conscientious and productive and her therapeutic expectations are optimistic, especially when she senses in the analyst any doubt about her progress.

In time technical innovations were introduced into the analysis. At first they were forced into the treatment by the patient. She responded to interventions with a variety of maneuvers, particularly with verbal constructions that had the characteristics of primary process magical incantations. Interpretations were perceived as criticism to which she reacted as if something had been taken away from her. To replace the loss she would proclaim her virtues, her therapeutic gains.

The patient has never really questioned the truth and power of psychoanalysis or its therapeutic expectations, but she does not grasp the concept of the analytic hour or of the psychoanalytic situation as a work operation. She will come into the room with an aggressive, overly familiar greeting, often with some personal inquiry or comment about the decorations in the waiting room or office. Sometimes she will address me as 'Sam'. She aggressively presses her questions on me but is never aware of the selectiveness of my responses.

I came to realize the predictive value of listening to affect-laden expressions as if they were equivalent to primary process magic gestures expressed in verbal maneuvers and in acting out. Moreover, it became apparent that this quasi-acting out served her need to cling to aggressive and objectless erotic aims; it was for her a sentience that forestalled extinction. Her lack of internalized objects corresponded to an inadequate ego and a primitive superego. The loosely organized ego accounted for the impulsive character of her acting out.

The patient is in constant dread of loss of feeling. Thus it is possible to appreciate the peremptory nature and overriding importance to her of orgasm, with which she seeks to overcome the narcissistic mortification she has felt as the consequence of loss of feeling. In addition, the extinction of her sensual feel-

ings by hostility and aggression frightens her. Curiously, the analysis is welcome precisely because it is intrusive. This patient needs, and wants, control by someone who can view her with firm consistency and who can serve as an ego ideal.

The analysis is an intense learning experience for her, to which she brings enough ego strength with which to respond. She also has come to partially recognize her undeveloped faculty of cognition as well as a qualitative defect in her affective capacities, which she aspires to correct through the analysis. Perhaps her complete acceptance of the analyst may be understood as her preconscious, and often conscious, awareness of what the analyst has that she lacks and aspires to: an integrated world, cathected with affect and contiguous to the world of social reality. To live in the analyst's unified and synthesized world comprises the anaclitic component of the transference. Only through the analysis can she extricate herself from her confusion, which superficially resembles obsessional doubt. It is the analyst's 'boundless' love and approval that she tries to obtain. Perhaps she will eventually learn to postpone, to wait, to endure.

Much of the work with this patient has been to introduce her to the simple facts of life, such as mores, conventions, and that uncertainty and chance are unavoidable in the pursuit of plans and designs in living. I have tried to introduce her to the meaning and function of mourning: she must make a choice which means she must give up something. Since she has depended entirely on immediate gratification of her desires—all her desires and from the same person—, it has not been necessary for her to make a choice.

A basic principle in the verbal intervention made to a patient possessed of a well-integrated inner world is for the analyst to clearly state an idea, as unburdened as possible by the subjectivity and specificity of his personality, which serves to fit into the frame of reference of the patient's personality. With my patient, however, it has been necessary to introduce the analyst's personality and universe as a component in the

treatment situation in order to modify and broaden her 'unfinished' world into a more complete personal configuration. The analyst's statements not only have to be semantically precise but emotionally expressive, dramatic, or incisive or intense. I may go so far as to scold the patient when she sets a compass course simultaneously north and south. The personality of the analyst is offered to the patient for her comprehension, identification, and eventual internalization.

In the obligatory utilization of parameters in the analysis of such a patient, the analyst recognizes at least two kinds of countertransference. First, an illusory and largely unconscious assumption that there is adequate intercommunication between patient and analyst, i.e., that they share a common enough universe and therefore a common enough universe of discourse. However, the formally intact language (the shared language) does not necessarily correspond to mutual experience or meanings. The premise that there exists a mutually shared world of reality, values, feelings, and attitudes is misleading and can serve as the analyst's 'blind spot'; he must divest himself of the premise. Second, the wish, only partially conscious, to impose the analyst's world on the patient, is ordinarily avoided and minimized. But in this borderline case, it has been essential to introduce the analyst's universe as a component intended to advance the completion of the maturation of the patient's personality. Learning by imitation, an educational benefit, was a minimum expectation.

COURSE OF THE ANALYSIS

In the first phase of the analysis—the narcissistic phase which lasted almost a year—the patient's behavior followed the usual course of a narcissistic neurosis. The transference neurosis became evident when hysterical and obsessional symptoms and emotional conflicts emerged on a more object-related level. The patient and analyst could then assume the required distance that made analytic intervention and interpretation possible. Only then could the patient, to some degree at least, postpone

action, reflect, introject, and internalize. While this change only partially replaced old patterns, some of the anaclitic manifestations in the transference were permanently attenuated and even eliminated. The analyst was no longer the all-powerful parent who was there to fulfil all her wishes. Now, for the first time the analysis of the so-called 'disjunctive' phenomenon—the psychoanalytic demand that she abandon her simultaneous striving toward contradictory goals—produced anxiety.

The subsequent process of development can best be described in two ways. First, there was a slow, subtle, almost imperceptible change in her involvement with objects. This was concurrent with a shift in the transference from the anaclitic to the object-related, most clearly expressed in the father transference. More mature ego functioning, including a change in defenses, a greater capacity for sublimation, and enhanced superego faculties were manifested. The primitive features in the patient's cognition and thought also became less extensive.

Second, with the reactivation of the œdipal conflict, neurotic symptoms and defenses emerged which lent themselves to the unfolding analysis of her transference neurosis and provided evidence of her growth and maturation. Her hostile aggression became less ego-syntonic and her implacable feelings of hate toward her family diminished. In fact, she began to see her father as kindly and concerned about her, and her mother, toward whom she had expressed only contempt for over three years of analysis, as wise and generous. She also established a relationship with her brother. She began to recall with some pleasure her family's summer home where she had stayed from infancy on and to which she is still invited. (In the early part of the analysis, she mentioned the place only in connection with her envy of her brother who used it more than she.)

There now emerged strong feelings expressed in a metaphor that her affairs were 'winding roads' to return there. In the session in which she recalled the family's summer home, she had vivid sadomasochistic fantasies involving her father and prostitution. She reported that she was always constipated at

their summer home and that after being there last, on returning to her own home she had been sexually excited and had masturbated on the toilet by inserting her finger in her anus and feeling her stool. As she spoke of this, she blinked her eyes, something she apparently had not done since age five. She continued: 'The pain I had with Bob. I'm a masochist. In school I did and said things to have them laugh at me—also with my brother.' Later she reported a dream in which she recalled and relieved her sadomasochistic involvement and identification with her father.

As her hostility toward her family decreased, there was less narcissistic withdrawal and this contributed to an improved relationship with her children. Moreover, she gradually assumed full responsibility for her own home and became less dependent on her ex-husband. Her lifelong traits of revenge, spite, and retaliation have practically disappeared. Her litigiousness has also decreased. Now when she feels impelled to destroy an object that has frustrated her, she pauses and sometimes manages to suppress the impulse.

The transference neurosis was ushered in with blushing when she reported a dream in which she recognized feelings of tenderness toward her lover and a wish to be close to him. Her associations to the blushing led to recovery of feelings that had accompanied her pregnancy and abortion at sixteen. She then reported a vivid screen memory of a room with purple hues—a room in which something mysterious happened, clearly a primal scene. The analysis was now proceeding comparatively unhampered by the extra-analytic maneuvers introduced in the anaclitic phase.

For a long time the patient's love affairs were always with need-satisfying objects and her reactions were either of brief satisfaction or frustration and rage. Now men are felt to be less narcissistic and more warmly in love with her, and she has become capable of more emotional involvement with them. As her object feelings increased, she developed increasing tension, sometimes with choking, anxiety, and hysterical conversions

on the couch, such as headaches, backaches, and pain in her arms and hands. Most important to her, however, is that she has lost her capacity for orgasm, and this alarms her greatly. The boredom she formerly experienced with possible marriage prospects has been replaced by orgastic frigidity and the fear of it, fear both of feeling and of not feeling. Men no longer 'stink'; they are now too fat, or too old, or are poorly dressed; for one reason or another, her initial excitement with them rapidly wanes.

The dyspareunia she experienced in her marriage has reappeared. Because of this and her orgastic impotence, she often regresses to her bowel movement ritual—the self-delivery of her stool. She continues to believe she will be able to marry and to respond sexually only when she no longer does this.

The patient has gradually moved toward surrendering her attempts at simultaneous gratification of mutually exclusive goals. By way of illustration, she reports that Joe has declared his love but made no offer of marriage. 'I'm embarrassed that I care.' She blushes, then adds: 'I want to live with him this summer, then get married. He will change.' I point out that she told me Joe does not want to get married; since she does, Joe's wishes do not exist. She responds to this with palpitations and shortness of breath. She says, 'I'll have a heart attack. I'll go to sleep.' The following day she reported, 'Something broke through last night. I could masturbate and I felt him inside me.'

Another new feature, which seems to have the structure of a reaction-formation, is sentimentality. She now says, 'I am a warm person' and there is an emotional intention to 'do' for the man, which she proudly reports to the analyst. But the bartering and the primary process magical gestures are still present although they are now interspersed with flashes of awareness.

The history of her work career during the analysis demonstrates a growing capacity to sublimate. Her interests in home decorating and fashion have found an outlet in creative achievement. She is now a successful interior designer and competent

business woman. In this salutary sublimatory development, she has manifested her identification with her artist-mother and businessman-father. The development of her career also has increased her capacity to assume social roles and to move from her highly personalized environment into a larger social world. Also she is pleased to be less dependent on her father. Recently she has begun to pay, although irregularly, part of the analytic fee.

Optimism about the stability of the growth she has achieved in the analysis must be qualified. For instance, recently when a rich man proposed marriage to her, her interest in her work vanished. But she reacted to the analyst's interpretation of the incident with shame and reported feeling 'vile and disgusting', and her interest in her work immediately returned. Here one could see self-observation and self-criticism, a growing superego.

She attests to the therapeutic effect of the educational parameter in the analysis thus: 'I pushed myself to be happy. It [the psychoanalysis] worked for me. All doing it with my head.'

SUMMARY AND CONCLUSIONS

In the ongoing analysis of a borderline patient, defects in the cognitive and conative spheres have been prominent. They seem to have their genesis in some arrest or early disturbance in the patient's integrative capacity and are compounded by regression due to neurotic conflict. The integrative defect may also have affected the patient's psychosexual development, which appears to have stopped short of genital primacy. As Freud (1923) said, the achievement of genital primacy is a highly synthetic process which requires the coördination of the component instincts directed toward an object constancy.

The immature state of the patient's ego in the area of object relations is discussed. Her pregenital libidinal aims are directed either toward part objects or toward primitive, global, all-need-satisfying objects. She readily destroys objects that frustrate her, is limited in her capacity to mourn, and moves from object to object on whom she displaces her needs and

drives. At the same time, however, there is a pseudo-object constancy: timeless involvement with objects who disappear and reappear.

In her relationships, there is lack of empathy. For empathy, she substitutes fusion with the object accompanied by an inefficient projection. Under the influence of objective anxiety, the little empathic capacity she has serves as a primitive superego and has a paranoid element.

Ego functioning in this patient is at the two to three-year-old level; there is a primary failure of the integrative function of the ego. She lives in a fragmented world, in large part the result of inconsistencies in her thinking which affect her language, sense of time, judgment, and reality testing. (In most adult patients what is quantitatively preponderant are the accumulated secondary interactional effects of the functional deficiencies due to the primary integrative lag.)

Upon analysis, her secondary process thinking and lucid verbalizations proved to contain large masked increments of primary process thinking. Unlike the schizophrenic's thought disorder in which id symbolism is ordered within the primary process, the patient uses solely authentic language symbols with features of primary process thinking. We see here an intermediate stage between the hierarchical levels of schizophrenic thought and mature thought.

Most important in this case is the defect consequent to the patient's integrative capacity. This defect is not accompanied by a dampening of libido, such as one sees in some narcissistic neuroses or in the schizophrenias. Except for feelings of aggression, there is a restriction of affects and a relative failure to bind affects to ego apparatuses. Unlike the individual who has a well-structured and well-organized ego through which he can channel a wish or drive toward an internalized object, this borderline patient is incapable of adequately discharging instinctual drives or tension.

The analysis has unfolded in two distinct stages: first, a narcissistic phase and then a transference neurosis. During the

course of treatment, the patient's reaction to the analysis of the simultaneous entertaining of contradictory ideas and aims underwent a change. In the beginning, there was no manifestation of resistance; later, however, resistance to the analysis of the disjunction produced defensive anxiety and symptoms. Her advance from the narcissistic-anaclitic phase of the analysis to the transference neurosis phase was apparent in a variety of functional areas. Salutary psychosexual developments occurred but to some degree were replaced by neurotic conflict and guilt, resistance, anxiety, and other defensive maneuvers.

The clinical manifestations of maturation have been gradual. In the analysis of the transference neurosis, there was a ready interchangeability of the pregenital and genital components with frequent shifts of the anaclitic and neurotic transference, which conformed to the patient's general immaturity.

In summary, this patient's ego development was retarded at so early a level that the functional cleavage preceding more advanced integration was retained. Where we find a juxtaposed narcissistic neurosis and a transference neurosis accompanied by a functional cleavage, we have a borderline patient. The borderline case has no typological or nosological specificity. Borderline patients manifest a variety of syndromes but have in common a crucial defect in synthetic function. Such considerations have an important bearing on both the prognosis and analyzability of each borderline patient.

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CONGENITAL AND PERINATAL SENSORY DEPRIVATIONS:

THEIR EFFECT ON THE CAPACITY TO EXPERIENCE AFFECT

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Longitudinal observations of youngsters suffering from a variety of congenital and perinatal sensory deficits indicate a systematic relation between deprivation in particular modes and in cognitive and affective development. The data presented indicate that the capacity to experience and express affect, as well as to form affective ties, is strongly associated with visual experience. The effects of even extended periods of sensory deprivation in other modalities appear to be reversible if the visual system is intact. On the other hand, the effects of distorting experiences persist even when they are limited to very early infancy and childhood.

I

The term 'oral' as it is used to refer to the earliest postnatal phase is a metaphor which falls woefully short of characterizing what we assume to be the subjective experiences of that period. It persists, one suspects, both because of its historical significance for psychoanalysis and because the mouth is indeed the only effector organ available to the newborn. At the same time, because we have so little information concerning what the infant is actually aware of, our inclination is to impute to him qualities of experience like our own. We tend to ignore the evidence that his ability to register and process sensation is not comparable to that of the adult. Unlike the stimulus barrier of the more mature individual, the primordial stimulus barrier (*cf.*, Benjamin, 1963) is probably not a dynamic ego apparatus in the sense of a group of functions which operate to maintain the equilibrium of the psychic apparatus. Rather, it would seem to reflect the incomplete state of the maturation of the nervous system. If this is the case, not the least of the problems one faces in the study of early development is the

determination of precisely what aspects of a given array of stimuli can, in fact, affect both the form and the function of the infant's evolving nervous system and—as a derivative of its effect at this level—influence the evolution of psychic functions, including the capacity to experience affect.

The available evidence in this regard is certainly ambiguous and its interpretation subject to all those pitfalls which must accompany any effort to extrapolate from neurology to psychology. What psychological significance is one to attribute, for example, to the fact that an infant as young as twenty days old follows a visual stimulus (Bower, 1966)? That his behavior is compatible with the assumption that he is attending to the object and can differentiate it on the basis of its relative size from other similarly shaped objects is apparently well established. But does it follow from this observable behavior that he does in fact perceive the visual stimulus in the sense that a more mature individual can be shown to perceive it? In the same vein are we justified in extrapolating from the evidence of physiologic stress in the newborn that he is experiencing anxiety or discomfort analogous to that which we know as adults? One suspects that the answers to these questions are negative. Aside from the lack of experience which is an inevitable concomitant of infancy, the incomplete state of the very structure of his brain militates against any other conclusion.

Not only does the unfinished state of the infant's brain make it necessary to infer that his experience is qualitatively different from adult experience, but also it follows that the very process of anatomic maturation (and, therefore, of the emergence of later functional characteristics) may be influenced by experience. With respect to general somatic development this seems well established. Even well-nourished children deprived of appropriate environmental stimulation simply fail to grow (*cf.*, Freedman, 1969; Patton and Gardner, 1962). With respect to the brain as a whole, the data are less clear (*cf.*, Perry and Freedman, 1973). Yet the assumption would seem to be inevitable. The structure of the nervous system—the core of what Escalona

(1965) has referred to as the organismic factor—must be altered by the nature of the experiences to which the developing individual is exposed as well as by gene factors. The implications of this assumption, particularly for the genetic and economic aspects of psychoanalytic theory, seem to me to be enormous. If the very organ of his mind is an evolving structure, qualitatively different from that of the adult, it is obviously impossible to impute to the infant that either his sensory experiences or the central assimilative and adaptive processes he uses with respect to stimulation are comparable to those of the adult. If, furthermore, the very anatomic substrate of his mind is significantly affected by his experiences, the anatomic and physiologic effects of these experiences should play a considerable role in determining the ultimate nature of psychic structures.

Spitz (1945, 1965) has suggested that during the first six months of postnatal life, and to a lesser extent beyond that time, the infant's sensory experience is in the coenesthetic mode. In contrast to diacritic sensation, which assumes increasing importance as maturation and development proceed, coenesthesia is diffuse and poorly localized. During the period of coenesthetic preponderance, the infant responds to a wide variety of signs and signals. Spitz's list includes such items as equilibrium, tension (muscular and other), posture, temperature, vibration, skin and body contact, rhythm, tempo, duration, pitch, tone, resonance, clang, and probably a number of others of which the adult is hardly aware. Other evidence (*cf.*, Freedman, 1971) indicates that beginning at five to six months diacritic vision assumes an increasingly important role and that the discriminating cognitive use of audition begins at roughly ten to eleven months.

From the standpoint of the adult observer, Spitz's list may seem to be a reasonably complete catalogue of what is imputable to the infant as subjective experience. However, and quite aside from any curiosity one might have concerning those experiences of which the adult is 'hardly aware', it also raises new questions. Granted that the infant can respond to this wide

variety of stimuli, does it follow that all the enumerated modalities are, in fact, necessary for human mental development? If so, is there a quantitative factor involved—i.e., does one require 'x' number of units of muscle tension change per unit time in order to develop normally? Alternatively, is it possible to make substitutions? Can, for example, 'x' number of units of visual experience compensate for a corresponding lack of tactile experience? Again, are there some differentia operating with respect to specific aspects of development? Would, for example, particular facets of the developing individual (for instance, ego nuclei in Glover's [1930] sense) be selectively connected with specific modes of experience? Are there critical periods for particular qualities of experience—i.e., does deprivation in a particular mode ultimately result in a fixing of the corresponding functional characteristics of the nervous system so that delayed exposure to the modality in question no longer can affect the developmental process? Finally, if the answer to this last question is in the affirmative, what are the limits of duration of deprivation compatible with the ultimate emergence of average expectable psychic structures?

The importance of such questions for the understanding of later psychological development seems to me to be self-evident. The experiences of the coenesthetic period are, after all, the experiences of the relatively undifferentiated individual. One is, in effect, asking how various modes of sensory experience affect the processes of differentiation of self and object and those earliest internalizations which form the matrix out of which later capacities for relatedness, for motivation, and for the experience of affect emerge.

II

The exploitation of those experiments of nature which involve specific modes of congenital and perinatal sensory deprivation has proven to be a fruitful approach to these problems. Using data from such experiments, both as they appear in the literature and from my own observations, I will consider some of the

questions I have posed. While the problem of the emergence of the capacity for affect and affective expression will be my primary concern, it is obviously not possible to entirely exclude considerations relevant to cognitive development, to the emergence of instinctual drives, or to the genesis of the capacity for object relatedness. The separation of these aspects of the functioning individual would at best be forced and artificial.

There is, however, another important separation: the distinction between those forms of behavior by which we are led to impute a particular affective experience to an individual, and the subjective experience of affect. Lewin (1965) has pointed out that as recently as the heroic age of the Greeks the two were not distinguished. For Homer's heroes the action 'I flee' and the concept 'I am afraid' were identical. Although we would today use the conjunction 'because' to connect the thought and the action, we continue to act on the assumption that specific qualities of affect are necessarily linked to particular forms of behavior. I can best illustrate the problem with a brief clinical example.

As a neurology resident I had a patient with multiple sclerosis who showed the emotional lability and euphoria which tend to be associated with that disease. On one occasion when he laughed under highly inappropriate circumstances, I demanded to know what he found so funny. He replied in his best choked pseudobulbar voice that he didn't find anything funny—it just came out that way. His laughter, one had to conclude, was predicated on the operation of a relatively peripheral mechanism which had escaped from the modulating effect of whatever structures are involved in the subjective experience of affect. One could say of this man that he was a living refutation of the James-Lange theory of emotion. Here was an instance in which the peripheral expression of an affect clearly did not influence, let alone determine, the subjective experience.

If, on the basis of disruptive changes secondary to neuropathology, experienced affect can be distinguished subjectively from affective behavior, it would seem a fair assumption

that there is a developmental sequence which results in the establishment of those connections between the particular modes of expression and the particular affective experiences which we take for granted in the adult. Evidence in support of such an assumption is found in the literature which deals with environmentally deprived children. The Reverend J. A. L. Singh (1921) stated the situation succinctly when he said of the 'wolf' child Kamala that she '. . . had a smiling face but the emotion of joy was far from it' (p. 38). I have had the opportunity to observe a brother and sister whose psychotic mother had kept them in virtually total isolation until they were age four and six respectively (*cf.*, Freedman and Brown, 1968). Both in movies I have made and to the casual observer they seemed to be friendly, affectionate children. On closer inspection, however, these qualities proved illusory. They showed no capacity to be concerned either with the people around them or with their own feelings. They made, for example, no differentiation between familiar and strange people. When they were presented to a large conference, five months after they were discovered, they went as readily to total strangers in the room as they did to their teachers and the social worker with whom they had been in frequent contact. They showed no evidence of anxiety, shyness, or embarrassment.

This vapid, indiscriminate, feelingless behavior involved more than their relations with others. When they were first observed, they seemed unaware of their own bodily sensations. They gave no indication, for example, of experiencing pain when they injured themselves and they seemed insensitive to visceral stimuli. They would eat voraciously as long as food remained in front of them. Although this behavior abated, the indiscriminate quality of their behavior toward others persisted throughout the thirty-one-month period they were followed. At no time did they seem able to either make an affectionate attachment or to experience antipathy toward another person. Both when they were removed from the care of their biological parents and, eighteen months later, when they left a warm and

loving foster home in order to be adopted, they showed no evidence of grief or even of a sense of loss. It was as though neither their earlier home nor their caretakers had ever existed.

The fact that these children gave minimal evidence of self/object differentiation is probably relevant to their lack of concern for others. Two years after I began observing them, when they were six and eight, they continued to refer to themselves either by their proper names or in the third person. When their adoptive parents, seeking to make a clean break with their pathologic pasts, decided to change their given names, they accepted the new ones at once—at ages six and eight, Albert became Joseph and Anne, Claire. Moreover, they manifested no concern or distress and at once began to respond to their new names as though they had always been theirs.

The utter indifference with which they responded to being separated from everything that might have been familiar to them, as well as to being thrust into totally new environments, is in striking contrast to the separation reactions we expect of similarly aged youngsters. From this standpoint, by ages four and six, when they were discovered, their characters appeared to have been fixed. The likelihood that they will ever be able to differentiate self from nonself, make attachments, or experience feeling for others that is independent of action seems exceedingly remote.

Their situations, however, cannot be considered to epitomize the destiny of all infants and children who have suffered periods of environmental deprivation. Both the duration of the deprivation and the age at which it begins seem to be significant in this respect. Kagan (1973) has recently reported that Guatamalan children who were kept almost totally isolated during their first year, and appeared to be grossly defective when first seen, developed very rapidly once the period of isolation was terminated. Skeels (1966) in a study which included a thirty-year follow-up came to a similar conclusion. His work merits elaboration. It began during the economic depression of the early 1930's when he was a psychologist with the Welfare Department of the State of Iowa. Among his responsibilities was

the supervising of a foundling home. For reasons which are not immediately relevant, he arranged to have thirteen of his charges who were between seven and thirty-six months old placed in the care of women who were living in a home for the mentally defective. Twelve other children remained at the foundling home. All twenty-five were of similar backgrounds and displayed similar environmental deprivation syndromes when the study began. Some thirty years later, Skeel was able to locate all of these individuals. Ultimately, all the children placed in the home for the mentally defective and most of those who remained in the foundling home were adopted by families in the community. Of the thirteen who had received adequate 'mothering' by the mentally defective surrogates, all had achieved levels of functioning and relationship to objects appropriate to their adoptive families. Most had at least graduated from high school, some had attended college. The median educational attainment was completion of the twelfth grade. All but two had married and had families of their own. By contrast, the children who remained in the foundling home until adopted continued to function at the presumed level of their biological parents. One, an inmate at a school for the mentally retarded, had died at age sixteen. One was married and one had divorced. Typically, eleven of the survivors were drifters or, at most, engaged in menial tasks on the periphery of society. The median educational attainment was attendance in the third grade. Many continued to be wards of the state. Only one of the twelve individuals in this group rose above the level of adaptation I have outlined. It is a sufficient commentary on the status of the rest that he, a linotype operator in adult life, earned more money than the other ten combined.

