The Concrete Patient, Massive Trauma, and the Psychosomatic Focus

All of the patients who have been discussed in previous chapters have had depriving and traumatic infantile environments. They have suffered varying degrees of privation and deprivation, as Winnicott (1963b) has described. Therapeutically, they pose specific and difficult problems that have to be understood in the context of structural psychopathology if therapy has any hope of achieving some degree of resolution.

The patients I am about to describe have also had very traumatic childhoods, even more traumatic than those just de-
scribed, if such comparisons are possible. Many of the patients I will discuss have been physically assaulted and sexually abused.

Clinicians are confronted with an ever-increasing number of patients, especially women, who report episodes of incest and other types of sexual abuse during childhood and adolescence. Freud (1896), at one time, believed that the cause of hysteria was seduction during early childhood, around the ages of 3 or 4. The child, usually a girl, played a passive role as she was approached by an older person, usually the father. Freud also discussed an older male child, around the age of 7, being the active seducer but later suffering from remorse and guilt feelings. He would develop an obsessive-compulsive neurosis. Freud further believed that this child had also been the passive victim of sexual abuse at an earlier age.

Later, as is well known, Freud (1905a) changed his mind and instead believed that when patients were discussing childhood sexual experiences, these were not actual experiences but fantasies, often wish-fulfillment fantasies. This did not mean that sexual trauma did not occur or did not produce neuroses; rather, he was challenging the universality of such occurrences.

Recently, Freud has been attacked for having given up his so-called seduction hypothesis. He has been criticized for believing that his patients were reporting fantasies rather than facts. Presumably, then, the cause of all emotional problems is a childhood sexual violation. This would mean that every patient who seeks psychiatric consultation or psychotherapy has been a victim of sexual abuse, which is a blatant absurdity. Nevertheless, a large number of patients claim that they have been sexually assaulted, and in numerous instances it has been possible to verify these claims. The question arises as to whether there has been such an increase in the number of patients who allege that they have been sexually mistreated, particularly in the past decade. These are often highly concretely oriented patients.

Perhaps the situation is the same as that which occurred with homosexuality. Clinicians doubt that there are more homosexuals today than a generation ago. It is believed that with a more accepting and tolerant environment, they have come out of the closet. They do not see the need to hide their sexual preference. Similarly, victims of sexual abuse, especially after hearing about other such victims, feel encouraged to reveal their traumatic backgrounds.

The situation, however, is not that simple. Many of these patients are defensive and afraid of revealing what went on in the family. As children, these patients were threatened not to discuss or admit that there had been incestuous relationships. Regardless of the tumultuous atmosphere that characterized family interactions, these traumatized patients need to maintain the familial balance, and no matter how much they are suffering, they do not want to disrupt it.

Nevertheless, many patients openly discuss their childhood or adolescent sexual experiences. I find it especially interesting to note that some patients who have been in treatment for many years recently have begun to remember instances of sexual abuse.

A middle-aged woman who had been in treatment for 15 years and who had never reported such an incident began to remember an episode with an uncle who enticed her at the age of 6 into kissing his penis. She stated "began to remember" because, at first, she was highly uncertain as to the reality of this incident. As she concentrated on the past, the memory of that experience became clearer and more distinct. She then further remembered other situations in which this same uncle had her masturbate him, an activity that lasted until she was 8 years old. Although she had been in treatment for many years, the material was especially meaningful and represented a breakthrough in the analytic process.

Therapists may wonder why it took so many years for such material to emerge. They may note that the climate is especially propitious in that more and more such incidents are being openly discussed. They may even wonder if this is a histronic reconstruction and, as Freud surmised, based more on wishful fantasy than on historical truth (Spence 1982). The fact that it represented a breakthrough would not be particularly relevant, because psychoanalysts know how powerful fantasies can be and what far-reaching and sometimes devastating effects they can have when they come to the surface.