While Kagan's and Skeel's findings certainly do not contradict the assumption that very early sensory experiences (both coenesthetic and diacritic) are critical for later development, they do make it necessary to assume a considerable degree of plasticity in the developing infant. At least up to age three it would appear that inadequate stimulation may be compensated for by later experience.

In addition to the situation in which significant deprivation has been present literally from birth, it is possible to identify at least two patterns of deviant experience in which very early sensory experience can be shown to have resulted in specific, long-lasting effects. In the context of this presentation these situations are of importance because they indicate that whatever the plasticity of the unstimulated infantile nervous system, the fact of stimulation even at a very early age significantly influences the emerging psychic structure. To the extent that such modification is fundamental both to the individual's later ability to perceive and to his characteristic responses, it might be considered to influence the most primitive layers of his unconscious processes. Steele and Pollock (1968) present evidence, for example, that the propensity to batter helpless infants is transmitted from generation to generation. According to their observations, the process which leads to this form of deviance may be completed in the first two years of life. Stoller (1968) presents similar evidence with respect to the phenomenon of transsexualism. According to his data, the crucial internalizations and identifications which result in the conviction that one is really a female entrapped in a male body are completed by age two—i.e., before verbal communication has begun and before differentiation of self and object is completed.

Other data indicate that the effects of reasonable early care will also persist and be evident even after long periods of deprivation. Dahl (1965) has considered the experience of Helen Keller from this standpoint. The eighteen months of good 'mothering' she had experienced before her massive deprivation apparently provided her with an organismic substrate on which she could later build.

Finally, there are a variety of possibilities for insufficient exposure to the sensory modalities which, taken together, make up the experience of the average child. With respect to the two principal distance receptors—the eye and the ear—, a sufficient number of cases has now been observed by workers experienced in the conceptual as well as the clinical problems of psychoanalysis to provide good understanding of the complications

which derive from loss of vision or hearing. At the same time, we can come to some conclusions concerning the role these modalities play in the development of the average individual. The inordinately high incidence of syndromes like autism among the congenitally blind is well established (*cf.*, Freedman, 1971). By contrast, no such complication is associated with congenital hearing loss. Typically, the congenitally deaf precœdipal child is a friendly, outgoing, and interested person. His range of affective expression and his capacity to become interested in as well as involved in interpersonal relations are not noticeably different from those of the average child. Apart from his inability to utilize the vocal/auditory system, the deaf child is not readily distinguished during the precœdipal period from the normal youngster (*cf.*, Freedman, et al., 1971).

Selma Fraiberg (1974) has recently discussed some of the specific problems which face the blind infant and his mother. She demonstrates how the fact of blindness disrupts the system of mutually re-enforcing exchanges of stimuli out of which the primary mother/infant bond ordinarily develops. The blind infant fails both to generate signals which elicit maternal behavior and to re-enforce, by his responses, the mothering behavior of his caretaker. The latter is, therefore, left in a frustrating sensory vacuum which all too often leads her to withdraw from the ungratifying child. Thus the state of inadequate infantile stimulation is perpetuated.

That the high incidence of autism is not a direct result of the fact of blindness is evident from the many instances of congenital blindness in which autism does not occur. Evidently the state of blindness, by limiting the ability of mother and child to exchange signals, serves to increase the likelihood that the infant will experience deprivation in other critical modalities. But a mother who succeeds in overcoming this barrier can effect the development of a youngster so that despite his blindness, he will show none of the characteristics of autism.

To summarize what has been presented thus far, it would appear that vulnerability to the development of major deficiencies in the capacity to experience affect as well as of in-

adequate self/object differentiation is strongly associated with congenital blindness. Victims of protracted periods of environmental deprivation during the first three years of life regularly show similar disturbances when they are first discovered. The evidence indicates, however, that their deficiencies can be compensated for by appropriate modifications of the environment. By age four it is unlikely that the deprivation syndrome is reversible.

III

I will now present some data which seem to me to be pertinent—if only in a negative way—to the goal of defining more precisely what kind of stimulation from the environment the infant must have if he is to develop along 'average expectable' lines.[1]

For the past twenty-four months, I have had the opportunity to observe an infant born with a congenital defect of the immunological system. Since the child can produce no antibodies and would die if exposed to any infection, he has been reared since birth in a germ-free plastic bubble. As a result, he has been deprived of the usual kind of body contact and handling that children ordinarily experience in the earliest months of life. I present here the developmental aspects of this child's affectivity, object relations, motor skills, and other functions.

Although the observations I shall report are certainly unique, two other infants subjected to a similar experience have been observed by a group of immunologists in Germany (Simons, et al., 1973).[2]

[1] Drs. Raphael Wilson, Department of Experimental Biology, and John Montgomery, Department of Pediatrics, Baylor College of Medicine, made it possible for the author to make these observations.

[2] A historical precedent is worth mentioning. In 1945, B. F. Skinner (*cf.*, Skinner, 1961) described an air-conditioned box in which he reared his infant daughter. He claimed that the device was a highly effective medium from the standpoint of both the child and her mother. He has also claimed that there have now been several hundred children reared in such devices who have developed into effective adults (Skinner, personal communication). Later, in his utopian novel, Walden II, Skinner used this device as one of the important features of the child-rearing practices of that fictional commune.

Because the diagnosis of combined immune globulin deficiency was suspected before his birth, the child was delivered by Caesarean section and—under totally aseptic conditions—transferred to a germ-free environment. Up to the present (he is now twenty-seven months old), he has spent his entire life inside a plastic bubble which keeps him from contact with pathogens. At the same time, the conditions of his existence preclude his having certain experiences which we take for granted in more typical child-rearing situations. He has, for example, never felt another person's skin, smelt another person's body or breath, experienced the warmth of an embrace, or been able to mold himself to another person. Although he can be picked up and handled within the confines of his plastic world, he has never been able to embrace another person or cling to someone in the manner Bowlby (1960) considers to represent a basic human need. Although he spends about half his time at home, the exigencies of his condition are such that he spends the remainder in the hospital. He is, of course, subject to repeated painful assaults for the drawing of blood and the carrying out of other procedures. Needless to say, he receives much attention in the sense that celebrities receive attention. He has, for example, appeared on national television at least four times. Yet the conditions of his existence are such that he is all too easily left to his own devices. While he receives excellent hygienic care, the quality of the mothering experience available to him has been highly variable.

Certain other aspects of his experience merit mention. He has, for example, never been encumbered by more than very light clothes or bedding. He has never experienced the transitory malaise of colds or other minor infections. At least before he achieved toddler status, he had a much freer existence and much more opportunity to exercise his muscles and explore his limited environment than does a child reared in more conventional circumstances. From the very beginning of his extrauterine existence he has also been exposed to a rich variety

of visual and auditory stimuli. Against this background, I shall review some aspects of this child's developmental progress.

In the area of motor development and locomotion, which is regularly delayed in the environmentally deprived and the deviant blind, he achieved the following. At less than four months he was able to get up on his hands and knees and raise his abdomen from the surface. He could also sit with slight support. In the literature, the youngest age at which these achievements are reported is six and a half months (McGraw, 1943.) He could also squirm to and retrieve objects when he was prone. At four months—i.e., a month younger than the norm—he was able to coördinate hand and eye. By six months he could crawl on all fours and get over obstacles without difficulty—ordinarily a tenth month achievement. At six months he could also recover objects that he had dropped and he was already using both hands in coördination. In addition to handling and transferring objects from hand to hand, he was able to handle two objects independently. These are eighth to ninth month achievements according to standard developmental norms (Griffiths, 1946). Two months later, at eight months, he crawled skilfully, a twelfth to fifteenth month achievement, sat himself up and sat for protracted periods without support (norm, ten months), stood without support (norm, thirteen to fourteen months), and could both squat down and stoop (norm, seventeen months). By eleven months he walked freely and was said to be able to turn around and seat himself in a little chair. I, however, was not able to confirm this last ability until he was thirteen months old. The ability to turn around and sit down in a chair is usually considered an eighteenth month achievement.

In the areas of social and affective development, his progress has neither been as consistent nor as impressive. At four months he appeared alert and he was usually responsive. He responded to being bounced about by smiling and he also smiled when visitors came into the room. At six months he made babbling noises in relation to his activities—an age appropriate activity. He did not, however, direct his vocalizations to me or to other

more familiar observers when we spoke to him. To do so would also have been age appropriate. Whether he was on his hands and knees, sitting or standing, rhythmic rocking occupied increasing amounts of his waking time during the period up to his ninth month. Although he was responsive to the overtures of others, during this period he made no effort by sound or gesture to initiate an interaction with another person.

At eight months our speech pathologist estimated his language development to be at a four month level. At twelve months, if he babbled (a sixth month achievement) he did so only infrequently. He would also squeal occasionally as he went about his play activities. He did not, at twelve months, ever try to attract attention by shouting (an eighth month achievement) or make the phrase-like babbles which Griffiths lists as a ninth month achievement.

Throughout this period he manifested a wide range of affective behavior. He reacted with evidence of pleasure when he was held and tossed about, became visibly angry when he was frustrated, and protested appropriately when he was subjected to the various assaults perpetrated by the medical team. However, we were impressed that he rarely, if ever, initiated contact with others by either voice or gesture, and his repetitive rhythmical behavior persisted. Although he played with the wide variety of toys available to him, he showed no interest in involving others in his activities. Typically, his play activities were also accompanied by rocking.

His disregard of his environment, the delay in prelanguage development and the persisting involvement in rhythmical self-stimulatory behavior led us to reassess the quality of the care the child was receiving. In considering the findings and what appear to have been the results of our interventions, it is important to keep in mind that this is an isolated case. While it is likely that the interventions to be described were significant in his subsequent development, there is no way of proving the point. Conceivably, much of what has been observed during the past eighteen months could have been the result

of maturational processes alone. The possibility that gene-determined differences may account for the discrepancies between our findings and those of the German workers also cannot be excluded. Our subject is the child of a stable middle class professional family whereas the parents of the German children are known to be unstable and of limited intellectual capacity. In addition, if we assume our efforts were effective, we have no way of being certain what role any one of the specific interventions we undertook played in his over-all developmental progress.

At the outset we were impressed that despite the highly varying environment in which he lived and the very large number of people to whom he was exposed, he had little opportunity to establish affective ties with any one individual or even with a small group of individuals. When he was in the hospital he was subjected to the routines of a busy service. Whether he was played with or not depended on the work load at any given time. There was little socializing in the course of such routine activities as cleaning and feeding. It is noteworthy, for example, that even at twenty-four months, he did not regularly participate in feeding himself. The reason given both at home and at the hospital was that it would be too difficult to clean up after him. It seemed to us that the isolating effect of his environment, as well as the often perfunctory manner in which caretaking activities were carried out, might be relevant to the relative retardation of language and social development.

On this basis, we began a campaign of intensified stimulation during caretaking activities and outside them. A systematic program of prespeech stimulation was instituted. In order to increase further his awareness of coördinated sight and sound, a television set was placed near his isolator. A specific caretaking person was assigned to him during his periods of hospitalization. When he was at home, too, systematic efforts were devoted to playing both while caring for him and at other times. Within a few weeks, there was a considerable increase in the amount of his 'prespeech vocalizing' in the form of babbling, as well as evidence of greater word comprehen-

sion. For many months, however, his speech development continued to lag roughly four months behind the norms for his age. At twenty-two months he understood and followed directions to the extent of helping the nurses with such tasks as the transfer of materials into the isolator and the tidying of the isolator. He would also repeat the names of familiar objects and identify the objects themselves appropriately. Occasionally, he spontaneously used single nouns such as 'mama' and the names of nurses and various toys. Spontaneous speech in the form of initiating requests was still only rare.

Two months later—at twenty-four months—he was a happy, outgoing, mischievous little boy. He would initiate requests—e.g., say 'light on', when he wanted just that. The speech therapist estimated his ability to communicate to be at least at normal age level. She noted, however, that his vocabulary could not be tested against standard two-year-old norms. How many toddlers, after all, have occasion to use words like 'isolator' and 'transfer'? The rhythmic self-stimulating behavior was still detectable in the form of less noticeable rocking when he was manipulating and studying objects. However, he played actively and displayed a range of affect and capacity for involvement which also seemed to me expectable for two year olds. At this time, he left the observer with little doubt that he experienced and expressed understandable and appropriate affect. One understood his expressions of both positive and negative feeling and had no difficulty in relating them to the events one observed. In a word, one could empathize with him. This is not, of course, to say that his extraordinary experience will leave no mark on his later life. One has to assume, however, that it will be manifested in the nature of the conditions under which specific modes of feeling are evoked rather than in his capacity for affective experience per se.

IV

Even on the basis of these brief anecdotal reports, it is possible to approach answers to the questions raised earlier in this paper. It would appear, for example, that the development of average

expectable capacity to experience affect does not require exposure to all the qualities of coenesthetic experience enumerated by Spitz. To a considerable extent, sensory input in one modality can offset deprivation in another. Thus, affective disturbances which are observed in roughly twenty-five per cent of the congenitally blind can be prevented by a mothering one who makes appropriate alternative interventions. At the same time, it would also appear to be well established that for the normally developing child, vision and those forms of behavior, reflexive or intentional which are based on visual stimulation, are of particular significance. To a greater extent than is true for any other modality, it is on the basis of his response to visual stimuli that the infant reacts in ways which re-enforce maternal behavior. It also appears to be the case that it is through the medium of vision that the infant first develops the discriminatory capacity for which Spitz uses the term 'diacritic sensation'.

The evidence from the germ-free infant makes it clear that those aspects of the mother-infant dialogue which involve direct skin contact, molding to the mother's body, and the ability to embrace and cuddle, are not critical for the development of a wide range of affective capacity. While, as I have already noted, we have no way of knowing how his atypical experience will affect our subjects's later integrative functions—i.e., which, if any, of Glover's ego nuclei will be differentially affected—or whether he can establish a quality of object relations which will prove adaptive in later life, it is clear that both the range and appropriateness of his affective responses are not significantly different from the norm for his present age.

Finally, I would like to point out that the evidence I have presented underscores the importance of distinguishing between a lack of experience and distorted experience. It would appear from the work of Skeel, and the more recent observations of Kagan, that the massively deprived infant may retain sufficient plasticity so that a program of adequate stimulation and care beginning as late as thirty-six months is likely to result in the emergence of a capacity for feeling and the establishment

of object relatedness and self/object differentiation which is compatible with the norm. My own observations indicate that this plasticity may not be present by age four.

The plasticity of the unstimulated infant, however, is apparently not shared by the youngster who has been exposed to stimulation. Both the child who has suffered from distorted aberrant stimulation from the beginning—e.g., the battered child—and the individual who, like Helen Keller, has suffered massive sensory deprivation after a period of relatively normal experience in infancy, show lasting effects of their earliest experiences.

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Mind-Body-Environment: Toward Understanding the Impact of Loss on Psyche and Soma

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MIND-BODY-ENVIRONMENT:
TOWARD UNDERSTANDING THE IMPACT OF LOSS ON PSYCHE AND SOMA

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The special vulnerability of individuals to loss or separation may result in precipitation not only of emotional but of somatic disorders. Material from the study of psychosomatic, psychotic, and borderline patients is used to show how the interrelationship between the individual and his environment can be expressed in both health and disease by either mental or physical activity. The problem is approached through study of sensory perception, internalized symbolization, and extension of Freud's theory of conversion and their relationship to personality and body image development.

The impact of loss, concrete or symbolic, of key persons in the environment, as well as the impact of disruption of the self-image in triggering both emotional and psychosomatic disorders has been described by many writers including Abraham (1924), Bressler (1956), Freud (1917 [1915]), Hilgard (1953), Lindemann (1945), Mushatt (1954, 1959, 1972), and Pollock (1970). An attempt is made in this essay to elucidate this mind-body-environment relationship through the study of an extension of Freud's theory of conversion, and through the study of sensory perception and of internalized symbolization. I shall try to show the significance of this approach for understanding normal and pathological emotional development, the separation-individuation process, and especially psychosomatic function and dysfunction.

In choosing this particular treatment of the problem, I

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should like to contribute to the work of the Boston Psychoanalytic Society's Committee for a Memorial to Felix Deutsch, which is currently active under the chairmanship of Dr. Sanford Gifford. For this reason, primary emphasis will be placed on the scientific contributions of Felix Deutsch and on my own interpretations and utilization of Deutsch's unique and versatile approach to the mind-body problem. The paper is not intended to be a comprehensive review of the various other theories applicable to this topic.

Freud (1894) proposed the term 'conversion' for the process by which 'an unbearable idea is rendered innocuous by the quantity of excitation attached to it being transmuted into some bodily form of expression' (p. 63), that is, for the process by which a defensive effect is achieved by somatic dramatization of unconscious fantasies evoked by a traumatic experience. According to Freud, conversion proceeds along the line of motor or sensory innervation. The motor or sensory symptoms can be shown to have a connection with the original trauma. The ego, by the physical symptom-formation, is freed from conflict at the price of being burdened by a somatic memory symbol. Conflict is the result of faulty repression of intolerable œdipal sexual and aggressive fantasies. Motor symptoms predominate where sadistic elements have played an important part in the fantasy life and they both symbolize and deny infantile masturbation and accompanying fantasies from the œdipal phase. Sensory symptoms usually represent compromises between acceptance and denial of the sensual aspects of the infantile sexual fantasies (Glover, 1939). Both heterosexual and homosexual components usually find representation in the symptoms because of the bisexual nature of fantasy life at this developmental level. At the œdipal phase, thinking is freely expressed in symbolic form so that, by displacement, those parts of the body most adapted to genital symbolizations, male or female, are most readily involved in conversion symptoms (Glover, 1939). Under these circumstances the motor or sensory organ no longer functions in accordance with purely physio-

logical needs, but the physiological function is governed and even altered by symbolic psychological needs.

In circumstances other than œdipal sexual conflict within the ego and with key persons, according to Freud (1910) physical symptoms related to emotional conflict in themselves have no significant meaning and are only the end result or an abnormal form of physical discharge in response to intolerable ideas. In addition, Freud limited the phenomenon of conversion to the sensorimotor system under control of the voluntary nervous system. He granted that conversion symptoms could occur in the gastrointestinal tract. In From the History of an Infantile Neurosis, Freud (1918 [1914]) remarks that the patient's 'bowel began, like a hysterically affected organ, to "join in the conversation" ' (p. 76), an allusion also by Freud to the significance of body language. However, for Freud this view of the gastrointestinal tract depended on its suitability to symbolize sexual organs and functions. According to Freud, it would seem that the conversion symptom and the conversion process are pathological responses in which displacement and identification play an essential part. Because identification is developmentally a later form of defense in contrast to introjection and incorporation, conversion tends to be regarded as a phenomenon derived from the later stages of childhood development.

It is around this restricted view of conversion that controversy arises when it comes to the psychological study of bodily function. Glover (1939) and Alexander (1950), whose contributions to psychosomatic medicine are extensive, held firmly to Freud's view of conversion and its limitation to the domain of the voluntary nervous system control and to the view that physical symptoms in organs under control of the autonomic nervous system are discharge phenomena and in themselves have no symbolic meaning. To Alexander, normal bodily processes in particular had no symbolic meaning in themselves. Others, however, such at Fenichel (1945), Garma (1958), Groddeck (1923), Mushatt (1954, 1959), Engel and Schmale (1967), Schur (1955), Sperling (1946) and, especially, Felix Deutsch

(1940, 1959) and Schilder (1935) have made a strong case for the extension of the concept of conversion to include derivation from pregenital levels and to include organs under the control of the autonomic nervous system.

In this connection, it is pertinent to comment that œdipal material often is but a mask behind which more primitive strivings are played out. Genital activity may mask predominantly oral fantasies so that sexual fantasies toward the mother, genital on the surface, may be expressive chiefly of the intolerance of separation from the mother in a more regressive position than the œdipal one. Fenichel (1945) took a middle position that is more generally accepted today, namely that conversion symptoms occur in organ systems under control of the vegetative nervous system, but he did not believe that all somatic changes of a psychogenic nature should be called conversion because not all were nonverbal dramatizations of specific fantasies. Unconscious instinctual attitudes could influence organ function without the change necessarily having a specific meaning.

Deutsch as early as 1924 conceived of the conversion process as distinct from conversion symptoms as a universal and normal developmental process, primarily related to restitution for loss. He regarded the conversion process as essential to healthy life. Through this concept he felt he could begin to try to explain the concept of the unity of mind and body in the sense that mental and physical activities normally are in fact only different modes of expression for the same internal events. A number of Deutsch's papers have the general title, Thus Speaks the Body,[1] emphasizing that his approach was through the study of

[1] *Cf.,* Deutsch, F. (1949): *Thus Speaks the Body. I. An Analysis of Postural Behavior.* Transactions New York Acad. Sci., Series II, Vol. XII, No. 2, pp. 58-62; (1950): *Thus Speaks the Body. II. A Psychosomatic Study of Vasomotor Behavior (Capillaroscopy and Plethysmography).* Acta Med. Orient., IX, pp. 199-215; (1950): *Thus Speaks the Body. III. Analytic Posturology.* Presented before the N. Y. Psychoanalytic Society. (Published under title, *Analytic Posturology,* This QUARTERLY, XXI, 1952, pp. 196-214); (1951): *Thus Speaks the Body. IV. Some Psychosomatic Aspects of the Respiratory Disorder Asthma.* Acta Med. Orient., X, pp. 67-86. Read before the Schilder Society, N. Y., 1950.

the development of the body image or body ego. By this route he could provide the possibility for greater understanding not only of normal and abnormal somatic function but of normal and abnormal psychic structure. Schilder (1935) approached the question of development from the same vantage point and his hypotheses lend support to those of Deutsch. To both, the development of the body image is one of the basic psychological processes in the human organism. It depends on internalized symbolization and identification, both of which they equate with the conversion process when they are expressed physically. As part of the development of the body image, basic physiological functions are influenced permanently and even altered. Without its evolution beyond primitive stages there can be no ego development, only symbiotic existence, psychosis, or death. Its evolution is an essential protection against the threat of disintegration from separation from the earliest period of life onwards.

The organism depends on its formation for the growth of the ego. The commonly accepted view is that the body image is a relatively late development and comes about only when the later process of identification is in operation. Deutsch and Schilder believe that internalized symbol formation and thereby body image, however archaic they may be, begin before the relationship to constant objects and may begin with the beginning of life and perhaps *in utero*. Accordingly, they hold that from the beginning of life there does not exist a purely organic process, but from the beginning the organism is fundamentally a psychophysical entity through fusion of bodily and emotional processes.

This hypothesis depends on the interdependence of sensory perception and symbolization. In his Project for a Scientific Psychology, Freud (1950[1895]) says: 'We become aware of living objects around us by perception complexes which come forth from them but which are fused with similar perceptions of one's own body. The memories of these are associatively linked with reactive movements which one has experienced in one's self. Hence the objects are perceptively recognized through

recollective mechanisms which are rooted in sensory perceptions of one's own body.'[2] A simple example is that the precursors of the abstract concept of mother are the inner perceptions represented by the fusion of sensations arising from touch, smell, taste, hearing, vision, and movement of the object, with all the sensory perceptions arising from changes in bodily sensation, bodily activity, and movement within the body induced by these external stimuli. Any of these sensory perceptions occurring from within or without, such as the experience of warmth or cold, may evoke associatively or symbolically a condensed history of the individual's relationship to the mother or early key objects. Internal reactions to sensory stimuli do not follow exclusively physiological laws because of this symbolic objectification of sensory stimuli—that is, because specific sensory stimuli become tied to objects and evoke in condensed form the history of specific object relationships. This influences the regulation of bodily functions and the manner in which sensory organs are used (Deutsch, 1953; Mushatt, 1959). In acute grief, the sound of approaching footsteps or of a door opening may evoke the hallucinatory experience of the presence of the one who died and with it the history of the relationship to that person.

Sean O'Casey (1963) in his sixth autobiographical volume, Sunset and Evening Star, gives a remarkable example of a massive response to specific sensory stimuli in an account of a visit by him one winter to the University of Cambridge for a talk with students. At a relatively early hour at night during the meeting, the college lights were switched off, in accordance with regulations, and the students stayed to carry on their discussions with O'Casey by flashlight. The conversations ended when the last flashlight failed, and the students made their way to their rooms in pitch-black darkness. For a man who since childhood had had greatly impaired vision and who had com-

[2] This is Deutsch's translation from *Das Erinnern und das Urteilen*. In: *Entwurf einer Psychologie, Aus den Anfängen der Psychoanalyse*. London: Imago Publishing Co., pp. 415-416.

pensated for it by developing an intense capacity for visual imagery, on the surface O'Casey appeared to react mildly by musing on the spiritlessness of the students for their passive acceptance of such college regulations.

But this scorn indicated a deeper arousal than he was aware of. It suggested the revival of the recollection of his own struggle to overcome his visual difficulty and, through it, the memory of the years of special closeness to his mother re-enforced by his visual impairment. It is only when O'Casey is brought to the sleeping quarters assigned to him in the dormitory that he begins to react. For him alone a dim naked light has been left on and immediately he is shaken by the dreariness of the room. 'A slum room without a slum room's brightness . . . the floor bare, dirty . . . no fireplace . . . the one window unclad even with the symbol of a rag.' But it is the bone-chilling cold of the unheated room and virtually blanketless bed that finally undoes him and overwhelms him. All this evoked in capsule form the whole history of his past with its terrible privations beginning in childhood with the death of his father. His account quickly leads to a very brief but vivid indication of the source of strength with which he could more than survive the most abject poverty.

> There was an air of bruised poverty about the place . . . sadder because of its emptiness. He [Sean] himself sat for hours that mounted into years studying the beginnings of knowledge in a room as poor and as bleak as this one; but behind its bitter bleakness had stretched the cozy pattern of a room nearby where a fire burned, its flames framing his mother mending an old shirt or darning an old sock. If one were a Christian, what would he pray for here [in Cambridge]? For a quiet death on the pale dejected bed, for if this was the usual habitat in a student's life, the best thing for him was to die.

O'Casey spent the night sleepless and acutely agitated. He regained his equanimity next morning when he was entertained at breakfast by one of the students. He was moved by

the fact that the student, though himself impoverished, had provided a brightly burning fire and a large breakfast for O'Casey, while he ate very little himself. Tactfully, O'Casey, as his mother had often done for him, persuaded the student to share a large portion of his breakfast and proceeded to offer the student encouragement. Loss of light (darkness) and loss of warmth (cold and bleakness of room) had combined to disrupt the unconscious bonds of O'Casey to his mother, and triggered a long delayed grief reaction to her death. Warmth, concrete and symbolic, and 'warm' light restored these bonds, and enabled him to re-establish his defenses by identification with his mother.

A clinical example demonstrates the overdetermination of the link between sensory stimuli and key objects.

A young woman who had been psychotic was referred for analysis after lengthy psychotherapy. One striking feature in the vis-à-vis evaluation was her silence and her intense quietness during her silence. Very soon after she started analysis, one determinant of her silence was seen to be that in her silence she was quietly listening, resenting any distractions such as my questioning. This was revealed in the first week of analysis when she described her job for the first time. She worked as a technician for a group studying sound. She compared my office to the anechoic chamber, a specially soundproofed room with no echo, a room that made her very uncomfortable. 'There is no echo. There is no echo. Every one of my senses is affected. Voice has no resonance and the sound-absorbing structures give me strange visual experiences. My equilibrium gets upset. If I am very quiet, I hear the blood rushing through my head.' When outside with the door closed, she became very uneasy at not being able to hear the people inside.

At the end of the first week, she described another chamber which intensified sound. 'If you make a sound, there is a tremendous vibration. If a door slams, the sound pounds on you.' During this period too she showed acute preoccupation with

sounds in my office including my movements and breathing. She began one session after a long silence by saying, 'I am lying silent, listening to the quiet'. Then she said that as a child she had often been aware of her parents having intercourse. In her adult life when she visited home, she was also aware of it. (Her room was next to her parents.) 'You can hear everything. Nobody closes doors in our house, except when father locks the door of his room it means he is going to have intercourse. I can hear a drawer opening and closing as he gets a condom. Later the toilet is flushed, the door is opened and all is quiet again. I have to hear this and it disturbs me.'

Then she described how she grew up in a warm climate in another country. Her parents made a practice of having the entire family sleep at night on the same screen porch through a good part of the year. She scarcely slept at night, trying to stay awake, scarcely breathing, trying to see in the dark, and especially listening to her parents. Their sexual activity both terrified and excited her, especially her mother's remarks on different occasions, 'Don't; stop; you're hurting me'. She also recalled how all the family raised their voices and shouted in anger. Her mother would yell at her and on one occasion took a knife and threatened to cut off her braids.

The trauma of constant exposure to such sensory stimulation had a profound effect on the patient's personality structure. She lived in a continual state of sexual excitement and fear of violence between mother and father, between men and women; she was absorbed in sexual fantasies in which she played both the role of mother and father, man and woman. This excitement and her fantasy life were now sustained by the feeling that all sounds, especially speech, were sexualized and evoked the recollection of these experiences with her mother and father. Vision and sound maintained her bonds to her mother and father and to objects in a sexualized form. The use of the couch with its restriction of seeing me and of movement, together with the quietness of the office, frightened her by threatening the symbiotic bonds to her parents. The inability to see me,

that is, to use vision as a defense against a sense of separation, intensified her attention to sounds as a defensive attempt to restore her sense of relatedness to objects, but this in turn only evoked stronger sexual stimulation which for her was associated with hearing. Further, the sensorimotor deprivation induced by the use of the couch intensified fantasies related to touch and oral activity in order to restore contact with the world. A glimpse of this was provided by her remark, 'Touching is not enough to make things real. I feel I have to put them in my mouth.' The opening up of this whole area in regard to vision and hearing reduced her tendency to silence though it by no means entirely explained it. I would like to draw attention here also to the manner in which sensory modalities can be manipulated unconsciously and used defensively, one against the other, in their symbolic representations and expressed through a change in the line of associations.

This patient's verbal description of her reaction to sound and the determinants of her reaction show a striking similarity to those of a patient described by Niederland (1958) in his study of early auditory experiences. In addition, very pertinent here are the observations made by Arlow (1969) on the 'mutual and reciprocal effect of the pressure of unconscious fantasy formations and sensory stimuli, especially stimuli emanating from the external world'. Arlow describes the manner in which 'unconscious fantasy activity provides the "mental set" in which sensory stimuli are perceived and integrated. External events, on the other hand, stimulate and organize the re-emergence of unconscious fantasies' (p. 8).

Smell can be considered in these terms, too, in the manner in which it becomes tied to objects and places and to sado-masochistic preoccupations and activities in relation both to the self and object. I believe that smell has much greater importance psychologically in humans than is usually attributed to it. Recently biologists have become interested in 'pheromones' (the excretion) in lower forms of life of varieties of substances

each with a specific odor and each emitting a specific communication and command to members of the species. There is evidence that similar phenomena occur in man (*cf.*, Graham, 1972).

The problem of perception and symbolization is complicated by the phenomenon of synesthesia. In the course of early development and throughout life, fusion of sensory perceptions takes place and there occurs a symbolic interchangeability of all sensory modalities (Deutsch, 1959). Visual perception, for instance, can take over the symbolic representation of other modalities. In this way vision not only involves physiological reception of visual stimuli but may subserve symbolically the function of other modalities such as touch and hearing. Niederland (1958) describes one manner by which fusion of hearing and touch may take place and its significance for early development.

The recognition of the phenomenon of synesthesia is of great importance in devising approaches to those not only with severe impairment of sensory functions, such as the blind and deaf, but to those who show marked impairment in the process of individuation. Where there is actual sensory deprivation from sensory organ defect early in life, other sensory modalities may take over to help reduce the traumatic effect on ego development. For this and for the successful development of the capacity for symbolic interchangeability of sensory perception, I believe a favorable emotional climate is necessary. These views are supported by the work of Blank (1957). Children with sensory organ defects, e.g., blindness, as a result of the hostile rejecting environment that may prevail are often deprived of appropriate sensory stimulation through other modalities, both physically and emotionally. This intensifies the interference with ego development caused by the primary defect so that incorporation and identification are affected adversely, resulting in severe defect in the bodily and the nonbodily ego (*cf.*, Hollenbeck, 1948; Blank, 1957; Mushatt, 1959). The work of Rank and MacNaughton (1950) has shown that this also applies to children without sensory defects who have suffered either

from sensory deprivation or from overstimulation, concretely or symbolically.

Thomas Carroll (1961) evolved a highly successful system of teaching the blind who were once sighted to heighten other sensory modalities so that they could be used to give an inner sense of seeing. Carroll was greatly influenced in the development of his programs by the psychoanalytic contributions of Blank to the study of the blind. One does not lead the blind by taking them by the arm but by offering them one's arm to touch and to hold. Touch in this way facilitates a sense of fusion and identification to provide a sense of seeing through the eyes of the sighted. A patient with severe visual impairment since birth said: 'I can jump into people's skin and see through their eyes' (Mushatt, 1959). For proper functioning of intact neuromuscular systems, such as coördinated movement and speech, Hollenbeck (1948) has shown that symbolization and identification through sensory perception of living individuals in a satisfactory emotional climate are essential.[3]

In regard to the phenomena of synesthesia, it is of further interest that Penfield and Rasmussen (1950), in their studies of the cerebral cortex, state that 'as far as our evidence goes, there are no sharply separating functional boundaries [between visual and auditory responses] in the temporal lobe. . . . Stimulation of the first temporal convolution may produce sound or a perceptual illusion or a psychical hallucination which is both auditory and visual in content . . . (p. 225). The temporal lobe is a secondary area for sensory and motor elaboration. . . . Within the temporal cortex there are mechanisms which play an important role in the act of remembering and of making comparisons between past and present sensory perceptions and past experiences' (p. 117).

The body image is thus formed by the deposit of images and

[3] At the Alexander Graham Bell Museum in Baddeck, Nova Scotia, a movie depicting the life of Bell shows how Bell and his father used this knowledge of synesthesia to evolve a system of teaching the deaf to speak through acquiring an inner sense of hearing through seeing and touching.

symbols of key external figures, internalized by stimuli from without, fusing with sensory perceptions from within. These images 'become alive as it were in the body in response to specific sensory stimuli' (Deutsch, 1962, p. 32). According to this concept of internalized symbolic representation of objects, a loss in the environment evokes a sense of body loss. Loss of a body part, or injury or disease in a body part, can evoke a sense of loss (with depression), or danger of loss (with anxiety) of a key person. In this way, the interrelationship between the individual and his environment can be expressed both in health and disease by physical activity. One of the simplest expressions of this is the sense of emptiness, often sharply located in the epigastrium, experienced by bereaved people. The regressive need for attention seen in the physically ill can be construed as a need for reassurance against not only a sense of loss of integrity of the body and of the self but against a sense of impending loss of key figures. People treat their bodies and themselves much as they react to meaningful persons in their lives, and vice versa. The less at peace an individual is with his environment and with himself, the less responsive he will be not only to psychological but also to medical and surgical treatment. The more in harmony the relationship of outside figures, such as a physician, is with the patient's maturational needs, the more likely is the patient to respond to medical or psychological treatment.

In an unpublished study of enuresis in children, Peebles (1972) has made interesting observations in this respect. He has found that predictions of response to medical treatment of enuresis can be made not only from psychological profiles of young boys, but can even be made from psychological profiles of their mothers. Where a mother 'shows evidence not only of strong empathy but also of an inner image of her son striving towards becoming a "little man"', that is, encouraging his normal maturational development, it can be predicted that the boy will respond positively to medication. Where a mother sees her son as passive and helpless, response tends to be poor.

It may also be noted that patients with physical disease often push for operative removal of body parts in the unconscious fantasy that they will be freed thereby from pathological attachments to key figures (Mushatt, 1954, 1959).

Thus as an extension of Freud's theory of conversion this view holds that 'a conversion process is continually in action' (Deutsch, 1959, p. 95). The body is in a continual dialogue with the individual, with his ego, id, and superego and with the environment. When symbolizations representing intolerable relationships within the individual or without are evoked, they become the determinants of conversion symptoms. Conversion, according to this hypothesis, is related not exclusively to sexual conflict but can reflect all aspects of the relationship of an individual with himself and key objects.

This concept can be restated in another way. The silent young woman described earlier had a special difficulty in studying art. When she was close to completion of a painting, she would obliterate it with paint. On one occasion, in analyzing her destruction of a landscape in this way, she exclaimed passionately, 'Those trees and fields are mine. They are part of me. If I leave them on canvas they will no longer be mine.' Such a fantasy is a residue of the earliest symbiotic state when for the newborn child 'the only reality is its own body and the whole world is part of this. By use of the senses and motility, the infant soon learns that what was once experienced as part of its self is sometimes gone and has to be given up'. (Deutsch, 1940, p. 5). 'This loss relates not only to the mother's breast but to bodily perceptions stimulated by far more than mouth and breast contact' (Deutsch, 1959, p. 91).

The beginning of objectification of the outer world is the first loss in this primitive state. Objectification of key objects takes place in part by projection of what primordially was once considered part of one's self. The loss is undone by introjection and incorporation of objects and parts of objects with symbolization within the body. This takes place by way of all sensory modalities, as well as symbolically through oral and respiratory

routes. The psychotic expresses this in his fear of fusion with objects, for instance, through vision or touch. The function of sensory organs is further influenced by their symbolic interchangeability with the functions of other organs, e.g., eyes and mouth; touch and mouth; eyes, mouth and breathing; eyes, limbs and phallus as aggressive organs, etc. (*cf.*, Blank, 1957; Mushatt, 1959).

On one level, the process of evolution of a sense of individuality can be understood as characterized by a series of experiences involving projection, loss, and reunion within the body through symbolization of external objects. This theoretical position of Deutsch in regard to individuation and objectivation of the outside world antedates and adds an important dimension to the work of Mahler (1968) on the separation-individuation process. It is curious that Deutsch did not incorporate his theoretical views on loss and separation into his clinical reports on psychosomatic disorders as a central focus. Reactions in later life to separation may carry with them, to a varying degree, the history of the adaptive reactions in the earliest shifts from primary narcissistic to the most mature degree of separation of self from object.

The reopening, as well as the persistence, of the history of internal adaptive reactions in the early phases of development and individuation is seen in the following condensation of material from one phase in the analysis of a young man. With much embarrassment this patient reported one day that, as he sat at the hospital bedside of his dying mother, he had the fantasy of slipping his hand inside her nightgown to caress her breasts. He fantasied that this would have soothed and comforted her. Later in the same session, he spoke of his recollection of seeing his mother's naked breasts when he was a child. 'They were beautiful.' Then followed a fantasy of seizing hold of his mother's breasts as she lay in bed, of pulling them off and pushing them under the skin of his own chest. This was followed by an alternating argument, 'they are old and shrivelled;

no, they are beautiful'. His further associations, expressed with much emotion, were: 'She is my mother. I don't want her to go. I want her. I lived inside her once. She is *my* mother.'

The patient's mother died shortly after this session and about ten days later he described in greater detail his mother's state before her death. She had been confused and kept calling, 'Momma, Momma'. She kept calling for the nurses (i.e., for her mother) and tried to climb out of bed to go home (i.e., to her mother). As the patient told of his mother clawing at her nightgown and at her body in her confusion, he recalled his own earlier fantasy of tearing off her breasts. Then he recalled college classes in zoology when once he 'tore out the insides of an animal'. His professor remarked on the animal's 'big duff' (vagina). With great discomfort, the patient then reported his fantasy of tearing out his mother's heart and her 'duff'. When he was young, he said, his mother had made wonderful '*kischke*', 'animal insides cleaned and stuffed'. The fantasy occurred to him that he would 'eat her duff and I would have one myself'. Here he felt his scrotum shrivel up. Then with his hands, he demonstrated, to his surprise, how he would press his mother's heart against his chest, press it into his chest. 'Then I'd have my mother with me.' Then after much display of resistance, he spoke of his mother being no longer around outside and said that maybe he wanted to say, 'Mother, come back'. With an outburst of crying, he added, 'I want my mother', an anguished cry of longing and tears out of childhood.

The patient then talked of his love for his mother; next came recollections of his childhood referred to in earlier sessions but now with much greater detail, clarity, and feeling. The material centered around the loneliness and emptiness of the house when he would come home from school during a period when both his parents had to be out working long hours. He now also reviewed his compulsive looking at women, attracted by the size of their bosoms. The earlier fantasies could now be seen as the unconscious fantasies of a young child through which he could try to restore within himself the presence of his

absent mother by incorporating into his own image parts of his mother, thereby identifying with her.

This patient had often worked over his fantasies of himself as an attractive woman, and now this became an issue to be reworked, a reworking of the unsolved symbiotic fixation induced by the persistent unavailability of his mother as well as by other powerful disruptive forces in the early family climate. The expressions of love and longing for the mother were soon replaced by the breakthrough of unrelenting repressed childhood rage at the mother, expressed through the same fantasies as well as other primitive destructive fantasies. Both polarities of love and hate found expression in adult life in what seemed to the patient to be an irreconcilable intense longing for the companionship of a woman and the simultaneous spiteful resentment of women. During this phase of analysis, the patient intermittently developed defensive and expressive psychosomatic symptoms identical with those of which his mother frequently complained when she had returned home at night after a long day's work.

This material demonstrates some of the primitive determinants of poor differentiation between love and hate. It also demonstrates the kind of fantasies which evoke an inner threat of disintegration from rage and guilt, and which create in individuals a powerful sense of intolerance of separation and of insolubility of the task of individuation and of sexual differentiation in the self. They force, in varying degrees of intensity and pervasiveness in the ego, a defensive response with fixation in a narcissistic borderline or psychotic position, or with severe psychosomatic disorders.

The primitive processes of union and separation as well as the later derivatives—identification and projection respectively, and destruction and restitution of the object—may be expressed through bodily functions. Union and identification and restitution may be expressed symbolically by intake processes, such as eating, inspiration, all the senses, and by motility. Separation

and destruction of the object can be expressed by output or riddance processes, such as excretion, secretion, expiration, as well as by motility. Even speech and its opposite can express separation and union respectively.

The silent patient mentioned earlier uncovered the fantasy of having my penis held tightly in her mouth as she lay on the couch. This she related directly to her silence. 'If I speak freely I shall have to let go of your penis and of you.' In her silence she maintained her symbiotic bonds disguised as detachment; through speech she separated herself as well as lost something of herself to me. It is of no little interest that this patient suffered from anorexia which was seen to be directly connected with her silence, expressing the same inner conflicts over separation and union, over destruction and restitution. For this woman the symbolic representation of eating–not eating and of the mutual exchange through speech, carried over into her nonbodily ego as a determinant of her ambivalence and of her difficulty in forming identifications. One difficult problem in the treatment was that frequently she would accept an interpretation and bring out confirming associations, but then very quickly either openly reject the interpretation or give associations which denied its validity. On one occasion, when questioned about this phenomenon, she replied: 'Every time you interpret something to me, I feel that if I accept it, I am nibbling away at your brain, and in the end there will be nothing left of your mind'. Here again one can see an early determinant of the blurring between love and hate, and of ambivalence.

The development of speech is central to the separation-individuation process. Speaking becomes an expression of multiple identifications on which the acquisition of language depends. It can be understood as externalizing one's inner perceptions and relationships to internalized objects and in this sense can symbolize a loss or separation, as well as restitution. Where there is no return or response from the environment, either verbally or nonverbally, discomfort over the loss is

heightened and threatens the individual's ego integrity. In a room with no echo, the word when spoken is gone and nothing returns to replace it. (I have indicated earlier how disruptive this can be to the ego.) With less individuated persons, the more impassive the therapist, the more threatening are the interview sessions. The more restricted the opportunity for sensory perceptions through all modalities and for motility and for appropriate response from the environment, concretely or symbolically, the greater the threat to the body ego and, through it, to the ego. This in part accounts for the intensity of reaction, and of the transference, by the use of the couch in analysis. The special sensitivity of an individual to separation conceptualized in these terms can be used as a criterion for the appropriateness or inappropriateness of classical analysis for any one individual.

A graphic example of the significance of bodily secretions and excretions in expressing the separation-union conflict is seen in the case of a young man treated by psychotherapy and then by analysis after an acute schizophrenic reaction in his first year of college. During his first three years of life, his parents had left him in the care of relatives while they pursued business interests in another country. His subsequent life with his parents followed this pattern. Fear of abandonment and separation was a central theme for him. At one point in analysis he had been working on his difficulty in completing the proposals for his thesis. He had been going through the motions, producing many essays of little relevance to these proposals, for which he expected praise from his professors. His behavior in analysis followed the same pattern. In one session in the course of analyzing this, he said he felt like saying, 'I won't, I won't, I won't'. He then recalled how as a child, on Sundays, he would sit interminably on the toilet while his parents waited to go to church. This gave him a sense of control over them and of revenge, and, I could add, it served to tell them that they should never have left him. He said that he felt he was keeping me and

his professors waiting. Then taking some Kleenex from his pocket, he blew his nose and remarked on his indecision about what to do with the Kleenex. After much uncertainty and indecisiveness, he said that he would hold it until the end of the session and then would throw it in the wastebasket, whereupon he burst out crying convulsively, saying, 'I don't want to throw away this snot. It's mine. It's part of me. It's something that belongs to me.'

In the next few hours he spoke of his fear that finishing his thesis meant that he would have to leave me. This, he said, explained why he did not want to do any work in analysis. He was terrified of the world, but he 'did not want to get rid of the crap' that made him so terrified because he would then have to leave me. The meaning of the reluctance to part with his nasal mucus was seen later to be carried over to all bodily secretions and excretions. It showed itself in his masturbatory practice of postponing ejaculation and in the sexual act, both in his difficulty in reaching a climax and the opposite, impotence or premature ejaculation. Speech became intimately connected with this symbolically. This man's proclivity to droning and his difficulty in expressing himself affectively could be understood in these terms.

Elsewhere (Mushatt, 1954) I have described the symbolic interchangeability of all bodily functions to express the loss-destruction-restitution conflict. These phenomena extended in this man into the ego and could be seen, for instance, as fear and resentment over having to give anything meaningful of himself to others, even thoughts or feelings, especially those expressive of love. In his academic profession, he resented lecturing, but he was infinitely more at ease conducting seminars where the students communicated their ideas to him. It will not be surprising to note that in childhood this man had asthma. I could add that premature ejaculation and impotence are physical symptoms with more than encapsulated psychological significance. These symptoms and the individual's behavior in the sexual act can find expression in many ways in ego ac-

tivities, in nonsexual interpersonal behavior, and even in the manner of association in analysis.

The representations in the personality of the processes expressed through these sexual symptoms can become a source for chronic and severe resistance. Let me give two brief examples. A young man with premature ejaculation, for a considerable time seemed inaccessible by virtue of the fact that he continually produced a succession of associations and fantasies, each significant on the surface, but they were expressed without emotion and led nowhere. Finally, progress was made when it was recognized that he associated in this fashion in the unconscious hope of arousing my interest and leaving me excited but without any understanding. This became clear when he described his perfunctory foreplay which aroused his wife and then 'poof' he ejaculated; she 'was left high and frustrated'.

The same man, at a later point, became enraged over his progress in analysis. 'What's in analysis for me? All that happens is that as I get in deeper and deeper, I have to keep going more. I have to think more about my wife and children and their needs, and I have to work harder.' Around the same time, he had his first experience in some years of relief from premature ejaculation. He spoke in almost identical angry terms. 'I got in deep, and then I had to keep going and going, and my wife wanted more and she got more pleasure.'

Frigidity can be usefully examined in a way similar to that used here for premature ejaculation and impotence. It scarcely needs be observed that such body ego phenomena and their representations in the ego, as I have described here, are very important for the understanding and treatment of the narcissistic personality.

All of these processes are seen in grief in which attempts are made both to express the loss (and destruction) and to undo it by introjection, incorporation, and identification on both a psychic and physical level, organs even becoming identified

with the diseased organs of the dead person (Mushatt, 1972). The organs then function not only according to basic physiological laws but their functions are determined by psychological requirements. Since symbolic representations are laid down in the body as a whole and in its separate parts from all phases of growth, separation and loss can trigger reactions from all phases of the separation-individuation process. Psychosomatic illness can represent responses from any point along a whole continuum from primary narcissistic to genital levels, that is, from psychosis to hysteria. The most severe reactions are seen in those for whom the fantasy that the external world was once part of themselves still retains the strength of the original sense of reality; that is, in instances of loss, severe somatic and psychic reactions can be expected in individuals with marked ego impairment and with marked intolerance of separation (Mushatt, 1954, 1959).