Clinicians also know that traumatic memories can be deeply repressed. In fact, as discussed in Chapter 2, it was such an insight that led to the discovery of psychoanalysis. Consequently, some patients may have to struggle for many years before they can get in touch with such memories. The calm acceptance by the external world, rather than its shocked rejecting reaction, may encourage the uncovering process. The milieu may have been the variable that permitted what had been repressed to emerge.

The aforementioned patient is in many respects different from those whom I will soon discuss. To begin, she was psychologically minded and was able to free-associate with relative ease. Her parents were unstable people, but they provided a fairly secure and safe setting. It was not an environment in which she was bombarded by disruptive external stimuli. Her mother was able, to some extent, to provide her with a protective shield.

It was not a sufficiently secure environment, however, to protect her as much as she needed to be protected. She was raised in what she called a
noisy atmosphere but not a turbulent and highly disruptive milieu. She had a large extended family—unts, uncles, cousins, and grandparents—and in her early childhood some relative or relatives lived in her household, including the uncle she believed had "seduced" her. To some extent, she had internalized aspects of her early environment that caused her to feel constantly agitated.

SOMATIC PROCESSES AND PSYCHIC INTEGRATION

Patients who fall within the borderline spectrum are frequently agitated, and, as has been discussed, their inner disruption stems from prementational levels. Attempts at soothing often involve somatic processes, which are manifested by psychosomatic symptoms and a concrete perspective.

In Chapter 5 I discussed hypochondriasis, which can be considered to be a link between the psyche and soma. Hypochondriacal preoccupation serves as a defensive organizer. Focusing on the soma has a binding effect and maintains a type of integration and integrity.

Hypochondriacal symptoms are the manifestations of a particular type of psychic integration that involves object relationships and, at the same time, is associated with withdrawal or a partial withdrawal from the external world. As Freud (1923) stated, the ego is first and foremost a body ego, meaning that the interface of the ego and the outer world that contains the soma as the skin is the periphery facing reality. The mind is somewhere behind the soma. Hypochondriacal preoccupation and psychosomatic symptoms are located at this interface. Insofar as patients’ preoccupations are at the borderland between the internal and external world, they are directed toward both the inner and outer, representing a focus toward reality and the inside at the same time. Thus somatic fixations have the qualities of both object relations and withdrawal from object relations qualities.

As discussed in Chapter 5, both hypochondriasis and psychosomatic phenomena become means of communication, directing the ego toward the external world of object relations. As stated, these are secondary defensive functions.

Whatever degree of stabilization is achieved by somatic dysfunctions is still the outcome of psychopathology based on splitting mechanisms that may be the result of defensive regression or the lack of development of integrated and synthesized ego states. The psyche is fixed on a transitional area, the interface between the inner and outer world, and although these are somatically based object relations, these patients are, in an emotional sense, frozen. Affective exchanges are confined to reactions about somatic turmoil. Object relations revolve around a narcissistic axis. Thus the capacity to become truly involved with the external world is limited.

Focusing on the body draws attention away from the mind. These patients are concretely oriented and show no appreciation of the concept of psychic determinism. Understandably, this would make them difficult to treat in a psychoanalytic frame of reference, and in some instances, initially attempting psychoanalysis is a fruitless if not ludicrous approach.

It is as if psychopathology creates a Cartesian dualism. Rather than a smooth continuum between somatic activities and mental processes, the mind and body are split off from each other. This is another type of dissociation, which emphasizes different parts of the psychic apparatus. Ordinarily, clinicians think of the splitting of various parts of the mind, whereas with concrete and psychosomatic patients I am stressing a separation of the psyche from the soma.

To be more accurate, I am still discussing a splitting of various parts of the mind, but the parts involved include that section of the psyche that contains somatic representations. Again, clinicians have to determine whether this division of the mind is the outcome of defective development or regression. The former would be characterized by an extremely rigid, concrete orientation, whereas the latter would be found in patients who might have reached a level of integration that permits a significant degree of psychological mindedness and therefore makes them more amenable to psychoanalytic treatment. I will soon discuss this type of clinical interaction.