From this point of view all physical function is psychophysical or psychosomatic, that is, there are psychological elements in all instances of physical function or dysfunction. Often it is difficult to assess how much of what is mobilized is psychosomatic and how much is somatopsychic. The kind of responses aroused may be similar, and this can be explained by the view that loss (with depression) or anticipation of loss (with anxiety) may be expressed in physical terms while physical dysfunction evokes a sense of loss or threat of it. Physical dysfunction thus is conceived psychologically as symbolizing disharmony in key relationships, internal and external. Restoration of good function depends psychologically on the undoing of the fusion of early sensory configurations with bodily function through resolution of conflict between the individual and key persons in his past and present environment, with resolution of disharmony between symbolizations within the body and through it in the ego. More harmonious identifications can then replace old ones (Deutsch, 1955).

It must be made clear that these remarks are not intended to claim that psychological considerations override the significance

of biological or organic factors in causing organ dysfunction. They represent an attempt to study physical function in psychological terms and to provide a rationale for understanding the effectiveness, as well as the complexity, of a psychological approach in the treatment of the physically ill. In addition, an effort is made here to explain the need to extend the use of psychological study to all forms of physical illness rather than to limit it to the so-called classic 'psychosomatic illnesses'. The relative significance of psychological elements needs to be evaluated in regard to the part they play in precipitating, aggravating, or sustaining physical dysfunction, even when the latter is caused by organic factors. Specific medical treatment influences physical function directly by its direct effect on organ systems. Psychological treatment influences physical function indirectly by disentangling the amalgamation of emotional and physical processes.

It is appropriate to add here a few remarks on the need for study of somatic symptoms occurring in the course of analysis and especially in the analytic hour. Such symptoms, according to Deutsch (1958) and Sperling (1967), are frequently important signals of highly charged but repressed conflicts in the transference. Their study offers a pathway into the study of the body ego where, as we have seen, we find the more primitive and more affective representations of the reciprocal patterns of relationships between the ego, superego, id, and environment. The restructuring and integration of these representations within the body and its parts with the rest of the ego and the environment are required for the fullest undoing of neurotic patterns. A new synthesis can then more readily take place with new objects and new self-images in the ego and body ego (Deutsch, 1954). Thus when the study of bodily symptoms is neglected in analysis, the individual tends to retain greater potentialities for reactivation of neurotic patterns under stress, even though such patterns may have become undone sufficiently in order to permit growth and maturation.

SUMMARY

In this essay an attempt has been made to bring together two aspects of Felix Deutsch's scientific thinking that lie scattered through his voluminous writings, and which Deutsch himself did not try to integrate into a unified concept. One aspect is his general theory of the 'conversion process' as a continual interplay among mental, physical, and environmental representations that goes on throughout life in states of health as well as illlness. The other aspect is a special theory about the formation of early object relations through the incorporation of inner and outer perceptions along with associated affects and physiological processes. One particular source of usefulness of these views is that through them Deutsch avoided the problem of 'conflict-specificity' or 'organ-specificity' that beset and hampered Alexander and his followers. Deutsch's broader concept meant that any body representation within a wide range can express any one of a variety of conflicts. Thus each person can be understood as a unique system in terms of his own individual past and present experiences without the need of fitting specific conflicts to particular organ systems (Gifford, 1973).

Finally, the theoretical concepts proposed by Deutsch, and spelled out here in some of their ramifications, despite unanswered questions and difficulties which they present, provide a significant dimension in psychoanalytic work. They also offer a rationale for devising methods of application of psychoanalytic principles in the treatment both of psychiatric and psychosomatic disorders. Particularly, Deutsch's concepts contribute to a fuller understanding of the separation-individuation process and of the effect of loss and separation in triggering both somatic and psychological illness.

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The Proprioceptive Body Image in Self-Object Differentiation: A Case of Congenital Indifference to Pain and Head-Banging

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THE PROPRIOCEPTIVE BODY IMAGE IN SELF-OBJECT DIFFERENTIATION:

A CASE OF CONGENITAL INDIFFERENCE TO PAIN AND HEAD-BANGING

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The significance of proprioceptive stimuli in body image formation and in self-object differentiation is explored. The suggestion is made that in some cases head-banging represents an attempt to heighten a proprioceptive sense of self to achieve separation from the object world. Material to illustrate this thesis is drawn from a case of a head-banger who suffers from congenital indifference to pain.

INTRODUCTION

In The Ego and the Id, Freud (1923) stated:

> A person's own body, and above all its surface, is a place from which both external and internal perception may spring. It is *seen* like any other object, but to *touch* it yields two kinds of sensations, one of which may be equivalent to an internal perception. Psychophysiology has fully discussed the manner in which a person's own body attains its special position among other objects in the world of perception. Pain, too, seems to play a part . . . and the way in which we gain new knowledge of our organs during painful illnesses is perhaps a model of the way by which in general we arrive at the idea of our body.
>
> The ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself a projection of a surface. . . . [I.e. the ego is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body . . .] (pp. 25-26, 26, n.) .

The opportunity to study an eighteen-year-old patient who suffers from congenital inability to experience pain led us to

consider the significance of pain sensation and of its absence in the formation of body image. Of added interest is the patient's persistent and intense pattern of head-banging which he described in a manner that suggested it had played an integral part in the development of his body image and self boundaries. Further, this patient offered an opportunity to study the relative contribution of the physical perception of pain to the individual's development of anxiety, psychic pain, and superego.

There were many unusual experiences in the patient's life in addition to those resulting from indifference to pain. Our later discussion will concentrate on only a small portion of the material we present here and is not intended to be inclusive. Dynamic explanations alternative or complementary to those we offer will doubtless occur to the reader, as they have to us.

A review of the neurological literature reveals fewer than twenty case reports of congenital indifference to pain. The condition is defined as a congenital absence of discomfort and of response to noxious stimuli, which cannot be explained by mental retardation, psychosis, hysteria, peripheral nerve disease, or demonstrable neurologic lesions either in vivo or at postmortem examination. Neurological testing reveals normal appreciation of all sensory modalities, including an ability to discriminate between pin prick and dull stimulus. The etiology is uncertain, but it is presumed that such patients have a deficit in the higher integration of pain perception so that they are aware of sensations without experiencing them as painful, unpleasant, or alarming and thus cannot avoid the bodily harm that might ensue (*cf.*, Jewesbury, 1970). As a result, such patients have a propensity for traumatic injury, self-mutilation in childhood (including chewing of fingertips and tongue and the destruction of the nose), lack of painful response to infections, absence of sneezing and itching, and eventually the occurrence of degenerative arthritis of the lumbar spine and weight-bearing joints. In at least four of the patients reported in the literature, head-banging was specifically

described (*cf.,* Madonick, 1954; Sternbach, 1968; Rapoport, 1969; McMurray, 1950). The other cases were written by neurologists without detailed developmental history and may, in this regard, be incomplete. It thus seems likely that this population has a higher incidence of head-banging than occurs in normal infants, which has been given for large series as from three to seven per cent (*cf.*, Kravitz and Boehm, 1971).

A puzzling aspect of the syndrome is that the patients involved are not uniformly and continuously indifferent to pain. Several reports describe individuals who have isolated episodes of painful sensations usually arising from a visceral locus. This has been explained by Sternbach (1968) as a semantic or a defensive reaction: 'By the "semantic" problem we mean simply that the patients have no referents in their experience for words like "pain" or "hurt", the feelings such words refer to are simply not in their phenomenology' (p. 233). In other words, their descriptions of pain are confabulatory. The defensive motivation implies a desire to avoid 'missing out on some experiences other humans share, of not being wholly a part of the sensitive human race'.

Since psychiatric evaluation of these patients has been limited, the bulk of the personality descriptions has been derived from neurologic evaluations. Intrinsic to the diagnosis of the syndrome is a lack of sufficient psychotic or hysterical pathology to account for the deficit. This is not to say that a more refined analysis of personality structure would not reveal other areas of psychopathology, either as an inherent result of the syndrome or as a secondary reaction to it. Magee, et al. (1961) studied three adult patients and described certain common traits. These included a narcissistic sense of omnipotence and invincibility, difficulties in object relations, a lack of empathy, a denial of weakness, and a tendency to channel intrapsychic conflict into motoric expressions.

CASE HISTORY

Our patient, an eighteen-year-old white male, came to our attention while he was awaiting surgery for the most recent of his

many orthopedic disasters. He appeared frail, angular, and tense and displayed a high energy level, an eagerness to please, and a flippant, impudent boyish charm. He was in the midst of a life crisis, facing the specter of paralysis, impotence, and incontinence if a second laminectomy failed, as had his first. Heightened anxiety, the blockage of his motoric defenses, the relative sensory deprivation, and the dependency of prolonged hospitalization induced him to quickly develop an intense transference and to pour forth an abundance of material. The fact that his productions came in this context rather than in a prolonged therapy reduces the likelihood that this highly suggestible individual was 'playing to his audience'.

His congenital indifference to pain was first noted in his infancy with the onset of teething when he began to bite his tongue and lips. (This has been a persistent problem which has resulted in lips contracted from scarring and numerous tongue suturings.) At one year of age he severely blistered his hand under scalding water without expressing any discomfort. At age two he fell from a high chair and did not cry despite having sutures without analgesic. Infections and fevers never produced localized pain, and he was able to undergo dental procedures without discomfort. His parents realized early that 'he had no feelings, he wasn't afraid of pain'. They learned, however, that he was afraid of being sprinkled with water and they used this as a means of disciplining him and teaching him to avoid danger. His first memory is of being sprinkled with water by his mother. When she at times became uncontrollably angry, he would feign tears during a spanking so that she would not become more angry at the futility of hitting him.

At age four the patient sustained the first of the six major fractures he has had during his lifetime. Each fracture went undetected until obvious deformity, swelling, or redness was noticed by someone else. Characteristically, he has seemed oblivious to the obvious body distortions accompanying his injuries. He has engaged in self-mutilating behavior such as deeply biting his fingernails and fingertips and peeling off

skin, which he describes as being 'like peeling a banana'. He would nonchalantly pull off toenails because 'they always grew back', and would engineer elaborate bicycle accidents for public display.

A quiescent period of freedom from injury during latency was shattered by a series of injuries at age thirteen. During pubescence he participated in sports and motorcycling with fearless abandon and an exhibitionistic flair. He began to demonstrate his 'freakish' but impressive insensitivity to pain by applying lighted cigarettes to various extremities. This often became a contest with other boys for both money and pride, with the patient the undefeated champion. He had no apprehension over the disfigurement and only later came to regret it because of a growing awareness that the scars made him less attractive to others, particularly girls. Skin grafts were required on separate occasions to cover third degree burns sustained from unnoticed contact with a motorcycle muffler and a shorted electric blanket. In spite of his clear cognitive understanding of his vulnerability to injury and the experience of numerous broken limbs, the patient participated without restraint in contact sports and frequent fist fights. At no time did he conduct checks on his body parts to insure the absence of injury. The patient describes his injuries with an indifference which would seem to belie the fact that they had happened to him. Paradoxically, he would be more upset by damage to his clothing than by bodily injury. He oscillates between experiencing himself as uniquely invincible or freakishly unique. When he notices his body, he denigrates it as 'a skinny, weak thing'.

The patient was born out of wedlock and was offered for adoption by his mother one week after delivery. He may have suffered traumatic injury at her hands, as he was hospitalized from age two weeks to two months. He was adopted early in this hospitalization by an infertile middle-aged couple who had previously adopted two other children, a boy four years older and a girl seven months older.

The patient's foster father is a well-meaning, supportive but passive man who carries little weight in the household and has had recurrent failures, such as unemployment and drinking episodes, outside it. He has a penchant for mediocrity that the patient, who has a penchant for grandiosity, finds embarrassing. Nonetheless, the father demonstrates considerable warmth and feels especially close to underdogs, including the patient.

His foster mother looks old and worn. She pictures herself as the captain of the ship, beset by difficulties at every turn, and exudes a protective possessiveness for her children. She is understandably suspicious of doctors, feeling that they use her son as an interesting 'guinea pig'. She stated: 'Doctors would always jab him with needles if I turned my back'. She and the patient are in a chronic state of conflict because she feels he is undisciplined and he feels she is smothering. Both opinions are accurate. The patient says of his parents, 'They grew up poor, no education, in the country—what can you expect of them?'

The patient's developmental milestones were unremarkable. He was, however, the only child in the family to begin rocking and shortly thereafter, at the age of seven months, he graduated to strenuous and persistent head-banging. This would occur most frequently when he was alone, especially before sleep and in the dark. He would maintain a rapid regular rhythm, banging against pillow or floor, registering a sharp report with each impact, and displaying no evidence of pain. He had also shown an early fascination with music. Head-banging, accompanied by music, has persisted unabated and continues to play an important role in the patient's life.

The patient did not achieve urinary continency until his early teens, and was thus rendered the victim of childhood humiliations. His bed-wetting was often in association with dreams of burning buildings and fire trucks. At the age of eight he set the first of many fires in a career that fortunately has caused no great damage. His parents noted that from early childhood he has been tense, high-strung, and perhaps hyper-

active. He slept fitfully and always seemed to be in motion. Although he is bright and has never experienced learning difficulties, he was distractible at school and performed below capacity. He has been emotionally labile and impulsive, quick to anger and to fight.

Within the family, he has been closest to his foster sister, whom he proudly calls 'my twin'. Until the age of nine, they were practically inseparable, especially as their rural home made other playmates relatively inaccessible. To please her, they would play house and his boy doll would marry her girl doll. She is described by the patient as 'the only girl I ever saw naked', as they bathed together until the age of seven. He felt a great loss when she developed outside interests and left him for other friends.

His favorite preoccupations from five years of age until his early teens were martial games executed in precise detail and with endless variations. He studied the Alamo, Civil War battles, Custer's Last Stand, and the Titanic disaster intensively and accurately re-enacted the events, sometimes with his sister's collaboration. He notes that massacres were his specialty. A soldier doll, 'Corporal Junior', made for him by his mother from the scraps of other dolls, was and remains a treasured possession. The patient dressed his doll and himself in renditions of army uniforms, had a large collection of toy soldiers, and wanted to be in the army like his father. In games often played alone, he would 'get killed but always get up again, had to be a hero'. His play and fantasy were vivid, intense, and deeply pleasurable. They gradually became less important in adolescence when he became interested in sports and in attempts to form relationships with others.

Often alone during his latency, the patient felt that children were cruel and likely to tease and abuse him. He noted, 'The kids could annihilate you'. He ascribed his sense of being an outsider to his lack of pain sensation. However, he did have a chum at school for several years who, unfortunately, lived too far away to be available after school.

During his adolescence there was of course an upsurge of both sexual and aggressive activity. Feeling that he had 'a cheap body', he never dated and began compulsive masturbation, as often as six times a day, associated with vague fantasies of naked women. When presented with a BB gun, he shot fifty-seven birds during a one-month period and stopped only when he encountered a nest of five starving, orphaned baby birds with whom he felt kinship. Interestingly, he had empathy for hunger and loneliness but not for the physical pain inflicted upon his wounded targets.

Alterations in his social role occurred as he moved from the shyness of latency and became an exuberant show-off in the classroom as well as a reckless participant in sports. During this period the patient sustained the numerous injuries, both accidental and self-inflicted, described before. His adolescence was in contrast to that of his older brother who was everything the patient wanted to be—tall, coördinated, and socially adept. He experienced his brother's premature death in Vietnam as a major loss, was depressed and had suicidal fantasies of reunion. The patient enjoyed the thought of his own death and of his parents grieving.

In several ways the patient has done remarkably well under difficult circumstances. He is at grade level in school in spite of numerous hospitalizations. To a great extent he has outgrown the exhibitionistic self-mutilation and excessive activity of his early adolescence. He still has difficulty forming friendships but has been able to develop strong ties within the structure of his group therapy. The patient writes moving and poignant poetry, using powerful language, rhythm, and interestingly, many synesthetic images. There are frequent allusions to death, decay, and isolation but the poems are a useful sublimation of his exhibitionistic impulses and are a way of sharing painful feelings with others. He also sings and plays the harmonica in a band.

The patient has not displayed any overt signs of psychosis, but his responses both during interviews and on psychological

testing impart a vague but lingering impression that he operates on a borderline level of ego integration. His porous ego boundaries are demonstrated by not infrequent experiences of *déjà vu* and depersonalization, vivid hypnagogic phenomena, frequent use of projection and also introjection (as in his suggestibility and low resistance to contagious affects), and indifferences to the body surface. His deficits in the integrating and regulatory ego functions seem greater than can be attributed merely to his adolescence and current stresses. Psychological tests reveal that he has an I.Q. of one hundred fifteen and no organic impairment. Certain Rorschach responses, however, show contamination, perhaps revealing an underlying thought disorder, while many responses denote depression and anxiety over the current threats to his body.

There are several indications that the patient is not nearly so comfortable with visual as with auditory perception. He finds shiny objects distracting and unpleasant, keeps his eyes closed during head-banging because light interferes with the experience, and sometimes loses track of visual percepts such as stop signs when overcome by the vibrations of his motorcycle. His poetry often converts visual images into sounds, smells, or movements. His lowest score on the Wechsler Adult Intelligence Scale test was on visual-motor coördination.

DISCUSSION

Various explanations have been offered to account for rocking and head-banging. Spitz and Wolf (1949) ascribed these rhythmic activities to autoerotic pursuits. They regard rocking as the most primitive of autoerotic behaviors since it does not require even a part object from one's own body, as does genital stimulation, fecal play, or thumb sucking. They feel that the rocking 'is caused by a maternal personality which does not permit the formation of any object relation whatsoever' and that it represents 'a regression to the primary narcissistic stage' (p. 118).

Anna Freud (1954) in a discussion of the problems of in-

fantile neurosis stated that 'what is sought in head knocking is a sensation of pain . . . . head knocking seems to me to be unquestionably autoaggressive.' She referred to Greenacre's interesting suggestion that 'the pain produced by head knocking may serve the purpose of establishing an otherwise missing body reality for the child'. Miss Freud continued: 'Perhaps the aim of establishing a closer relationship with one's body underlies many of the autoerotic or autoaggressive practices as a secondary subsidiary purpose' (p. 41). Miss Freud's thought, however, that head-banging is an effort to inflict pain on oneself cannot apply in all cases; our patient practiced it with no sensation of pain. We must look further to explain more precisely the role of head-banging in body-image formation and its likely increased occurrence in patients who have no pain perception.

Escalona (1954), in discussing these theories, stated: '. . . what we have been calling discharge phenomena, whether they are autoerotic or autoaggressive, are never just discharge, but are stimulating, exciting, arousing conditions' (p. 46). It seems likely that in varying circumstances head-banging may serve as a reliever of erotic or aggressive tension, as a self-stimulator, or as a combination of elements of each. These views are of obvious interest. Our study, however, focuses on another major explanation given for head-banging, one that has usually not been clearly described: that it furthers body-image formation and self-object differentiation.

In the absence of adequate external stimulation, the incidence of head-banging increases. The stimulus deficit can be a result of environmental deprivation which can follow from inadequate maternal input (as in institutions), or it can be found in children with defective perceptual and integrative functions (as in mental retardation, autism, blindness, deafness, aphasia, or perhaps congenital indifference to pain). Support for this concept comes from the work of Harlow and Harlow (1962) who noted rhythmic body movements in monkeys raised in isolation. Our patient's sense of instilling life through

rhythm in a body otherwise experienced as dead seems to be a similar phenomenon.

Greenacre (1954) suggested that 'there was something in . . . head knocking which had to do with a need, in some peculiar way, to establish a body reality in that particular area' (p. 38). Bychowski (1954) viewed the head-banging of schizophrenics and latent psychotics as a way to 'help them in tracing the ego boundaries, delimiting themselves against external realities' (p. 67). Schilder (1950) ascribed the development of a child's body image to the child's experience of cutaneous, visceral, kinesthetic, and special sensory sensation.

We will attempt to understand the origin and the role of head-banging in our patient's current functioning and then offer some necessarily tentative genetic explanations for some head-banging in children and adults. We have not had extensive experience with child head-bangers and so are reasoning by construct and analogy.

Our patient vividly described his sensations during head-banging: 'The music and rocking are all inside. My insides are dancing, pulsing, glowing, moving. It's complete, whole. Inside the sound beats through my ears and flows and engulfs the body. I'm not aware of anything when I'm doing it. I lose contact with the outside. Float, drift from space. World drifts away, not part of the world. *I'm just Bill.* Without it I'd be dead.' It seems to us that head-banging is the patient's way of establishing a sense of personal reality by flooding himself with proprioceptive inputs. His firmest and most comforting sense of body image derives from intense vestibular and kinesthetic sensations during which he feels clearly differentiated from the outside world.

It is interesting to speculate why he feels himself most fully only in this special way and how this may be related to his lack of pain sensation. Another of his statements pertains here: 'A body is like a car, it can be dented but it pops out again and can be fixed like a car. Someone can get in and use it but the

body isn't you, you just inhabit it.' The patient has indeed related to his body surface with a good deal of indifference. This was most striking in his much greater concern over the preservation of his clothing than of his skin and in the casual self-mutilation of his body surface. It seems to us quite possible that his lack of cutaneous pain sensation has caused him to have a diminished sense of surface body image—to regard it as 'not me'. The powerful feeling of 'I'm just Bill' and of personal integrity and cohesiveness resides more deeply *within* his body and comes to consciousness in a trancelike state of rhythmic total immersion. During these episodes there is a high level of arousal with low external stimulation (*cf.*, West, 1967), which is a necessary precondition for the patient's feeling 'me'—intense self-investment through rhythm with reduced awareness of and confusion with the outside.

Various authors have commented that a head-banger is involved in a narcissistic withdrawal. Anna Freud (1954) stated: 'Children who are rockers and head knockers are usually of the type more concentrated on themselves than on the object world' (p. 61). It seems that withdrawal serves a protective and reparative purpose in our patient. His generally porous ego boundaries are threatened in situations of either too intense external stimuli, or by stimulus deprivations, as before sleep. In either situation he is able to confirm and strengthen ego boundaries and ego defenses by excluding from awareness all external and internal stimulation except in the highly cathected proprioceptive sphere which the patient feels is the core and substance of his being. This dissociation pre-empts thinking and even affects and is thus also in the service of repression and denial. The need to buttress ego boundaries against excessive external or internal stimuli recalls Freud's (1920, pp. 24-37) protective barrier and is perhaps one purpose of proprioceptive flooding in head-banging.

A challenge to intact ego boundaries also occurs in an individual experiencing stimulus deprivations, who thus lacks an environment against which to define himself. It is con-

ceivable that our patient has a chronic sense of stimulus deprivation because of his inability to feel pain. This would be in line with Freud's (1923) concept that pain is involved in the formation of the body ego, particularly of the surface body ego. In Civilization and Its Discontents, Freud (1930 [1929]) stated:

> A further incentive to the disengagement of the ego from the general mass of sensation—that is, to the recognition of an 'outside', external world—is provided by the frequent, manifold and unavoidable sensations of pain and unpleasure. . . . One comes to learn a procedure by which, through a deliberate direction of one's sensory activities and through suitable muscular action, one can differentiate between what is internal—what belongs to the ego—and what is external—what emanates from the outer world (p. 67).

Another observation supporting the importance of pain in body image formation is that a phantom limb after amputation may persist indefinitely if it is painful, but gradually shrinks if painless (*cf.*, Brain, 1962; Sternbach, 1968). And it is a commonplace that pain can be used to terminate episodes of depersonalization by powerfully establishing the reality of the body. It thus seems possible that an absence of pain sensation limited our patient's capacity to experience and to enjoy a clearly defined and cathected surface body image and predisposed him to using other modalities, primarily proprioceptive, in defining an internal body image. This required active reenforcement in repeated head-banging episodes and blocking out of the external, whereas most people retain a body image as a preconscious construct without the need of activity to constantly re-enforce it.

One may argue that our patient's use of music as a concomitant of head knocking contradicts our formulation that he has withdrawn from external stimulation. However, it seems to us that he experienced the music not as something coming from without or even felt on the surface; instead, the patient might

be viewed as being analogous to a tuning fork that resonates to an externally provided vibration. 'The music gets into my whole body. The band feels like it's inside, the guitar here [points to chest], the piano there [points to abdomen], the drums here.' He uses headphones to increase this sense of the music's coming from within. A similar experience of external vibration being incorporated and felt from within occurs when he rides a motorcycle: 'I feel alive with the vibrations. It takes me over, all involved, lose track of the speed and the road.' Many authors have noted that head-bangers have a precocious fascination with music.

Trancelike dissociative states are sometimes oceanic with a sense of fusion between self and the outside (*cf.,* Freud, 1930 [1929]). In our patient, the contrary seems to obtain; he is at these times most separate and individuated. He avoids confusion between inner and outer by focusing upon the inner—in effect, 'the movement is me'. Edith Jacobson (1954) has discussed this issue in another context:

> . . . the cathexes of the self-representations, though gaining such powerful contributions from the object-libidinous sources, are certainly founded on the original stock of undifferentiated psychic energy with which the whole self, including the organs that are the kernels of the future system ego, had been primarily vested. . . . The autistic schizophrenic, the Kanner type, which [Mahler, 1952] describes, appears to avoid any outside stimuli that would lead to contact with the object world. Unable to cathect objects, this type evidently develops primitive, defective self-images which are primarily hypercathected at the expense of the object world. This certainly suggests that even in normal development the cathectic core of the self-image is the psychic energy originally vested in the self . . . . self-representations profit from the transformation of object into narcissistic libido . . . (pp. 91-92).

It is of course speculative to assume that the functions of head-banging in our patient's current life are identical to those responsible for the etiology of the symptom in infancy

and that we can proceed by analogy to explain the origin of the symptom by its present manifestations. Most head-bangers desist during childhood (*cf.*, DeLissovoy, 1962). It is therefore likely that our patient's head-banging has been secondarily elaborated and refined over the course of the years so that it may in many ways play a different role in the adult than it did in the infant. One obvious elaboration is the current symptom's resemblance, in the patient's description of it, to his experiences during masturbation. Actually, there are marked differences as well: he describes masturbation as being always object-directed in fantasy, as not removing him from the world, and as a much less global, total body sensation. His masturbation not only has external objects that persist in his fantasy but a part object, his penis, which also attracts his attention. In contrast, the head knocking is an affective experience that focuses on a diffuse, total, inner 'me'. It is preverbal and relatively devoid of fantasy.

Kravitz and Boehm (1971) noted that the onset of head-banging clusters around the last half of the first year of life, with the mean age in several studies of normal infants ranging between five and twelve months. During this same period the infant begins to experience stranger anxiety and it is presumed that he is establishing object permanency, a sense of body ego and separateness from the outside world. It seems plausible for a variety of reasons to suggest that infant head-banging may occur in the service of body image formation and concurrently with differentiation between the self and the object world. The fact that mentally retarded children begin head-banging later than do normal children suggests to us that it takes them longer to reach this developmental stage.

Kolb (1959) has stated that '. . . the individual organizes his body-image through the integration of multiple perceptions, a process beginning with the earliest stages of development. The embryonic and infantile nervous system is exposed to proprioceptive sensory impressions from the vestibular apparatus and the receptors in muscles and joints' (p. 752).

In the construction of one's body image, then, there is a synthesis of input from various perceptual modalities. Most important of these are the visual, the surface-cutaneous (pain, touch, and temperature), and perception derived from motion (the proprioceptive and vestibular). Auditory perception is vitally important in relating to the outside but it is a very inadequate means of differentiating from it. The visceral contribution to body image is imprecise because of the paucity of autonomic afferents, their poor localization, and the tendency toward referred sensation (*cf.*, Schilder, 1950). There may be discongruity of body image representations derived from the different modalities, as in the phantom limb, in schizophrenics, or in the obese patient who feels thin but looks fat to himself.

It would seem to us that there are two major aspects of the body sense: the surface boundary body which arises mostly from vision, touch, and pain; and the inner body which results from motion, vestibular and proprioceptive input. As pointed out by Freud (1923), vision alone cannot differentiate inner from outer and must be integrated with proprioception and tactile sensation, especially pain.

Abnormalities in the development of body image may result from perceptual defects in the infant or from an environment that is either understimulating or overwhelming in its perceptual load. The infant who for a combination of these reasons cannot utilize the usual patterning of sensory inputs in establishing a congruent body image may resort to a more primitive but reparative endeavor—the use of rocking, head-banging, and other rhythmic motor activities for maximum stimulation and for creating awareness of self by way of a core proprioceptive body image. Motor behavior is obviously of great importance in any infant's developing body image and remains so in the adult, as illustrated by such pleasures as dancing and sports. We postulate that the infant head-banger, lacking sufficient other perceptual and motoric means of establishing a body sense, must resort to a motor-proprioceptive mode at a

time when his rudimentary motor skills limit him to this primitive but compelling total body motion (*cf.,* Mittelmann, 1954; Peto, 1970).

Motor behavior in the normal development of body sense is executed outward in close relationship to the object world. It is goal directed, offering a feeling of mastery and control, and becomes progressively more refined and focused upon the specialized movements of parts rather than the whole. It contrasts with head-banging in all of these regards. Movement is inevitably linked to a sensation of body image (*cf.,* Straus, 1963) but the feeling involved will vary depending upon the quality and function of the particular type of motor activity in the total economy of the individual. One has a different sense of self in playing a piano than one has in swaying to its rhythms. Head-banging and other rhythmic motor patterns are available to the infant before he can walk and perform more complicated tasks of coördination. Thus they represent a premature and necessarily primitive use of motor-proprioception in body-image formation.

The infant's perception is largely mediated by the mother to avoid overstimulation or understimulation. The availability and consistency of object relations is obviously of paramount importance in separation and individuation, but this is not our concern here.

The development of a body image and boundaries is, perhaps, central to the early formation of the ego and is at the same time an important early ego task. We may speculate that early body image deficits, as in our patient, may affect that epigenetic development of the ego. His use of motor rhythms to establish body image may have influenced his current motoric defensive structure, impulsivity, and borderline character.

Psychoanalysis has from its inception placed emphasis on the importance of pleasure and unpleasure (sometimes described as pain) in psychological development. Freud (1920; 1926, pp. 169-172) discussed the relationship between physical and

psychic pain and anxiety. Our patient, deprived of a sense of physical pain, nonetheless clearly has a capacity, or even a predisposition, to experience anxiety and depression. This indicates that these affects are linked to the vicissitudes of early object relations and are not clearly derivatives of pain perception. Since physical pain and unpleasure (tension) are not synonymous, this argument has limited theoretical applicability to a discussion of the pleasure principle. Our patient has an isolated loss of anxiety about body injury, which may result from his absence of pain, from his proprioceptive internal body image, or from masochism. It seems to us that his fears of incapacitation are only partly colored by castration issues and are rather more global; he fears the loss of movement because he defines himself in this modality.

The patient's superego has hypertrophied and underdeveloped aspects, but over-all shows no specific changes resulting from his indifference to pain. This suggests that physical pain is at most peripheral in superego formation. It is of interest that his parents ritualized his water phobia to shape his behavior, much as other parents use spankings.

SUMMARY

An eighteen-year-old male patient with congenital indifference to pain is discussed. His body image is primarily internal rather than at the surface and is related to motorically derived vestibular proprioceptive sensation. This is re-enforced by frequent periods of head-banging during which the patient feels most himself and most distinct from the outside world. The general role of various sensations in the development of body image is discussed and the suggestion made that at least for some infant head-bangers, the activity is an attempt to achieve separation from the object world when, because of defects in other perceptual modes or because of excessive or deficient stimulation, this separation may best be made by heightening the proprioceptive awareness of self. This may help explain the relatively high frequency of head-banging in blind, deaf,

aphasic, autistic, and neglected children who have difficulty differentiating themselves in other ways. The relationship of the appreciation of physical pain to the development of anxiety and superego is briefly discussed.

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Notes on Frustration

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NOTES ON FRUSTRATION

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Frustration, translated from Freud's Versagung, *has been broadened in its popular usage to describe various experiences. Cultural and technical developments that have influenced the tolerance of frustration are discussed. With the disappearance of some neurotic symptoms, the neurotic has been deprived of substitute satisfactions which he formerly found in his symptoms but the frustration that produced the symptoms remains. The present cultural climate with its confusion of values seems to deprive many people of satisfactions derived from their ego-ideal demands and contributes to a sense of narcissistic frustration.*

This paper is an attempt to call attention to a problem that has been neglected in the recent psychoanalytic literature—frustration. Frustration may be normal, or neurotic and pathological. Although it is not always obvious to which branch of science it belongs, frustration concerns sociologists, economists, city planners, and philosophers. But the concept of frustration is a psychological one and is derived from psychoanalysis.

The sense in which Freud wrote about frustration has entered vernacular language; it is now popular as a noun or verb. But, Freud's concept of frustration has almost disappeared from psychoanalytic discussions of adult neuroses.[1] One looks in vain for this term in the excellent and comprehensive Glossary of Psychoanalytic Terms by Moore and Fine (1967). It cannot be accidental either that the term has found such a tremendous circulation all over the world.[2] 'I feel frustrated' seems to ex-

[1] Its importance is emphasized in the development of children, particularly in the writings of Anna Freud.

[2] It has had the peculiar fate of returning into the German language. From the translation of Freud's *'Versagung'* into English it is now used as noun and verb with German pronunciation: *frustriert* and *frustration*. Brandt (1961) points out that the term *'Versagung'* refers to the failure of something to occur. No outside agent is required. The term frustration 'conveys the feeling that something is done to somebody . . .'. Jones, et al. (1924) in their glossary of psychoanalytical terms translated Freud's term *'Versagung'* more literally as 'privation'. Frustration describes the feeling that results from privation.

press the experiences of innumerable people. The term (as well as the term, repression) has even gone from its purely psychological meaning and found its way into the experience and use of the radical left. Society is blamed for the individual's feeling of frustration and the anger is turned upon the 'establishment'.

As we are trained to listen to our patients and to extract the true meaning from their words, we should also listen to the popular use of the word 'frustration', its constant appearance in the vernacular, in the press, and in fiction. But the questions this usage raises are not easily answered. Perhaps we must look for a combination of determinants. Does the present use result from a real change in the experience of people? Or has the popular spread of analytic slogans made them more conscious of a feeling that always existed, so that frustration is merely a new word for an experience always dormant in our culture?

Strachey (1958), in his introduction to Types of Onset of Neurosis, recounted the development of Freud's concept of frustration. The notion of sexual privation (*sexuelle Entbehrung*) makes an occasional appearance, for example in On Psychotherapy (Freud, 1905 [1904]); the onset of neuroses from an internal obstacle to satisfaction emerges at a somewhat later date. In 'Civilized' Sexual Morality (Freud, 1908), the concept of frustration is discussed more fully. In his account of a case of paranoia, Freud (1911) assumes frustration to be one of the causes of the outbreak of Schreber's illness. In the Introductory Lectures, Freud (1916-1917) writes '. . . that people fall ill of a neurosis if they are deprived of the possibility of satisfying their libido—that they fall ill owing to "frustration", as I put it—and that their symptoms are precisely a substitute for their frustrated satisfaction . . . . this assertion does not claim to reveal the whole secret of the aetiology of neuroses but is only bringing into prominence one important and indispensable determinant' (p. 344).[3]

[3] A literal translation would be 'indispensable condition'.

In Civilization and Its Discontents, Freud (1930 [1929]) turned to the more general restrictions to which everybody is subjected—the 'cultural frustration' (p. 97). In The Future of an Illusion (1927) he wrote: 'Among these instinctual wishes are those of incest, cannibalism and lust for killing' (p. 10). Thus frustration referred to the lack of satisfaction of libidinal and aggressive drives. The cause may be an external or internal prohibition, or the lack or loss of satisfying objects of love or hate. The internal frustration results from the conflict between the drives and what later was named the superego and ego ideal.

In the case of the Wolf-man, Freud (1918 [1914]) introduced the term narcissistic frustration: 'He fell ill, therefore, as the result of a *narcissistic* "frustration" ' (p. 118). Although in Freud's later writings the term frustration *(Versagung)* appears less frequently, he once more mentions it in his letter to Rolland: 'As a rule people fall ill as a result of frustration, of the non-fulfilment of some vital necessity or desire' (Freud, 1936, p. 242). The term may have disappeared from our literature because sexual drives are less restricted than they commonly were when Freud made these formulations.

Freud frequently emphasized that the society itself influences the development and form of neurosis. His remarks are as true today as in former years. A changed society may inflict on its members frustrations that are different from former ones.

The change in neurosis demands a new exploration of the concept of frustration. The basic idea, that frustration is an 'indispensable condition' of neurotic development, may still be correct, but cultural developments seem to have altered the circumstances that produce the feeling of frustration and to have influenced its effects.

One reason to be concerned with this problem is the question of aggression. It cannot be doubted that frustration, particularly if it is prolonged, if it does not lead to apathy or to unhappiness, heightens the level of aggression. This leads to more frustration as the heightened aggression cannot easily be

discharged and relieved, creating a chain reaction. The present spread of violence may be a consequence.

Freud's term 'cultural frustration' meant essentially that the ethical standards developed and demanded by the culture imposed too much restriction on the individual's drives. The causes of cultural frustration today, it seems, are more complex. It may be necessary today to ask questions which we did not have to ask in a more stable and restrictive society.

The neurotic symptom whose 'indispensable condition' is a conscious or unconscious frustration is a compromise-formation, a substitute satisfaction. Adaptation to the symptom takes place (*cf.*, Freud, 1926, p. 98). The symptom, though it is caused by frustration, does not produce the experience of frustration. Freud emphasized that the tendency of symptom-formation is to give ever greater room to substitutive satisfaction at the expense of frustration (Freud, 1926, p. 118). But in present-day patients the conscious undisguised feeling of frustration appears to be the essential 'symptom'. The actual cause may still be an unconscious frustration of unresolved strivings. The substitute 'satisfaction' which the individual might have found in his symptoms is missing, the frustration remains.[4] Hence, the neurotic conflict is not settled through symptom-formation (Freud, 1920).

Freud (1910) expressed a certain apprehension about the removal of the symptoms of the neuroses. 'Neuroses have in fact their biological function as a protective contrivance. . . . What will these people have to do if their flight into illness is barred by the indiscreet revelations of psycho-analysis? . . . A good number . . . would . . . succumb or would cause a mischief greater than their own neurotic illness' (p. 150).[5]

Do we now face such consequences in our growing frustra-

[4] Freud (1910): 'When the riddle they [the substitutive satisfaction of the drives] present is solved . . . these diseases [the symptoms] cease to be able to exist' (p. 148).

[5] The word 'mischief' does not render the grave meaning of Freud's term '*Unheil*' which implies threatening disasters of unknown consequences.

tions and social upheavals? Today, for example, there may be a number of people who are deprived of a relatively successful solution of their conflicts in symptom-formation, and who are driven to act out their frustrations in other ways. But this assumption cannot explain the widespread experience of frustration at the present time.

The relatively healthy person tolerates frustration without falling ill. Or we may say that the ability to tolerate frustration defines the individual as being healthy. But the development of this ability depends on numerous factors. Experiments of psychologists, confirming common experience, are here of interest. For instance, Crespi (1944) found that when rats which were repeatedly given a large amount of food for traversing a runway were given instead a small amount, their performance dropped markedly below that of rats trained from the beginning on the small portion. In another experiment chimpanzees given lettuce under circumstances when they had formerly got bananas would show difficult behavior, although under other conditions they would accept lettuce readily.

These experiments demonstrate how much frustration is conditioned by previous experiences and by acquired expectations. They illustrate and confirm the evident fact that in the development of the experience of frustration the environment—and certainly the upbringing and education of children,—is of paramount importance. The freer child rearing of today promises more than is fulfilled; as œdipal wishes of course are always frustrated, freer child rearing promises more than later life fulfils.

We cannot yet fully assess the impact of the technological revolution on the individual, but it clearly has many contradictory effects. It is well known that industrialization makes work boring, monotonous, and pointless and deprives the worker of the satisfaction that sublimations of different drive-derivatives by variety in his work can give. Yet industrialization has protected many people from former causes of frustration, has freed them from severe and exhausting tasks now

taken over by machines, and has increased their time of freedom from work. And people now derive satisfaction from entertainment and cultural stimulation not formerly available. Television and movies are a source of pleasure, but they constantly picture a life of abundance, of sexual bliss, and of potential glory, making ordinary life of toil and trouble appear drab. Thus this technological development, although it gives pleasure, leads inevitably to more frustration. It also reduces the natural training in tolerance of frustration that children formerly received; the very nature of their environment used to force them to learn to master much harder tasks in order to grow up. Moreover the greater abundance of material goods today increases the general demand for happiness and expectation of it. Freud once wrote that much would be gained if we managed to transform neurotic misery into the common misery. This statement does not express the present expectations of our society.

Formerly, actual frustrations were mainly due to poverty, with deprivation of basic needs, and to sexual restrictions. Our more prosperous society which gives much more gratification of these needs has, it seems, not only produced a state of lower tolerance of frustration (the individual today is more like the pampered rat in the experiment) but has also created new types of frustration. Have cultural and societal changes deprived us of former satisfactions? Thus the problem of frustration becomes rather the question of what gives satisfaction.

Prosperity makes it more difficult for young people to prove their strength and value against their parents'. In former generations it was well known that children (particularly sons) of the rich suffered from a fate that deprived them of the need to assert their masculinity in the struggles of society. Many found themselves condemned to a meaningless search for pleasure, to a life of continual frustrations—although this term was not in use at that time.[6]

[6] *Cf.*, H. and Y. Lowenfeld (1970) where similar problems were discussed, without specific attention to the question of frustration.

It is certainly questionable whether the current feeling of frustration should be called a neurosis in the psychoanalytic sense. For many people the diagnosis of character neurosis may be correct, but not for the great number of individuals who describe themselves as frustrated. Yet people turn to psychiatrists seeking a cure for this state of mind (or even turn increasingly to other 'healers'). Thus they assume that this state of mind is a mental sickness and not man's natural condition. One might ask whether this expectation to be content and satisfied with life, natural as it appears to us today, can be attained by many people. For thousands of years mankind has hoped for happiness in the beyond and not expected it in this world. The frank 'pursuit of happiness' in itself increases the risk of disappointment. The decline of religious faith may have deprived many of a chance to reach contentment, as the hope for future rewards made it easier to tolerate the afflictions of this world,—a hope that at the same time promised fulfilment of infantile wishes for reward and love.[7]

Freud's (1912a) remark that 'the psychical value of erotic needs is reduced as soon as their satisfaction becomes easy' (p. 187) may also apply to all other pleasures. A striking example is the experience of mountain climbing: the exhilaration of reaching a peak in the Alps after strenuous exertion of long hours cannot be compared to the meager experience we have when today's fast trains carry us up in the shortest time. Even knowing that the train exists spoils the pleasure.

If an instinctual wish is frustrated (for external or internal reasons) a painful tension, a feeling of displeasure, may arise. But if the satisfaction becomes too easy, and the tension remains too low, this may also lead to a feeling of frustration. The drive tension has to reach a certain height, and needs time for this process if there is to ensue a pleasurable release. If not, the pleasure is weak, boredom and frustration set in, as so many young people feel today. All other pleasures can be understood in the light of this sexual model.

[7] *Cf.*, Freud (1930 [1929]): 'One feels inclined to say that the intention that man should be "happy" is not included in the plan of "Creation" ' (p. 76).

These remarks refer to the libidinal drives. The aggressive drives, on the contrary, become more painful as tension increases, for the individual is aware that society has no acceptable means for discharge of intense aggressive drives.

Thus poverty and restrictions lead to one kind of frustration, through privation of the id wishes, and prosperity and permissiveness to another kind, due to developments in the ego that weaken it.

The course of development peculiar to man seems to produce a disposition that makes it difficult for most people to find a state of contentment in direct drive-fulfilments. The need for sublimated experiences and activities must also be satisfied. But, as Freud emphasized, the capacity for sublimation is not equally distributed. As the culture puts the raw material for sublimations at the disposal of the individual, the attitude toward the surrounding culture influences the availability of sublimations. The present countercultural attitudes and the rejection of traditional values in a great number of young people, who do not find revelant what they are offered, deprives them of ways formerly available to them for solving conflicts and may deprive many of a chance to reach a reasonable degree of contentment.

Certainly not all people suffer from 'frustration'; some accept frustrations as a matter of course. To understand why, we must look at the differences in their rearing that have strengthened their egos, or at least not weakened them. The necessary training to tolerate frustrations, formerly an unavoidable side effect of society's deprivations and restrictions, is neglected in many families; children now have to learn that although we have the power to travel to the moon, we do not have the power to have all our wishes fulfilled.

Finally we have to consider another aspect of the problem which seems to influence the mood of many people today. We see patients who are outwardly successful in their work and their sexual life. Their superegos do not punish them, but permit them pleasures and satisfactions. Nevertheless they

feel 'frustrated'. It seems that this state, in many people, results from the fact that the moral demands of their ego are not fulfilled. That the wishes of the superego can be frustrated (as can the wishes of the id) is understandable, if we remember how it develops.

It is not intended in this paper to discuss concepts of the superego and ego ideal but rather to assume that the ego ideal is that part of the superego that comprises expectations and demands (*cf.*, Hartmann and Loewenstein, 1962). Freud (1923) emphasized that 'the superego is always close to the id' (pp. 48-49) and writes of 'its intimate relations with the unconscious id' (p. 52). In the ego ideal we have the substitute for the lost narcissism of childhood, in which the child was his own ideal (Freud, 1914, p. 94) and his libidinal attachments were to his overestimated, ideal parents. Thus the narcissistic drives and the derivatives of the œdipal period depend for satisfaction on the demands of the ego ideal (*cf.*, Schafer, 1960, 1967; Lampl-de Groot, 1962; Murray, 1964).

In Types of Onset of Neurosis, Freud (1912b) wrote: '. . . we see people falling ill just as often when they discard an ideal as when they seek to attain it' (p. 234). The 'discarding of ideals' seems to be typical of present-day cultural attitudes and of the current uncertain seeking for new ones. These new morals do not seem to fulfil the wishes of the ego ideal, acquired in the process of growing up in a family. Not only in man's work but also in the liberation of his sexual life some old desires of the superego ideals are frustrated.

Any activity is satisfying only if it satisfies to a certain degree all the agencies of the mind, id, ego, and superego (*cf.*, Waelder, 1930). In the satisfaction of one agency, a frustration derived from the other parts of the mind may cause discontent. One might ask why many people who seem to be troubled because they do not respond to the expectation of their ego ideals, do not strive to live up to them. The answer may be partly found in the effects of the cultural climate, which is more pervasive than ever as technical achievements have let communications

impinge constantly on every individual's life and development. The superego is always open to influences from the environment, helpful as well as disturbing. The ego ideal's urges force themselves into consciousness less strongly than do the unmitigated id drives. Many patients do not accept interpretations that point to frustrations of their ego ideal. Although such interpretations are often not completely suppressed, they are not really believed. Freud (1923) wrote: 'The abundant communication between the ideal and . . . unconscious instinctual impulses solves the puzzle of how it is that the ideal itself can to a great extent remain unconscious and inaccessible to the ego. The struggle which once raged in the deepest strata of the mind, and was not brought to an end by rapid sublimation and identification, is now continued in a higher region . . .' (p. 39).

A few remarks about a patient illustrate and clarify the meaning of the foregoing. A young optometrist sought help in a state of serious depression. He had been a proud student in his chosen field which he considered, in agreement with the teachings of his school, a noble service to society. After he got a job in a well known, reputable firm, he soon discovered that he had to do slightly dishonest work to promote business. His qualms about it were laughed at by his colleagues who called him a 'jerk'; their attitude was approved by the head of the firm. Brainwashed by his environment, the patient was not really aware of the cause of his depression. When in treatment he became aware of his inner conflicts, shook off the influence of the environment, and became himself again, his depression lifted. Fortunately he was later able, with the help of some relatives, to found his own firm and to live up to his standards of honest service to his clients. Many others cannot escape from their forced adjustment to a demoralized environment and have to continue to lead a life of continual frustration.

Cultural ideals have undergone constant change in the history of mankind. Changes in civilization refer basically to changes in man's ego ideals. The causes of these changes are of

course manifold and have led to different theories of historical development. But it seems correct to state that in a time of such changes the narcissistic and libidinal satisfactions derived from the fulfilment of these ideals are missing, and this condition may be one of the most important causes of the general climate of frustration. The confusion of values deprives the individual of the love and approval of the superego and this decisive narcissistic need is frustrated.

SUMMARY

Freud's concept of frustration, somewhat neglected in the recent psychoanalytic literature, has become a popular slogan and even a popular diagnosis. It seems to be a pervasive feeling in many people at the present time.

A number of causes have reduced the prevalence of neurotic symptoms; instead we find the frustrations that formerly contributed to the formation of the symptoms. The substitute satisfactions have diminished, and the frustrations have remained.

Technological developments, although giving relief from many frustrating chores, promise more fulfilment, incite expectations, but disappoint in the end. The frank pursuit of happiness leads inevitably to disappointment.

Psychoanalysis should ask what gives satisfaction to people. We may often find repression or suppression of wishes of the ego ideal as a cause of frustration in a new climate of confusion of values.

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BOOK REVIEWS

CLINICAL STUDIES IN CHILDHOOD PSYCHOSES. 25 Years in Collaborative Treatment and Research. The Langley Porter Children's Service. Edited by S. A. Szurek, M.D. and I. N. Berlin, M.D. New York: Brunner/Mazel Publishers; London: Butterworths, 1973. 780 pp.

The thirty-three papers in this volume represent twenty-five years of devoted work with psychotic children at The Langley Porter Children's Service. A big heavy book, it is nevertheless a tightly condensed sample of the authors' experiences and findings. Such work is so lengthy, demanding, and stressful that it would be impossible and inappropriate to present it in shortened capsules for hurried consumption. The interested reader, however, will find it well worth his time to study the entire book in detail.

Szurek and Berlin have inspired and directed a large staff of collaborators in a particular approach to the study and treatment of psychotic children. Their human values and scientific viewpoint permeate and unify the book. Each contribution is marked by painstaking, enlightened devotion to the work, by utmost honesty to self and patients, by sensitivity to the needs and feelings of the disturbed families as well as of co-workers, by respect for each patient, however regressed and thwarting his behavior, and by a fine appreciation of what constitutes a healthy relationship. These attributes, so crucial in work with emotionally disturbed persons, are rarely maintained in long-term close contact with psychotic children. Such youngsters' responses are so primitive, distorted, and unamenable to change that they tempt us, as they tempt their parents, to resort to rationalized short cuts, aberrations, and lapses in professional attitudes and techniques. Several clinical papers portray beautifully how acutely the most withdrawn children respond to the unspoken feelings and tensions in their human surroundings. It is a further mark of the professional maturity of these therapists that they are able to extend their empathy to the patients' parents and help them participate in the active care of their sick children.

Some aspects of this group's approach may be debatable. Objection may be raised to the lack of a metapsychological view-

point in regard to diagnosis and assessment of data. The authors diagnose childhood psychosis purely on the basis of manifest symptoms and behavior, although these descriptive signs vary greatly and the same manifestations represent different underlying constellations. They view childhood psychosis as quantitatively different from neurosis, disregarding the necessary search for qualitative variations in such areas as synthetic functioning, neutralization, and secondary ego autonomy. Similarly, the metapsychological differences between childhood psychoses and adolescent and adult schizophrenia are not explored but viewed as a continuum. The same difficulties pervade Szurek's essay on depression. The use of the developmental profile, introduced by Anna Freud, would have aided considerably in gaining a metapsychological perspective.

The authors' technique does not use the tool of analytic exploration, although they utilize some psychoanalytic concepts. Many patients are seen once weekly, some three times, none daily. The work with the parents and, in the case of inpatients, the observations of the staff, contribute additional data but they do not substitute for the essential continuity of sessions with patients whose anxiety tolerance is minimal. Further, whereas some patients are seen for several years by a permanent staff member, the majority keep their therapists for two years or less—the period of the therapist's training. Such an experience may be valuable to a well-supervised psychiatric trainee, but one questions the effects of the stress of such change on the patient. The therapeutic goal is frequently stated as 'conflict-reducing'. The descriptions of the actual sessions, however, suggest that the aim is to increase libidinal pleasures and cathexes and to provide an auxiliary ego for the control of aggressive motor discharge. This may help promote instinctual fusion in some patients but in others it may fixate masochistic and passive tendencies or primitive identifications with coercing adults. Verbalization is not stressed as an outlet and means of integration. A metapsychological understanding would help toward individually geared therapeutic methods.

Ekstein's introduction expresses the hope that this type of work will lead to a 'breakthrough' in the field of childhood psychosis. The studies of the Langley Porter Service remind us painfully that we will, at best, edge our way inch by inch toward a deeper understanding. This goal will require the human values, so

beautifully exemplified in the work of these authors, wedded to more rigorous scientific investigation of the genetic, dynamic, structural, and economic aspects of these disturbances.

ERNA FURMAN (CLEVELAND)

ADOLESCENT PSYCHIATRY, VOLUME II. Developmental and Clinical Studies. Edited by Sherman C. Feinstein and Peter L. Giovacchini. New York: Basic Books, Inc., 1973. 461 pp.

The second volume of a series sponsored by the American Society for Adolescent Psychiatry, this collection of articles, like the first volume, emphasizes the intrapsychic elements of the adolescent process and is essentially, although not entirely, unified through psychoanalytic theory. This volume expands its range of topics to include the impact of ideologies and culture on the adolescent: the adolescent's interactions with people and the external world are highlighted by the editors. There are a total of twenty-seven articles written by forty-one authors. The contents are divided into five parts: general considerations, sexuality, psychopathology, psychotherapy, and the adolescent in the world. Each section has an introduction summarizing the important points to be covered, and most of the articles have summaries or conclusions.

The wide range of studies gives looseness to the volume as a whole. At times there is a tendency to describe psychoanalytically observed phenomena or theory in terms that have limited value to the analyst accustomed to clearer concepts. For instance, Rudolph Ekstein, in an otherwise good paper, The Schizophrenic Adolescent's Struggle toward and against Separation and Individuation, states in his conclusions: 'These patients may benefit immensely from treatment, but [they] struggle with and against Mr. Punishment and Mr. Prudence, the longed-for object that turns into the destroying object, the vampire and the rational object who has no feelings and no empathy . . .' (pp. 22-23). It is hard to understand Ekstein's terms of explanations regarding these patients about whom he has a wealth of information.

Of special interest are Moses Laufer's description of the studies of the psychopathology of adolescence being conducted in London, and Humberto Nagera's approach to the diagnostic, prognostic, and developmental considerations of adolescence. Admirers

of the late D. W. Winnicott will enjoy his article, Delinquency as a Sign of Hope.

The volume could be considered a text in which certain current psychoanalytic theories—and to some extent, clinical practices—regarding the adolescent are applied to topics pertaining to development, pathology, and culture. This overview serves an important purpose at a time when there has been considerable interest in the adolescent's mind and development. The focus is on character, ego psychology, and object relations, reflecting a view (not shared by all of the authors) of adolescent mental functioning being more detached from the infantile neurosis than many psychoanalysts are willing to concede.

Peter Giovacchini in his article, Character Development and the Adolescent Process, presents his theories of adolescent psychic development. In essence he states: 'As biological and educational factors are the substrata of drive development, the socializing and educational aspects of the environment can be considered significant variables responsible for character formation. . . . Formation of character begins mainly during adolescence' (p. 412); and 'The belief that the most significant experiences are those of early childhood has to be modified. Adolescence is now seen as having [meaningfulness similar to] infancy, the latter in terms of achieving drive differentiation and the former in the final structure of the ego' (p. 413).

The importance of sociocultural factors in the development and the behavior of an individual is well accepted by psychoanalysts; adolescence is a period in which there is strong shaping of ideals and beliefs. The reciprocity of biological endowment with environmental influences, especially that of the mother, is recognized as the process by which mental development takes place. The concept that the adolescent phase of development is not *merely* a recapitulation of the infantile neurosis, but that new elements are added to the psychic structure of the adolescent is also generally accepted. However, that the experiences of early childhood are not the most significant experiences relating to psychopathology and mental development, and that character structure begins mainly during adolescence are modifications of theory which are open to serious debate. One would infer from Giovacchini's point of view that important concepts, such as intrapsychic conflicts, drive

reorganization, primary process thinking, ego defenses, and superego reorganization do not lie at the bottom of character and ego adaptive mechanisms. He applies his theories to the technique of psychoanalysis. He describes a patient he analyzed who tried to cast the analyst in the role of an adviser on how to conduct himself socially. Although he did not play this role, Giovacchini states: 'When this patient stated that he literally did not know how to conduct himself in certain adult situations he was accurately stating his problem. Rather than repression due to intrapsychic conflict and thereby leading to inhibitions, he did not have the adaptive techniques appropriate to the task. His executive ego systems did not know how to respond' (p. 408). He ascribes the adolescent's difficulties to lack of 'functional introjects' required to cope with the added complexities of adolescence.

One sees many adolescent patients like this one, and often one must patiently deal with the characterological and maladaptive problems until the patient can, through the analysis of defense and transference, analyze the unconscious derivatives of these behavioral problems. Difficult and incomplete as it often is, the analysis of the intrapsychic conflicts and the infantile neurosis is the ultimate goal of the analysis of the adolescent.

Giovacchini is representative of many psychoanalysts who, although they do not disagree with the concept, minimize the importance of the infantile neurosis, early infantile experiences, the sexual and aggressive drives, and the unconscious as explanatory concepts of adolescent mental structure. It is hard to reconcile these views with data gleaned from the use of standard psychoanalytic technique with adolescents. In addition, knowledge which has resulted from infant observations and child analysis indicates that the infantile period is indeed the time when severe ego defects become a basis for poor ego adaptive mechanisms later in life, and that these experiences and conflicts form the nucleus of character.

There remains a great need to map out, clarify, and understand the adolescent mental processes and, through these processes, behavior. Adolescent Psychiatry is a serious attempt to understand the adolescent and offers the reader a provocative stimulus to sort out his own views.

CARL P. ADATTO (NEW ORLEANS)

THE DEATH OF THE FAMILY. By David Cooper. New York: Pantheon Books, 1970. 145 pp.

This book presents an erratic scheme to revolutionize society. In his introduction, the author says his book 'is *not* dedicated to R. D. Laing, to whom I owe more than any other man on earth, or under it'; and then he reports that during the writing he went 'through a profound spiritual and bodily crisis that amounted to the death–and–rebirth experience of renewal that I speak of in these pages'.

Cooper's work has moved some reviewers to compare him to revolutionaries such as Bakunin and Nietzsche. It seems to me, however, that the book, in spite of its Dionysiac aspects and its dithyrambic style (often deteriorating into confusion), invites comparison instead with the work of C. G. Jung, not in scope, to be sure, but in direction. Jung advised his patients to enter into a dialogue with the persons of their dreams, to talk to them and to listen to their answers. Cooper reports in his introduction that he taught his four-year-old niece Heidi 'the language of water and how to shake hands with the branch of an oak tree and then listen to the astonishingly different answers trees give'. Both Cooper and Jung attempted to cure schizophrenic disturbances by applying a method of regressively living through the infantile conflict. Jung, in an obvious psychotic episode, for years stopped almost all work, played with building blocks, and drew mandalas. Cooper encourages undisguised and unrestricted acting out of archaic infantile fantasies and wishes.

According to Cooper, every bourgeois family is 'an ideological conditioning device in any exploitative society–slave, feudal, capitalist society'. To facilitate exploitation, the family destroys the autonomy toward which the infant is striving in his first year, with the result that all the members of bourgeois society who are thought to be normal are actually mad.

How does the family destroy the child's autonomy? Cooper writes: 'One of the first lessons one is taught in the course of one's family conditioning is that one is not enough to exist in the world on one's own. One is instructed in great detail to disown one's own self and to live agglutinatively, so that one glues bits of other

people onto oneself and then proceeds to ignore the difference between the otherness in one's self and the selfsameness of one's self. This alienation is a passive submission to invasion by others, originally the family others.' It is this invasion which destroys the 'selfsameness of the self' of the child (p. 9).

The paranoid condition is, according to Cooper, a protest against the destructive invasion: 'The therapist, in working with people, might far more often have to confirm the reality of paranoid fears than in any sense disconfirm or attempt to modify them'. Cooper therefore propagates the cultivation of paranoiac doubt as defense against the terror emanating from the realistic threat.

He regards unlimited sexual orgastic activity as the most potent healing factor. 'Orgasm is the total experience of transsexuality. The fucker is the fucked in the course of his or her fucking. One becomes not only both sexes but also all ages and all generations in making love. One becomes a blissful infant and also, simultaneously, an ancient bisexual sage. *Above all, one pours out of oneself,* in a massive evacuating act, the whole internalized family constellation. Making love becomes the transcendence of the nonfucking of one's parents and the nonlove of families' (p. 113).

Cooper thinks that it is through transference (a term he uses idiosyncratically) that the family imprints its functions on the society and its institutions. 'So we find the family form replicated through the social structures of the factory, the union branch, the school (primary and secondary), the university, the business corporation, the church, political parties and governmental apparatus, the armed forces, general and mental hospitals, and so on. There are always good or bad, loved or hated "mothers" and "fathers", older and younger "brothers" and "sisters", defunct and secretly controlling "grandparents" ' (p. 4).

Cooper's concept of revolution, consequently, has two aspects: the liberation of the individual from this madness through destruction of the family, and the liberation of the society from exploitation by the ruling class through destroying its institutions. Since he projects the specific infantile constellation of the psychotic child onto all families of society, both society and the normal family acquire the characteristics of the 'bad mother' of the psychotic family constellation. The revolution consequently becomes a therapeutic process. In the setting up of therapeutic communes, the final

goal is the destruction of the 'bad mother,' represented by the institutions of the society and the family.

Cooper has twice attempted to build such communes; when he took over the direction of a ward for four years in a great psychiatric hospital in the northwest of London, and then, in 1966, Kingsley Hall, a commune of his own. In contrast to the hospital ward, Kingsley Hall was open to both sexes. There was no differentiation between patients and therapists. Both lived and slept together and no diagnosis was permitted. Therapy could be carried out by every member of the commune, patient or therapist. 'If one person so elects, he need see no one else for weeks, months or years. When one wants or needs other people, one knows the places to find them' (p. 58). 'Two people who may be stuck in a one-sided and later two-sided sexual withdrawal are held by a third person, who is disciplined enough not to interfere with their relationship but to generate through her or his holding of them, with an intense fondness that he feels for both, their own holding of each other and then leave them to evolve a renewed fucking out of the holding they have achieved. One of them may later do the same for him or her' (p. 111).

Cooper, of course, realized that 'things cannot rest at this level of rapidly spreading subversion from the micropolitical base of personal liberation. The fulfillment of liberation comes only with effective macropolitical action. So the Centers of Revolutionary Consciousness have also to become Red Bases' (p. 63). The goal is elimination of any structure of society, of any differences between ruled and ruling, abolishment of all authorities, of the police, and its security laws (law is terror) which might interfere with the life of the individual. 'We have to paralyze the functioning of each family, school, university, factory, business corporation, television company, film industry segment—and then, having stopped it, invent mobile, nonhierarchaic structures that distribute the accumulated possessions over the world' (p. 112).

The asset of the book is the insight it provides into the effect of psychotic thinking on psychiatric concepts. For Cooper, social revolution and psychotherapy have the same goal: the unimpeded acting out of early infantile fantasies and wishes. This, Cooper

encouraged in his patients in his hospital wards which were to him the centers of the revolution.

The almost enthusiastic reception of the book reflects the trend toward dissolution and disassociation in our present-day culture. It is a sign of a transitional period visible in all branches of artistic activities as well as in social phenomena such as the Hippie movement. I am reminded of a remark by the old Professor Kretschmer from Marburg: 'In critical periods, those persons become leaders whom in normal times we commit to the mental institutions'.

MAX M. STERN (NEW YORK)

CONFRONTATION IN PSYCHOTHERAPY. Edited by Gerald Adler, M.D. and Paul G. Myerson, M.D. New York: Jason Aronson (Science House) 1973. 392 pp.

This volume consists of seventeen papers on the intervention of confrontation in psychotherapy and psychoanalysis. Since there is a scarcity of meaningful in-depth psychoanalytic studies of any of our basic technical measures and their validation, an undertaking of this kind is most welcome. Further, since there is still a need to delineate the specific indications, limitations, and risks of non-interpretive interventions in psychotherapy and especially in psychoanalysis, Adler and Myerson's book is a positive step in this direction. Thus, it may serve as a valuable tool for teachers of these techniques and also provide an opportunity for more experienced psychoanalysts to reconsider their attitudes toward the uses of confrontations in their daily work. As the papers in this book indicate, there is considerable diversity in this regard, and the fresh perspectives that they stimulate in the reader are helpful.

The papers have a wide range of style, originality, clarity, soundness, and subject matter. The authors explore the definition, meanings, and uses of confrontation in the usual therapy and analytic practices and focus on their application to disturbances in the therapeutic alliance, therapeutic emergencies and impasses, persistent resistances, and unmodified denials of inner and outer reality. The frequent use of such intervention with borderline and psychotic

patients, adolescents, and children is explored among a number of other special applications. Lastly, the countertransference problems reflected in failures to confront, as well as in both necessary and unnecessary, manipulative, angry and otherwise inappropriate uses of confrontations, are studied by several of the contributors.

In all, the book is a lengthy study of the nuances of the uses and misuses of confrontations. What, then, are its main drawbacks?

Perhaps the most noticeable is the repetition which tends to dull the reader's interest all too quickly. In addition, most of the writers fail to adhere to their own definition of confrontation—examples prove to allude to questions, interpretations, and reconstructions—and to study carefully the distinctions between interpretations and confrontations both in definition and use. Only Myron Stocking deals with this problem in any detail and his discussion is quite incomplete. Another problem may stem from the subject itself: confrontations focus on the surface and on what is readily available to consciousness; most of the presentations in this book lack a sense of depth, especially regarding the nuances of the patient-analyst (and therapist) relationship. The uses of confrontation in ways that entail deviations or parameters of standard analytic (or therapeutic) technique are explored by several writers but totally disregarded by others. Too often, there is inadequate consideration of the risks involved and the therapeutic work which must follow such interventions. Lastly, one would hope for more detailed consideration of such issues as the danger of using confrontations where interpretations are indicated and the pitfalls in using radical or 'heroic' confrontations where other, especially countertransference-based and interpretable, sources of the crisis in the therapy are likely.

In delineating the applications of this important aspect of technique, the authors have a particular responsibility to re-emphasize its limitations and misuses. It is to their credit that they often do so, but it is in their neglect of the relationship of confrontations to interpretations that they run the risk of inadvertently promoting an overvaluation of confrontations and erroneous, defensive, and countertransference-based overuse of this intervention.

Despite these shortcomings, this book makes a worthwhile contribution as a broad study of the many facets of confrontation, including the manner in which it promotes the therapeutic al-

liance, contributes to positive identifications with the analyst, and fosters movement toward insight.

ROBERT J. LANGS (ROSLYN HEIGHTS, N.Y.)

AN ELEMENTARY TEXTBOOK OF PSYCHOANALYSIS. Revised and Expanded Edition. By Charles Brenner, M.D. New York: International Universities Press, Inc., 1973. 280 pp.

In his foreword to this second edition, the first having been published in 1955, Charles Brenner reports, 'Some minor changes have been made in style and content; errors in the original edition have been corrected'.

The two new chapters at the end of the book provide the only substantive additional material in this edition. The first of these, Psychic Conflict and Normal Mental Functioning, deals with the influence of infantile experience on adult character traits and has psychoanalytic comments on religious feelings and practices, politics, and artistic expression. The final chapter, Psychoanalysis Today, is a broad yet brief survey of current psychoanalytic education and practice, together with some suggestions for future study and investigation.

This textbook continues to fulfil its purpose of 'introducing interested readers to the fundamentals of psychoanalysis'. Its reputation as a lucid, sound exposition is highly deserved.

JOHN A. MAC LEOD (CINCINNATI)

THE MANIPULATOR. A PSYCHOANALYTIC VIEW. By Ben Bursten, M.D. New Haven: Yale University Press, 1973. 277 pp.

Bursten attempts an objective study of a form of behavior to which many people in the mental health professions give a pejorative connotation. He rightly points out that manipulative behavior may be seen throughout the entire range of psychopathological states. Most psychiatrists and psychoanalysts still consider manipulative behavior to be an interference with their therapeutic efforts, but have directed very little systematic study toward it.

Bursten begins by establishing a diagnostic definition of the concept, emphasizing four essential components. 1. There must be an initial conflict of goals between the manipulator and the other person. 2. The manipulator must have a *conscious* intention to carry

out his manipulation. 3. The manipulation must occur through means of deception, insincerity, or elements of fraud. 4. Having been successful, the manipulator must then experience a sense of pleasure or exhilaration.

The author then describes each of these components in detail, from the descriptive, dynamic, and metapsychological points of view. His descriptions are interspersed with numerous clinical examples. In this connection one of the difficulties with the book is that, as the author himself indicates, relatively few people with manipulative personalities present themselves for psychoanalytic treatment. As a result, most of his clinical material is taken from experiences in psychotherapy, largely of inpatients, and much of his case material is secondhand, some of it even culled from newspaper stories and other similar sources. Inevitably this leads to broad and at times unsupported speculation and inference.

In the most interesting chapter the author attempts to distinguish three groupings of manipulative situations. 'In the first group we see the maneuvers of those people who do not ordinarily employ manipulation but who under certain social circumstances use manipulation as a strategy to achieve particular ends, as a means of attaining satisfaction and pleasure. . . . The second group contains the manipulations brought into play as a means of avoiding perceived danger and discomfort. . . . The third group of manipulative situations is distinguished from the first two groups in terms of the life style of the manipulator. . . . The patients involved in the third group manipulate for reasons that may be less obvious. Often they seem to manipulate for the sake of manipulating: this is a life style or predominant trait of their characters' (p. 153).

Bursten then goes on to discuss the psychopathology of the manipulative personality, developing the theme that these are intensely narcissistic people whose narcissism is fragile. Their lives are governed and regulated by the repeated need to repair narcissistic wounds through the mechanisms of purging the shameful introject and reunion with the narcissistically loved object. 'The manipulation itself is the primary goal of the manipulative personality and the fact that a manipulation may not work or may lead to punishment may have no more effect on his need to manipulate than the inconvenience of promptness may have on the needs of the obsessive-compulsive personality' (p. 157). Bursten finds

three areas that distinguish this subgroup from other narcissistic personalities: the degree of self-object differentiation, the mode of narcissistic repair, and the value systems. He feels the manipulative personality has a firmer sense of self and is not in much danger of losing his boundaries in object relationships. Putting something over becomes the mode of narcissistic repair, and contempt is its vehicle. By purging himself of the shameful introject, the manipulator is able to restore his sense of omnipotence and this purging, with its feeling of contempt, has strong libidinal roots in the anal phase of development. Bursten points out that lying requires a certain degree of reality testing and emphasizes that manipulative personalities are more interested in illusion and public image than they are in truth. He feels that the manipulator, like other liars, probably has less impairment of reality testing than many neurotic patients.

The book also discusses issues of treatment, both in general and specific terms, emphasizing particularly problems in the psychotherapy of hospitalized patients.

The book is written lucidly and while the heavy emphasis on the author's personal experiences makes it easily readable, at times it creates a tone of personal dogmatism. However, the book accomplishes what it sets out to do and should be of interest to all psychotherapists. It may well allow them to take a more objective, dynamic, and analytically based view of this particularly troublesome form of behavior.

PAUL A. DEWALD (ST. LOUIS)

PSYCHOANALYTIC PSYCHOLOGY. THE DEVELOPMENT OF FREUD'S THOUGHT. By Raymond E. Fancher. New York: W. W. Norton & Co., Inc., 1973. 241 pp.

To a psychoanalyst, an attempt to summarize psychoanalytic psychology by pursuing the development of Freud's thought in two hundred thirty-three pages seems either heroic or absurd. Fancher's book, however, is not meant for analysts. It is also not intended as a popularization, nor as an elementary exposition for the interested layman. Fancher says the work was undertaken in response to experiences with graduate and undergraduate students of psychology. This academic but analytically unsophisticated audience is the ob-

ject of his presentation of psychoanalytic fundamentals.

Attempts to present psychoanalysis to particular, restricted audiences seem not only appropriate but necessary at this point, and Fancher deserves the commendation of analysts for undertaking this effort. Furthermore, his book leaves no doubt that he concerned himself in his research with the original writings rather than distorted, derivative summaries.

Fancher's general attitude toward Freud's work is both sympathetic and scientific. He does maintain considerable reservations, but these do not seem to be fundamentally destructive; his book seeks to describe and explain rather than to undercut and condemn. The historical approach he takes is congenial to the subject matter. For example, he demonstrates convincingly that Freud's early theories arose from the practical necessities of dealing with the patients who came to him for treatment.

The general content of the book would probably be acceptable to the majority of analysts. Upon close scrutiny, however, there are a considerable number of errors, misemphases, and omissions. For instance, in his final chapter Fancher lists and discusses defense mechanisms, but makes no mention of repression. He also takes considerable freedom in interpreting Freud's meanings, often going well beyond what is justified, especially in his extensive review of The Project. And his organization is sometimes misleading. For example, the pleasure and reality principles are discussed under the subchapter heading, Compulsion to Repeat, while the psychoanalytic theory of drives is reviewed under the subheading, Death Instinct.

Despite these not insignificant defects, Fancher's knowledge of his audience, general acquaintance with his subject, and scientifically positive attitude make his book one which will offer a constructive contribution for serious college students seeking an introductory sampling of the conceptual aspects of psychoanalysis.

ALLAN COMPTON (TORRANCE, CALIF.)

PSYCHOANALYSIS AND THE LAW. By C. G. Schoenfeld, L.L.B., L.L.M. Springfield, Ill.: Charles C Thomas, 1973. 285 pp.

C. G. Schoenfeld is a lawyer, and his book is intended primarily, although not exclusively, for lawyers. His purpose is to show that

the knowledge of some basic psychoanalytic ideas may contribute to the solution of certain legal problems. He is careful to specify that the psychoanalytic contribution can never be more than one of several elements in a legal problem, and he is aware of the limited effect that intellectual knowledge alone can have.

The legal issues he addresses are those which seem likely to interest lawyers, such as constitutional law. For example, on the basis of substantial historical evidence, he suggests that one factor which has led to judicial review of legislative statutes is the regressive wish for parental supervision evoked by the trauma of the Civil War. Legal problems which have been of special interest to psychoanalysts, such as privileged communications, procedures governing adoption, and involuntary commitment are not discussed.

Psychoanalysts who are especially interested in the law or in the general problem of the application of psychoanalytic ideas to other fields might find it interesting to learn how this author has applied them.

SAMUEL D. LIPTON (CHICAGO)

THE NATURE AND EVOLUTION OF FEMALE SEXUALITY. By Mary Jane Sherfey, M.D. New York: Random House, 1972. 188 pp.

In 1966 Dr. Sherfey, a psychiatrist on the staff of Cornell Medical School, attempted a correlation of the work of Masters and Johnson with psychoanalysis. The article that resulted from her work was published in the Journal of the American Psychoanalytic Association.[1] This book poses the same challenges to basic psychoanalytic theory as her article, and it remains for psychoanalysis to answer some of the important questions raised by Sherfey. A reviewer can do nothing more than touch on some of her provocative conclusions and interesting speculations.

In this book, the first of a projected two-volume work entitled The Nature and Evolution of Female Sexuality, Sherfey states that she will concentrate 'on the nature, and meanings of several recent developments in biological and medical research on human sexuality . . . [touching] on the relationships between men and women and on religion and philosophy' (p. 3). Volume II will describe

[1] Sherfey, Mary Jane: *The Evolution and Nature of Female Sexuality in Relation to Psychoanalytic Theory.* J. Amer. Psa. Assn., XIV, 1966, pp. 28-128.

'the physical and cultural evolution of the sexuality of animals and humans with the focus on the female of the species' (p. 3).

Aside from the Introduction, the major portion of the book is an expanded version of her original paper. Thus, her article has been expanded into several chapters in the book, with annotations, additions, and changes. This now constitutes Chapters Two and Three: The Embryology and Nature of Bisexuality, and Clitoral Erotism and the Sexual Response Cycle in Human Females. Chapter Four, entitled Supplemental Data on Vaginal Insensitivity, also corresponds to Section Four in her paper. There is a useful primer on sexual anatomy with an extensive glossary and source section.

Sherfey's book is a valuable and scholarly piece of work with great detail given to the correlation of the physiological and psychological events in sexual relations. With much of it I agree wholeheartedly and praise the tremendous effort involved in correlating this material. However, it is necessary to refute several of her sweeping negative criticisms of psychoanalysis that are gaining popular acceptance through their very repetition in the literature.

For example, Sherfey states that in 1961 she discovered the 'inductor theory'—'the theory that mammalian male is derived from the female and not the other way around'. She comments: 'I had to bring this startling revelation to the attention of the psychoanalyst because the Freudian had always been the chief theorist of psychiatry and because the embryological fact would strike a body blow at the Freudian concepts of female sexual development, one of the few original theories of Freud that have remained unchanged since he wrote about them' (p. 14). It may come as a surprise to Sherfey that as early as 1949 psychoanalysts knew that in the human species male and female arise from a common embryonic origin with both male and female cells represented. Rado stated then: 'In the human species, the male reproductive apparatus and the female reproductive apparatus are mutually exclusive, *despite the fact that they develop from a common embryonic origin*. Hence, a human being is either a male, or a female, or due to a failure of differentiation, a sex-defective.'[2]

[2] Rado, Sandor: An Adaptational View of Sexual Behavior. In: *Psychosexual Development in Health and Disease*. Edited by P. Hoch and J. Zubin. New York: Grune & Stratton, 1949, p. 186.

In Chapter One, Psychoanalytic Theory and the Nature of the Orgasm, Sherfey states that the 'clitoral-vaginal transfer theory' has been held unchanged by analysts and psychiatrists in spite of many doubts and objections, with terrible consequences for our patients. This statement does a disservice to psychoanalysis; no psychoanalyst simply believes that vaginal orgasm by itself means 'mental health' nor its obverse. This 'dethronement' of the vagina by physiological research should not be followed by a 'coronation' of the clitoris as is done by the radical wing of the women's liberation movement and by some nonanalytic therapies. It has long been known that clitoral stimulation can lead to sexual arousal and orgasm; this is no discovery by Masters and Johnson.

The fear of penetration causes the vagina to become anesthetic at the moment of entry. Such an event is mediated through the cerebral cortex. Additional proof of this conclusion is derived not only from analytic material gathered during psychoanalytic treatment (dreams of terror or penetration), but also from the common observation that even during 'effective sexual stimulation', to use Masters and Johnson's phrase, there may be clitoral response simultaneous with vaginal anesthesia. When this double event occurs in a woman who consciously desires to be penetrated, it usually reflects an emotional incapacity to accept phallic penetration and is symptomatic of an unconscious fear. As such, it indicates difficulty in accepting the psychosexual role in the male-female relationship. It further connotes the presence of certain conscious and/or unconscious fears of damage whether to the genital itself or to a sense of personal integrity and self-esteem. Psychoanalysts believe that it is essential for the woman *herself,* aside from any consideration she may have about pleasing her mate, to overcome this fear of vaginal penetration, whether or not she can achieve orgasm by other methods.

Orgasm can be initiated from the stimulation of the clitoris or from any other bodily parts—the lips, the mouth, the mucous membrane of the anus, other membrane surfaces, or even the mind alone. Furthermore, the basic structures that actually partake in the peristaltic contractions in the pelvis are those of smooth muscles, vascular systems, and nerve cells of both male and female pelvic organs. Excitation may then spread to adjacent structures.

Powerful orgasms may in some instances involve the entire skeletal musculature. All these facts were well known to psychoanalysts, long before Masters and Johnson and women's liberation.

Therefore, one can only strongly object to Sherfey's declaration that 'Freud was wrong. Men were wrong—Women were wrong—Common sense was wrong. There is no such thing as a vaginal orgasm as heretofore conceived' (p. 17). The popular notion that it was Masters and Johnson who 'liberated' the female orgasm from the alleged strait jacket of psychoanalysis is untrue. Furthermore, the suggestion that the differentiation of vaginal and clitoral orgasms was fostered by psychiatrists for the purpose of the psychic enslavement of women is demonstrably false.

The multiplicity of orgastic response in females was common knowledge and an important part of instruction in all psychoanalytic training centers. Sandor Rado, for many years a leader among those responsible for much of the curriculum of psychoanalytic institutes in this country, clearly expressed his views in an article, nearly twenty years before publication of Masters and Johnson's 'new findings'. 'Orgasm in the male is attendant upon the production of the delivery of sperms. . . . This fact of reproductive anatomy helps to explain the clinical observation that the orgastic requirement of the sexually strong, healthy female by far exceeds that of the sexually strong, healthy male. Orgastic requirement is measured here in terms of desire, a capacity for frequency, and in particular for serial or multiple orgasm.'[3]

We can only look with alarm at one direction of new sex research at the St. Louis clinic, as reported by Sherfey. Masters has been studying and treating sexual dysfunction in 'same-sex' pairs. Sherfey reports that according to Masters '. . . male homosexuals practicing anal intercourse . . . show marked hypertrophy of the hemorrhoidal plexi, which respond to arousal with vasodilation and flow of transudate into the rectum' (p. 110). This effort to 'vaginalize' the anus in those with a sexual deviation, a product of deep intrapsychic distress, can only be deplored by medically trained psychoanalysts as a travesty of the use of 'science' to promote healthy sexual functioning.

CHARLES W. SOCARIDES (NEW YORK)

[3] Rado, Sandor, *op. cit.*, p. 166.

MYTHS TO LIVE BY. By Joseph Campbell. New York: The Viking Press, 1972. 276 pp.

This volume is composed of a series of lectures Joseph Campbell gave to 'open-eyed, open-hearted audiences' at The Cooper Union Forum between 1958 and 1971, a period that includes the publication dates of his monumental tetralogy on mythology, The Masks of God (Primitive Mythology, Oriental Mythology, Occidental Mythology, and Creative Mythology). His view of myths in that work and in these lectures is the same: myths are vital elements in man's life and they reflect his nature as well as shape it; they serve both to mobilize and to reconcile man to himself and to his environment. Campbell treats myths from the adaptive point of view and thus the title, Myths To Live By, though prosaic, is very apt.

> Now the first and most important effect of a living mythological symbol is to waken and give guidance to the energies of life. It is an energy-releasing and -directing sign, which not only 'turns you on' as they say today, but turns you on in a certain direction, making you function a certain way—which will be one conducive to your participation in the life and purposes of a functioning social group (p. 88).

Compare this with Jacob Arlow's statement:

> Through its mythology, the society tends to induce a climate favorable to the realization of appropriate identifications. Every society interprets and reinterprets its history and its heroes in keeping with this need. What makes this technique so effective is the powerful, motive force of the childhood instinctual wish through the medium of the vicarious (unconscious) gratification which comes from identification with the hero of the myth. The path is prepared for identification and subsequent character transformations in keeping with the idealized qualities of the hero.[1]

Drawing from many disciplines (the range of his erudition is truly extraordinary), Campbell shows how myths serve adaptive functions. Comparing myths across space (anthropology) and over time (history and archeology), he describes the way myths lead individuals within groups, and groups themselves, into effective economic and technological rapport with their material (geographic, climatic, ecological) environment, a rapport which enhances the

[1] Arlow, Jacob A.: *Ego Psychology and the Study of Mythology*. J. Amer. Psa. Assn., IX, 1961, p. 388.

chance of survival of both the individual and the group. According to Campbell, myths also reduce conflicts of various sorts *within* the individual, conflicts that are inevitable because of the essential biological and psychological nature of man. He cites the myths of hunting peoples which include elements that ameliorate the guilt over killing anthropomorphically viewed animals. In addition, he shows how the sexual urge is brought into harmony with prevailing value systems which constitute a basis of social order and material survival; he shows how rites and rituals, in their dramatization of collective fantasies, serve a socially cohesive function.

In this series of twelve loosely related lectures, Campbell demonstrates the influence of myths in practically every aspect of human life. Not surprisingly, there are lectures on collective activities embodying fantasy content: rites, religion, art, and philosophy (including comparisons of Occidental and Oriental versions of these phenomena and also their respective mythic treatment). However, there are also lectures on love, war and peace, schizophrenia, and even the recent landing of man on the moon.

All of these Cooper Union Forum lectures are informative and provocative, though occasionally they become chatty and mundane. Perhaps Campbell used them as a 'busman's holiday' from his arduous work on The Masks of God. In any case, there will only be discussion here of those lectures which particularly caught the interest of this reviewer. This should not lead to the impression that the other lectures are of less value, but rather that the ones discussed here are of more direct relevance to psychoanalysis.

The lecture titled Schizophrenia—The Inward Journey has as its basis the notion, currently fashionable in the popular culture, that schizophrenia and various *induced* states of regressed ego functioning are not only identical or equivalent but also possess therapeutic, or potentially therapeutic, powers. This concept is of course simplistically erroneous. And, indeed, Campbell does hedge on the issue of what exactly distinguishes an irreversible psychotic regression from an induced ego regression, say through drugs, with its subsequent 'consciousness expansion'. The distinction requires a more complex theory of psychology than the one Campbell seems to have, as well as a more extensive acquaintance with clinical data, which Campbell does not profess to have. That this pop-

ular view attracts Campbell, who usually shows a more sophisticated and even aristocratic intellectual stance, might be explained by the fact that both psychotic and induced ego regressions often contain rebirth fantasies. And in 1949 Campbell published a book[2] that showed the universal presence of the rebirth fantasy in hero-myths. In these myths the hero metaphorically 'dies and is reborn' before, and as a prelude to, his great heroic exploits. In his Cooper Union lecture, he argues that the presence of this same fantasy in pathological and nonpathological regressions demonstrates Jung's hypothesis of a biological (inherited) substratum to all psychic functioning which contains certain well-defined and stereotypic content.

It is questionable whether this phylogenetic explanation is sufficient to account for the thematic structure of hero-myths noted by Campbell. First, although rebirth fantasies are very common, it has not been demonstrated by Campbell, or anyone else, that they are 'universal'. Secondly, it is instructive to note their defensive function when they appear in other contexts. Both Freud and Reik[3] noted the presence of rebirth fantasies in the puberty rites of primitive peoples and correctly attributed to them the function of alleviating œdipal guilt in boys by denying the incestuous bond with the mother. Isidor Silbermann[4] has demonstrated the existence of these fantasies in patients undergoing electroshock therapy. Here again the issue is guilt and the wish to be reborn 'innocent'. And, in fact, these fantasies are always present in a shared context in utopian and messianic movements striving for a purely good, guiltless mankind. One might then wonder if the rebirth fantasies noted by Campbell in hero-myths serve the function of alleviating the œdipal guilt necessarily induced by hero-myths, for the heroic deeds are always ultimately the œdipal victory.

Perhaps the most valuable aspect of the lecture on schizophrenia is Campbell's simple description of the process of induced ego

[2] Campbell, Joseph: *The Hero with a Thousand Faces*. New York: Pantheon Books, 1949.

[3] Freud: *Introductory Lectures on Psycho-Analysis* (1916-1917). Standard Edition, XV/XVI; Reik, Theodor: *Ritual. Psycho-Analytic Studies*. London: The Hogarth Press and the Institute of Psycho-Analysis, 1931.

[4] Silbermann, Isidor: *The Psychical Experiences during the Shocks in Shock Therapy*. Int. J. Psa., XXI, 1940, pp. 179-200.

regressions practiced in various cultures to achieve the mitigation of psychic distress. In the Orient, Yoga achieves this through diminution of sensory stimulation, inhibition of muscular activity, and concentration of attention. The Eskimos use prolonged social isolation and starvation. Western history is replete with examples of religious 'exercises' involving intense contemplation and reappraisal of basic values and goals to achieve transcendental experiences leading to a state of grace or salvation. All of these methods were often, although not necessarily, administered and overseen by someone of authority and prestige in the local culture who had himself undergone the process. Thus each culture seems to have its own 'culturally syntonic' method of inducing supervised and psychotherapeutic ego regressions.

As provocative as his lecture on schizophrenia is, Campbell's chapter on the moon exploration, The Moon Walk—The Outward Journey, is even more so. Up to this point in the study of mythology all investigation has been focused upon the past. Now, a truly new situation is presented to man through the advance of his technology: his existence in nonterrestrial space. Campbell wonders, on the one hand, if man's mythic structures can organize this new experience in a truly vital way and, on the other hand, if this new human experience will transform man's mythic structures. He understands that he can only speculate on these questions and accordingly allows his fancy the widest range. But a wise man's fancy is always instructive; and so it is here.

Campbell has listened to the spontaneous statements of the first astronauts to reach the moon for a clue to the mythology of the future—very much in the style of the psychoanalyst's 'listening with the third ear'. He has fastened upon two comments made by the astronauts during their descent back to earth. One was a slightly facetious statement that Newton was navigating the space ship; the other was a description of the earth as being 'like an oasis in the desert of infinite space'. Campbell correctly interprets the first statement as an assertion that the mathematical concepts formulated by a man who lived centuries before led literally 'out of this world'. In the second statement, the earth becomes 'a sacred grove' for man, 'set aside for the rituals of life', 'a set-apart Blessed Place'. Extrapolating from these cues Campbell formulates an extremely optimistic view of a future mythology, a mythology

markedly mystical and Oriental in character, in which man will feel himself expand into the universe and the universe suffuse through him.

But a psychoanalyst may listen with Campbell's 'third ear', hear the same potentially mythic elements, and see the astronauts' experience, and perhaps a new mythology, in other terms. All mythologies take as their basis certain 'psychic moments' (to use Arlow's apt phrase) in the individual's development and use them as shared reference points to organize the common experience of the group. The oasis metaphor implies an experience of being away from a geographic focus which provides sustenance and support, a focus to which return is imperative under threat of loneliness and grave danger. The 'Newton' statement implies the opposite: the conquest of time and space, the exultant engagement of the world through movement. The 'psychic moment' reflected in the astronauts' experience is thus the time when bipedal locomotion is achieved by the child as he takes his first exciting and terrifying steps away from his mother. It is the radical turn Mahler has described in the separation-individuation process, the beginning of what Greenacre has called 'the love affair with the world'.

Certainly this insight into the utterances of astronauts coming back from 'outer space' pertains to those particular men in those particular circumstances. But contemplating a future when space travel will be commonplace, one may well wonder about the effects of this recurrent experience which harks back to and evokes the feelings of a crucial time in separation-individuation when narcissistic risk and magic are so important. But if one does wonder, the historical experiment is upon us now; it remains only to ascertain the effects of airplane travel upon the generation raised in the present time when this experience is very prevalent and increasingly formative.

From the standpoint of history and anthropology, Campbell's speculations are quite germane. They lead to his final lecture, No More Horizons, in which he directs his attention to a preoccupation underlying everything he writes: the universal need for 'myths to live by' and how these social-psychological mechanisms may operate in an effective manner in modern times.

Campbell's answer is as simple as it is optimistic. He sees modern technology, the population explosion on a limited planet, and the

cultural and political interpenetration of distant nations leading to one world in which all men recognize that they are participants in the same universe. Their common condition will make men see the essential sameness in their own and others' myths and the elemental foundation of *all* myths will become *the* mythology of humanity. Campbell states:

> On our planet itself all divided horizons have been shattered. We can no longer hold our loves at home and project our aggressions elsewhere; for on this spaceship Earth there is no 'elsewhere' anymore. And no mythology that continues to speak or to teach of 'elsewhere' and 'outsiders' meets the requirements of the hour.
>
> And so, to return to our opening question: What is—or what is to be—the new mythology?
>
> It is—and will forever be, as long as our human race exists—the old, everlasting perennial mythology, in its 'subjective sense', poetically renewed in terms neither of a remembered past nor of a projected future, but of now: addressed, that is to say, not to the flattery of 'peoples', but to the waking of individuals in the knowledge of themselves, not simply as egos fighting for place on the surface of this beautiful planet, but equally as centers of Mind at Large—each in his own way at one with all, and with no horizons (p. 266).

Campbell thus seeks to extend his original view of myths to live by—that is, myths as adaptive social-psychological mechanisms—by positing a human condition which transcends that of the present and the past. However, mythic solutions relate to adaptive problems of a much more immediate nature than the far-reaching ones noted by Campbell. If one looks for signs of developing trends in current mythology, one might look, on the one hand, to that surest of mythic indicators, popular culture and, on the other hand, to current attitudes toward instinctual life, especially around that most important organizer of sexual life, reproduction. Then, as Arlow pointed out, in the myths of current popular culture, at least in the United States, we would find a

> trend toward reinstitutionalization of the ego ideal, in keeping with intensified narcissistic needs, and tending toward the idealization of grandiosely conceived objects from childhood. . . . The outstanding cultural aspect of this problem is to be seen in the worship of the new demigods of the mass media of communication.[5]

[5] Arlow, *op. cit.*, p. 389.

And, from all indications, the general attitude toward reproduction in the industrialized nations (where there is no economic premium on progeny) has been one of devaluation—and, seemingly, with consequent weakening of genitality as an organizer of instinctual life. This shift in emphasis by a whole society (or groups of societies) cannot be underestimated in its ramifications. Not only will the shared fantasies of a society change but all other vital activities (the family, work, care for the aged, politics, etc.), all in mutual interaction, will change as well. It is not clear at all what the outcome will be.

Although Campbell's optimism is not warranted, his book does provoke many far-reaching speculations. For he shows in it, if not so much man's limitations, at least his wide plasticity over the course of history and through the range of the various cultures he has evolved. For anyone interested in these not so mundane matters, the book is highly recommended.

LEON BALTER (NEW YORK)

SIMILARITY IN VISUALLY PERCEIVED FORMS. By Erich Goldmeier. (Psychological Issues, Vol. VIII, No. 1, Monograph 29.) New York: International Universities Press, Inc., 1973. 135 pp.

This is the first English translation of a monograph originally published in German in 1936, which presents a series of interlocking experiments investigating the perception of similarity. Erich Goldmeier's study of the bases for 'similarity in visually perceived forms', like other gestalt investigations of cognitive and perceptual processes, is elegant in its apparent methodological simplicity and its sensitive articulation of the phenomenology of complex perceptual and cognitive processes. Goldmeier's elaboration of the concept of singularity (*Prägnanz*) in visual forms, like Duncker's and Wertheimer's formulations of functional fixedness and restructuring and Zeigarnik's investigation of the need for completion, is an insightful and penetrating analysis of cognition.

This study of the features of visual stimuli that determine similarity reveals those structures experienced as most salient in a perceptual configuration. Similarity, in a limited number of instances, can be defined in terms of the number of shared identical parts (partial identity) or the proportional relations between parts of the

stimulus (proportional identity); but the degree of similarity cannot be expressed by any particular mathematical function. Often the impression of similarity is less affected by a change in the 'form' of the figure than by a change in the 'material' of which it is composed. There is also a wide range of variations of attributes which have minimal effect on perceived similarity, and there are other attributes in which minimal change has maximal effect. These sensitive, 'phenomenologically realized', or active attributes are those with 'singular', invariant values such as regularity, horizontality, verticality, symmetry, circularity, linearity, rectangularity and parallelity. These singular values express the structural organization of the integrated, whole figure. Changes at the region of singularity lead to abrupt, qualitative changes; singular qualities determine the phenomenal appearance of a figure and perceived similarity.

Irvin Rock, in his excellent foreword to this monograph, discusses the implications of these findings for contemporary research in perception, information processing, pattern recognition, and computer simulation of cognitive processes. In terms of psychoanalytic theory and research, Goldmeier's findings suggest that perception is determined by more than the physical properties of the stimulus field and the need state of the individual. Rather, there are also established cognitive schemata or levels of organization of representation which play a major role in perception. Goldmeier's findings offer further understanding of how cognition and perception are organized as functional units and how these processes contribute to the building of the representational world. It is only with a recognition of similarity between external experience (such as between repeated experiences with the same object), or between the memory of an object and the object itself, that the representational world and object constancy can be constructed. Goldmeier's findings suggest that the experience of visual similarity and the establishment of representations may develop from an initial awareness of similarity between part properties, to an awareness of proportional relationships between various part properties, to an appreciation of the integration of the whole object along particular singular, invariant dimensions.

SIDNEY J. BLATT (NEW HAVEN)

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S. Warren Seides

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ABSTRACTS

Bulletin of the Menninger Clinic. XXXVII, 1973.

The following abstracts are from the July issue of the Bulletin, an issue honoring Dr. Karl Menninger on his eightieth birthday.

Murder (1928). Pp. 305-320.

In comparing the phenomenon of murder to a convulsion, Dr. Menninger finds similarities in that they are both symptoms of something wrong in the individual's adjustment to life. They are not diseases, but symptoms of a diseased personality and a difficult situation. The apparent difference between murder and convulsion (one is presumed to be a conscious, voluntary act and the other an involuntary, unconscious act) seems negated when one considers that the unconscious portion of the mind is so much more powerful than the conscious. Both murder and convulsion deserve psychiatric study into their various causes in every instance.

A case history of a murder as a symptom of psychological isolation is offered. The death of a young farmer's wife and baby, for which the farmer was held accountable, raised the speculation that he had been forced into an unequal and handicapped struggle with life, resulting in psychological isolation from proper contact with others. His incarceration in prison seemed a wasteful and useless punishment.

Psychiatric Commentary on Punishment (1930). Pp. 321-332.

Following five prison riots in 1929, Dr. Menninger noted the intolerable, provocative, and inadequate conditions in our prisons. He decried the out-of-date treatment of prisoners as contrary to science and decency. Reform should include the withdrawal of sentencing power from judges, to be replaced by independent sentencing boards which would consider the whole history of the offender. Punishment does not seem to deter other prisoners from committing crimes. Rather it seems only to gratify the general public. We all have repressed a guilt complex for having done forbidden things in childhood. The punishment the child receives from his parents, with its release of anger, contributes to a certain emotional pattern for reacting to offenses. The child then assumes the prerogative of punishment himself. At first this may be self-punishment. Later, through the mechanism of projection, this leads to punishment of others with corresponding severity. Society often has the need for scapegoats upon whom to vent punitive feelings, and criminals fit this role. Thus efforts to improve prisons are ignored by the public which does not want to give up this satisfaction. Capital punishment, too, gratifies the sadism and revenge feelings of many people who project their guilt upon scapegoats. Capital punishment ought to be rejected, for it deprives us of future safeguards that might be gained by learning more about homicide from the

criminals themselves. A rational penology must aim at protecting society, not at executing or punishing prisoners. What is needed is a system for segregating and detaining criminals in such a way that riots are not provoked nor parole boards expected to do miracles.

The Psychological Advantages of the Woman Physician (1936). Pp. 333-340.

If we view all sick people as trying to destroy themselves while at the same time fighting to live, then physicians in opposing self-destruction may be seen as constantly involved in miniature wars between life and death. In this struggle, women may have some constitutional advantages over men because of their better understanding of suffering and inferiority. The inferior position that women occupy in our society sharpens their perceptions of the needs of those who suffer for reasons other than sexual difference. Only one who has suffered to an unusual degree has either the interest or ability to become a psychiatrist. In this sense, all women are eligible to become psychiatrists. Rather than striving to disprove allegations of inferiority, railing at discrimination, or imitating men, women ought to exploit their advantage. Some women physicians do not recognize that unconsciously men envy them no less than they envy men. Women can make immensely valuable contributions which they are especially fitted to make as a result of the training that most little girls receive in anticipating the wants of others, in tact, consideration, and charm.

Somatic Suicide, Total and Partial (1939). Pp. 341-354.

The increased interest in psychosomatic medicine led Dr. Menninger to caution against direct cause and effect relationships in studying disease. Citing the influenza epidemics of 1918 and 1938, he points to the background of anxiety engendered by the world situation which may have contributed to the outbreak of physical illness. The very symptoms of influenza are suggestive of a suicidal fantasy—acuteness of onset, prostration, mental exhaustion, discouragement, and alarm, often followed by prompt recovery and then a long period of depression. Self-destruction and disease entities are always both psychological and physical. Freud's construct of the death instinct was one of his greatest contributions. The concept cannot be measured, quantified, or proved. Yet its operation can be observed in such clinical entities as suicide (an expression of the power of man's unconscious wish to die) and psychosomatic illness (an expression of partial suicide effected by the organs). The spectrum of self-destructiveness ranges from suicide (the most complete and irreversible form) through organic disease and hysterical disease, to such widespread and nearly normal activities as smoking. The sacrifice of an organ may be made to spare the life of the individual, and the hysterical symptom may develop to spare the life of the organ. Much of the objection to Freud's death instinct theory may be the result of repression of the observer's own self-destructive tendencies.

Some Recollections of the Birth, Infancy and Childhood of the American Orthopsychiatric Association (1963). Pp. 355-366.

In a way psychiatry in its modern sense, and also orthopsychiatry, was born in World War I. The genealogy of the Association was atypical, for it had three grandfathers: Ernest Southard, William Healy, and Dr. Menninger's own father. Southard was the first to use psychologists and social workers clinically in a diagnostic team. Healy in 1915 pointed to the need for scientific medical care of delinquent children. Dr. Menninger's father constantly encouraged him to maintain professional contacts throughout the country, thus contributing to a large organization of psychiatrists. The father of the Association was Herman Adler, who had a special genius for visualizing projects on a grand scale and was highly persuasive. He coined the name 'orthopsychiatric', a way of straightening people and getting them away from the idea that as the twig is bent, so the tree is permanently inclined. He hoped that even criminals could be treated.

The first meeting of the Association was at the home of David Levy in Chicago. He gave what he said was the first psychoanalytic paper ever read at a meeting of the Orthopsychiatric Association, a case of pseudocyesis in a ten-year-old girl. It became the stated intention of the Association to consider psychologic and social work colleagues as equal members. Among the motives for forming the Association were a wish to overcome the loneliness of psychiatry by getting together with allied disciplines and a reaction to the general spirit of therapeutic nihilism with its overemphasis on diagnosis in the 1920's.

Three Short Pieces. Pp. 375-384.

Fundamentalism and Modernism in Psychiatry (1929).

Concentration on the elaboration of a complicated nomenclature, which reached its climax in the work of Kraepelin, marked the dominance of fundamentalism in psychiatry, its characteristic being the descriptive and diagnostic attitude of the observers. Modernism in psychiatry was ushered in by World War I, with increased emphasis on therapy that followed recognition of the truth of the data concerning the unconscious. Psychiatry changed from static to dynamic concepts and was furthered by research on the childhood years and on the technique of analysis, with its application to the understanding of criminal behavior.

Psychological Factors in Cancer (1954, 1956).

It is no longer an unmentionable idea that psychology has an influence on tissue cells. Several articles are reviewed in which cancer patients were found to have undergone a high frequency of: 1, the loss of an important relationship with no satisfactory replacement; 2, death of a parent; 3, difficulty in expressing aggression.

On War (1938).

War in reality is not a romantic game. It is a highly organized business of making as many men as possible suffer or die, using in the process the most highly developed technological advances. The respectable murderers who plot these wars are simply human beings like ourselves who politely and sportingly supply arms to both sides. Yet they shudder with horror at the sight of one mangled corpse on the highway. Behind the problems of international war is the problem of interpersonal war—between man and man and especially between man and woman. It is through psychoanalytic recognition of our own destructive tendencies that a truce may be declared.

The Disappearance of Sin—An Eyewitness Account (1973). Pp. 385-400.

In regarding our present-day troubles, one misses the mention of the word 'sin', as if no one were guilty of anything that could be atoned for or repented. There seems to be a shift in the allocation of responsibility for evil. Psychoanalysts prefer to regard aggression and self-destruction as prima-facie evils rather than sin. However, sin is at heart a refusal of the love of others. By setting up rules and regulations about behavior, societies convert sins into crimes, thus rendering the designation of sin increasingly pointless from a practical standpoint. Sin began to disappear when both public and private punishment became too severe and human compassion increased. Through the centuries, the great sin of youth has been masturbation. Yet, amazingly, especially since the turn of the century, masturbation has come to be regarded as not sinful but rather as normal and healthy. Regrettably, other sins such as violence, ruthlessness, stealing, and lying have not diminished through understanding in the same mysterious way.

S. WARREN SEIDES

Journal of Nervous and Mental Disease. CLVII, 1973.

Unsolved Problems in the Use of Group Processes in Psychotherapy. Lawrence S. Kubie. Pp. 434-441.

One of those splendid 'minor papers' published shortly after Dr. Kubie's death, this paper begins and ends with the observation that 'unsolved' does not mean 'insoluble'. A significant number of vital issues about the group therapeutic process are presented which are, or should be, of as much interest to individual psychotherapists as to group therapists. Dr. Kubie posits no answers, but he makes it more difficult for us to pretend that such problems do not exist.

Issues which are of concern to psychoanalysis include the following. What kind of data can be evoked in group situations which are difficult if not impossible to obtain in the individual psychotherapy setting—and vice-versa? Is a group setting of use in inducting certain isolated patients into the process of therapy? Is there an optimal arrangement of a series of alternating individual and group psychodynamic experiences? When do groups mask and when do

they unmask material? In what manner is free association useful in group processes, or does it merely result in a useless cacophony of emotions?

Ego Function Assessment of Analytic Psychotherapy Combined with Drug Therapy. Leopold Bellak; Jack B. Chassan; Helen K. Gediman; Marvin Hurvich. Pp. 465-469.

This paper concerns the much discussed and controversial issue of whether the use of drugs in conjunction with analytic psychotherapy assists or actually hinders the psychotherapeutic process. The authors employed a carefully designed systematic assessment of twelve ego functions. At the same time diazepam (Valium) or placebo was administered in a double blind situation. Statistically significant differences favoring Valium were found in all but two of the scales: object relations and adaptive regression in the service of the ego. The authors feel they were able to differentiate the effects of the drug over and above the factors of time and psychotherapy. They are involved in seeking the optimal amount of 'anesthesia' to allow freedom from anxiety or its dread without interfering with ego functions (including signal anxiety) to the extent that motivation and change from the psychotherapy are vitiated.

HAROLD R. GALEF

Journal of Nervous and Mental Disease. CLVIII, 1974.

A Psychophysiological Study of Nightmares and Night Terrors: III. Mental Content and Recall of Stage 4 Night Terrors. Charles Fisher; Edwin Kahn; Adele Edwards; David M. Davis; Jeffrey Fine. Pp. 174-188.

Fisher and his co-workers present another in their series of studies of night terrors. A central problem in this paper, also discussed in their previous work, is the question of what triggers the onset of the attacks. The work of Broughton and of Arkin is reviewed. The former investigator felt that Stage 4 night terrors develop as part of an 'arousal response' of exaggerated physiological events and are only indirectly related to Stage 4 mental activity. Arkin and his co-workers found an appreciable degree of recall of NREM content in terrors or related phenomena. The night terror is not a dream in the ordinary sense, but rather a severe symptom arising out of Stage 4. It appears to resemble an acute, brief but reversible paranoid episode. In this study, the most frequent theme when recall occurred was fear of aggression by a person or persons. Fisher and his group found a mean of fifty-eight per cent recall of mental content from night terrors. They feel that their data argue for ongoing mental content which may be instrumental in triggering the night terror. Since night terrors may be elicited artificially by sounding a buzzer, however, it is concluded that mental activity need not be the only precipitating factor. The tentative hypothesis, therefore, includes the possibility of both exogenous and endogenous triggering factors.

HAROLD R. GALEF

Israel Annals of Psychiatry. XI, 1973.

The Significance of Psychoanalytical Methods in Historiography. H. Winnik. Pp. 288-295.

In William L. Langer's presidential address to the American Historical Association in 1957, he stated that psychoanalytic historiography was the historian's 'next assignment' and that this would bring about a 'deepening of historical understanding'. Winnik points out that when theories of incidental occurrence, rational human planning, or divine interference are rejected, interpretation by psychological methods becomes more relevant. He warns, however, against reductionist tendencies in psychological interpretation of complex events. In addition, he presents an analogy between the effects of the study of history and the effects of personal analysis: both help gain relief or greater freedom in the present by a deeper understanding of the past. He suggests that the historian should be more fully aware of his psychological involvement with the period he is studying.

Jewish Circumcision: A Birth and Initiation Rite of Passage. George Pollock. Pp. 297-300.

The author quotes Van Gennep on three major phases of each 'rite of passage': separation, transition, and incorporation. Rites of cutting (umbilical cord, foreskin, the first haircut) are generally rites of separation. But cutting off or mutilating any part of the body automatically incorporates the subject into a defined group whose members share similar ineradicable traces. Pollock speculates that certain rituals which are occasionally found in conjunction with circumcision indicate a mourning of the separation from the mother's body, which the circumcision completes symbolically in a group participation activity.

Socio-Cultural Expression and Implications of Death, Mourning and Bereavement Arising Out of the War Situation in Israel. P. Palgi. Pp. 301-329.

The fact that this article exists is in itself remarkable, since it represents a detailed account of bereavement in diverse cultural groups in Israel, apparently compiled only a month or so after the losses of the Yom Kippur War. The observations cover the widest range of cultural patterns originating from nearly half the globe. The author shows great sensitivity in understanding the special trauma death may have when the son's death precedes the father's, when the son's parents escaped the extermination camps, or when the son was the first of a poor Sephardic family to acculturate successfully.

M. DONALD COLEMAN

Psychoanalytic Review. LX, 1973.

Identity Crises in a Midsummer Nightmare: Comedy as Terror in Disguise. Melvin Goldstein. Pp. 169-204.

In Shakespeare's comedies, the characters are led through a series of obstacles to marriage. The marriage rite allows a denial of death and, through the pro-

ducing of children, an illusion of immortality. The obstacles consist mainly of identity confusions and transformations of a dreamlike, sometimes nightmarish quality. In the course of A Midsummer-Night's Dream, the characters work through the ambiguities of sexual identity, integrate their animality into more adult identity, accept reality, and proceed to the marriage rite.

Infantile Fantasies in Shakespearean Metaphor: I. The Fear of Being Smothered. Alan B. Rothenberg. Pp. 205-222.

Rothenberg quotes from Venus and Adonis, Titus Andronicus, Romeo and Juliet, Richard III, and other works to show Shakespeare's involvement with fears of being smothered and eaten by the precœdipal mother. These fears and the defenses against them are expressed in metaphors and images that disguise, distance, and soften them and thereby make them acceptable to the audience.

Baptista and His Daughters. S. C. V. Stetner. Pp. 223-237.

A common subject in Shakespeare's plays is the 'retentive father' who plods 'his dilatory way'. Love's Labour's Lost, The Tempest, Pericles, and other plays have fathers who attempt to keep their daughters. Baptista's insistence that Katharina marry before Bianca in The Taming of the Shrew masks his œdipal attachment to his daughters and his wish to keep them both to himself.

The Suicide of Young Werther. M. D. Faber. Pp. 239-276.

Werther's father had died when Werther was a boy and he had been disappointed in his hopes for intimacy with his mother. Charlotte is a mother substitute for Werther. Her marriage to Albert brings about increased ambivalence in Werther, an ambivalence further stimulated by her teasing seductiveness. Werther's suicide expresses rage, reunion fantasies, and an underlying infantile dependency on mother substitutes.

Adler, Œdipus, and the Tyranny of Weakness. Roy Huss. Pp. 277-295.

From the Adlerian viewpoint, Œdipus compensates for the organ deficiency induced when his feet were pinned together in infancy. The riddle of the Sphinx concerns feet; so do many images of climbing, hunting, and running in the play. Œdipus as paternalistic tyrant expresses masculine protest resulting from organ inferiority and fear of being revealed as a foundling.

Tragic Catharsis and the Resources of the Ego. Philip M. Withim. Pp. 498-518.

Tragedies permit the audience to reach a deeper psychological integration by providing an opportunity to identify with the world of a play in which suffering is accepted and an increased awareness of death and suffering, and often consolation, are achieved. 'The play and the characters begin in ignorance and

end in knowledge; they begin calmly, rise to fear, and conclude in consolation.' The Bacchae and Death of a Salesman are cited as illustrations of this view.

Dora Revisited. Karl K. Lewin. Pp. 519-532.

Lewin believes that a deeper analysis of Dora's problems reveals that her conflict over sexual feelings toward her father and other men was not primary, as Freud thought. Her true attachment was to her mother, who disappointed Dora by preferring Dora's brother and father. A negative introjection of the mother gave rise to Dora's intense masochism and contributed to her inability to displace her love for mother onto father.

Infantile Fantasies in Shakespearean Metaphor: II. Scopophilia and Fears of Ocular Rape and Castration. Alan B. Rothenberg. Pp. 533-556.

The author pursues his interest in Shakespeare's metaphor. In this paper, he discusses Shakespeare's imagery relating to exhibitionism, scopophilia, and the primal scene and demonstrates through many examples the transformations of the aggressive, sexual, and guilty aspects of the visual in Shakespeare.

On the Shores of Self: Samuel Beckett's 'Molloy'—Irredentism and the Creative Impulse. Gilbert J. Rose. Pp. 587-604.

The artist is seen as an irredentist: his pull toward a narcissistic fusion with the primal mother and his need for self-definition are played out in his work and in his relation to his work. 'What was one is now the artist and his work in a narcissistic interaction of rapprochement and detachment. . . .'

The 'As If' Personality and Transvestitism. Michael A. Sperber. Pp. 605-612.

A case of transvestitism is presented. The patient is seen as an 'as if' personality who, because of precœdipal disappointment with objects, is limited to imitation of them. He dresses like his mother but does not identify with her in her choice of sexual object, as a homosexual or transsexual would.

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Meeting of the New York Psychoanalytic Society

Gerald Epstein

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NOTES

With this issue of The QUARTERLY we welcome to our Editorial Board three new members: Dr. William I. Grossman of Tenafly, New Jersey; Dr. Vann Spruiell of New Orleans; and Dr. Herbert F. Waldhorn of Great Neck, New York.

We also take this opportunity to express our gratitude to three Editors who have retired from our Board: Dr. Leon J. Saul, who became one of our Editors in 1939; Dr. Karl Menninger, who joined the Editorial Board in 1943; and Dr. Brandt F. Steele, who joined us in 1960. The QUARTERLY could not be published without the invaluable help of the dedicated members of its Editorial Board on which Drs. Saul, Menninger, and Steele served for many years.

We express our thanks also to colleagues other than our Editors who graciously agreed to review papers submitted to us during the past year: Dr. Daniel S. Jaffe, Dr. Irwin Marcus, and Dr. Rebecca Z. Solomon.

During the coming year, we plan a separate section in The QUARTERLY devoted to *Clinical Vignettes* and *Brief Communications,* and we invite contributions from our readers. We are grateful to Dr. Martin A. Silverman for his help with this project.

MEETING OF THE NEW YORK PSYCHOANALYTIC SOCIETY

May 22, 1973. PSYCHOANALYTIC OBSERVATIONS ON THE LAST PAINTING AND SUICIDE OF VINCENT VAN GOGH. Marcel Heiman, M.D.

Dr. Heiman discussed the important events in the last two years of Van Gogh's life, the concatenation of which led the artist to surrender his yearning for life and to choose suicide instead. His last painting, Crows Over A Wheatfield, represents his despair and hopelessness; according to Dr. Heiman it is a pictorial suicide note. The size of the canvas and its content are interpreted in terms of maternal deprivation, aggressive breasts, portents of death, and a longing for union.

Four elements in the last period of Van Gogh's life are emphasized: the painting, *La Berceuse* (the lullaby); the 'abandoned' canvases; the last painting; and the connection between Vincent's suicide and his brother Theo's death. Dr. Heiman assumes that Mme. Roulin, 'the woman rocking the cradle', represented Van Gogh's longed-for mother and was also identified with Gauguin by bringing back the friend whom he had killed in fantasy. Hence, Mme. Roulin represents a fusion of father and mother images. The 'abandoned' canvases represent Vincent's 'children', paintings he felt had been neglected and which were deteriorating. The artist's depression, Dr. Heiman believes, was communicated in Crows Over A Wheatfield by the use of inverted perspective: attainment of a vanishing point which represents 'no life' and 'no death'. Drawing on Lewin's concepts about wide expanses and the dream screen, Dr. Heiman sees the over-all composition of this last painting as a representation of mother,

and compares the soft, inviting mother in *La Berceuse* with the attacking, aggressive mother in Crows Over A Wheatfield.

DISCUSSION: Dr. Harold Blum noted that although Vincent was psychotic for the last two years of his life, he painted fervently—a restitutive attempt to ward off continuing psychotic disintegration. He agreed that Vincent's suicide was probably triggered by the loss of Theo through marriage and death. He postulated a family romance, shared by the brothers, to account for their special relationship. Vincent was the risen older brother who had died, a man of special destiny; the brother pair represented the two Vincents and the two parents. Vincent would arise in rebirth and resurrection to reunite with his dead namesake, father, and brother.

Dr. Bernard Brodsky questioned whether Crows Over A Wheatfield was indeed Van Gogh's last painting. Statements of Hirschig cast doubt that it was; Meyer Schapiro believed it to be among Vincent's last works. Dr. Brodsky noted that crows are a 'universal' symbol of death in the West, which would support the idea that Vincent was depressed and suicidal when he painted the picture. Despite repeated psychotic intervals, his painting never diminished in quality as the work was a result of an attempt to channel the forces released by his psychosis as well as a result of an autonomous ego function operating alongside the psychosis. Some aspects of his illness were transformed into the form and content of his painting. Dr. Brodsky believes that the psychoanalytic approach has something to add to art criticism, particularly the iconographical, iconological approach exemplified in the work of Panofsky and Gombrich.

GERALD EPSTEIN

MEETING OF THE PSYCHOANALYTIC ASSOCIATION OF NEW YORK

February 26, 1973. DISTURBANCE IN SEXUAL IDENTITY BEGINNING AT EIGHTEEN MONTHS OF AGE. Eleanor Galenson, M.D. and Herman Roiphe, M.D.

The authors described an eighteen-month-old boy who had begun to show confusion in sexual identity and a peculiar fetishistic use of inanimate objects. The child's mother, who manifested strong maternal ambivalence, had discontinued breast feeding at five days. The period of his symbiotic attachment to his mother was marked by a high degree of bodily intimacy with both parents, *including being bathed with* them. This resulted in a premature emergence of genital arousal at age five months and considerable delay in the separation-individuation process. At the start of his second year, a series of traumatic events that included injury to the crucial oral area (the lip) and the beginning of his mother's new pregnancy led to a marked increase of aggression and difficulty in his developing self and object differentiation. At seventeen months, with his growing awareness of the genital difference between the sexes came overwhelming fears of genital loss, body disintegration, and object loss, and the peculiar use of a group of inanimate objects—stuffed animals. These objects

were used as infantile fetishes to bolster his wavering sense of phallic and general body integrity. His mother's increasing withdrawal from him at this time led to intense attempts to identify with her: he began to wear her clothing and hold on to her possessions. In addition, he began to bite his mother, gag himself, and wrap his legs around a stuffed bear as he fell asleep at night. He would rhythmically rub his perineal area against the bear in unmistakable erotic masturbation. This seemed to be an attempt to reproduce actively the sensation that had been aroused passively during his early physical intimacy with his parents.

When the child was two years old, a serious family loss precipitated his use of a whole cluster of inanimate objects. Increased masturbation with the bear, manual masturbation, and the use of assorted stuffed animals were followed by anal masturbation, fecal smearing, and phobias, including water, dogs, horses, and hair cuts. A brief period of psychotherapy was terminated by his parents. Follow-up at almost four years of age revealed separation anxiety that interfered with nursery school attendance. He was very concerned with genital difference, verbalized and acted out his castration anxiety, showed some regression to anal smearing, used his mother's cosmetics, and developed a ritual of exposing his nude body before a mirror as he experienced phallic erection. These severe disturbances in object relations and body image, particularly in regard to the genital area, suggest the later development of severe sexual deviation and/or a possible psychosis.

DISCUSSION: Dr. Roy Lilleskov questioned some aspects of the authors' method. First, the setting in which their observations were made exposed toddlers to a greater opportunity than usual to observe genital differences, and this was re-enforced by their being observed while observing these differences. This might have stimulated precocious genital interest. Secondly, the theoretical set of the researchers might have led them to interpret behaviors as genital that others might interpret differently. Dr. Lilleskov was more impressed by the child's separation-individuation conflict than by his castration anxiety. The 'fetishistic' use of the inanimate object seemed an attempt to deal with the fear of object loss and self-annihilation, with precocious 'castration' anxiety only a part of the general body image instability. Parental seduction combined with the fostering of dependence on the mother for tension reduction undoubtedly intensified the symbiotic relationship and interfered with the individuation process.

Dr. Jerome S. Silverman felt that the research methodology was extremely convincing as described. He was concerned, however, about the problem of avoiding the genetic fallacy: correlating later psychopathology with earlier observations of its presumed precursors. Anatomic locale does not necessarily imply zonal libidinal phasic development. The paper raised the question of whether such adultomorphic terms as fetish, perversion, or even castration anxiety can be used at such an early developmental period. Dr. Silverman wondered if the fetishistic defenses could be ascribed to sexual rediscovery and castration anxiety at seventeen months. Massive trauma over the first

year of life may have already altered the development of ego functions so that the later conflicts might be attributed to early arrest and atypical ego formation.

SIMON A. GROLNICK

The Annual Meeting of THE AMERICAN PSYCHOANALYTIC ASSOCIATION will be held at the Beverly Hilton Hotel, Los Angeles, California, April 30-May 5, 1975.

The DEVEREUX FOUNDATION has announced a new program of Pre-Doctoral Internships and Post-Doctoral Fellowships in which trainees will be offered a unique supervised professional experience in clinical psychological services with children, adolescents, and young adults who present problems of learning and personal adjustment. For further information, contact Henry Platt, Ph.D., Institute of Clinical Training, The Devereux Foundation, Devon, Pennsylvania 19333.

The next annual meeting of the INTERNATIONAL SOCIETY FOR THE COMPARATIVE STUDY OF CIVILIZATIONS will be held at the Center for International Studies, University of Pittsburgh, March 21-23, 1975. Topics of the sessions include: Analytical Problems in the Study of Civilizations; Pioneers of Civilizational Analysis (Burckhardt. Huizinga, M. Weber, Durkheim, and the Neo-Durkheimians); Islam in Civilizational Perspective; Frontiers and Conflicts of Civilization; Civilizational Encounters, East and West. Scholars are invited to submit papers on these and allied topics to Professor Benjamin Nelson, 29 Woodbine Avenue, Stony Brook, New York 11790.