I believe that concreteness and dissociation of the somatic parts of the psyche from the psychologically oriented mind is often found in patients who seek and cling to biological theories of etiology of emotional disorders. These patients forcefully resist any explanations that refer to intrapsychic etiologies. For these patients, all disturbances are the outcome of somatic processes and have to be understood on a somatic basis. However, the soma is viewed as being outside the self, so they feel that the sources of their difficulties also reside in the external world. They refuse to accept an intrapsychic contribution to their problems, thereby abnegating any responsibility for the production of emotional disharmony. Many psychiatrists reinforce these patients' concreteness and dissociation by stressing biological sources and totally ignoring intrapsychic elements.

The reinforcement of a characterological defect may help alleviate symptoms, but it may also lead to a state of frustrated hopelessness. I have seen several patients who have had every drug imaginable and their conditions had only worsened. Finally, in desperation they sought psychotherapy. Unfortunately, in some instances, because of their concreteness, psychotherapy was also ineffective, but there have been other patients who were able to relate and to improve in a psychoanalytic context.
As mentioned in the Preface, psychoanalysts are not finding many patients who are psychoanalytically treatable. Furthermore, it has been stated that patients are no longer as interested in being analyzed as they had been in past decades. They want symptomatic relief but do not care to become involved in self-examination. This attitude is in keeping with their concrete orientation, which is supported by many elements of society, especially biologically oriented psychiatrists as well as other physicians. This implies that the surrounding world makes a contribution to the production of structural psychopathology, which, in turn, determines whether a patient is analyzable.

It is difficult to believe that cultural influences are etiological factors in the causation of structural defects. The converse, however, is more plausible; that is, that the population of patients within the borderline spectrum contributes to the shaping of the current milieu. Concretely oriented patients would produce segments of society that are concretely oriented. Then these segments would reinforce and justify the rigid concrete positions these patients hold. There is a reciprocal relationship between the culture and certain character configurations, which has cast shadows on the value of the psychoanalytic method.

STRUCTURAL DISCONTINUITY AND THE PSYCHOSOMATIC FOCUS

Nevertheless, in spite of the patient's concreteness and focus on somatic symptoms, it is sometimes possible to engage such a patient in a psychoanalytic relationship.

I will begin this section with a clinical example.

The patient, a middle-aged professional man, was pushed into treatment by his wife and friends as a last desperate attempt to save his life. He was severely depressed and was suffering from a life-threatening regional ileitis (Crohn's disease). At the time he entered treatment, he was unable to work and was severely debilitated. He was about 50 pounds underweight and so weak that he could hardly climb stairs. He was extremely thin and emaciated.

His therapist found that gathering information about him was a tedious task, because he was cryptic and usually gave monosyllabic answers to questions. Furthermore, he seemed to totally lack an intrapsychic focus. His attitude was concretely oriented, and he looked for the causes of his difficulties in the outside world or in somatic processes rather than considering the possibility that something inside, that is, in his mind, might be a factor in the production of his emotional and physical problems. He was typical of the group of patients I referred to in the preceding chapter.

The analyst felt discouraged about the prospects of being able to analyze or otherwise help him. In the third session, he discussed free association with him and suggested that he use the couch. He did not believe that the patient understood a word he said, but he was glad that the patient did not object to lying down on the couch. In fact, the patient seemed eager to be on the couch.

He did not free-associate; instead, he instantly fell asleep. His analyst was surprised, but he had no inclination to wake him up. He let him sleep through the entire session. At the end of the session, he awakened him and gave him his schedule for the following week. The analyst anticipated that the patient would not return, feeling that he was wasting his time, as would be in keeping with his practical and thrifty outlook. On the contrary, he was eager to get his appointments and seemed obviously pleased with his therapeutic experience.

For several months the patient said nothing except the usual amenities at the beginning and the end of the session. He slept throughout the rest of the session and found this sleep refreshing, whereas otherwise he suffered from insomnia and could not get any rest. The analyst's office was the only place he could sleep and relax without medications. Furthermore, for the first time he could remember in many years, he began to dream.

He felt better in all aspects of his life. He could now work part-time, had regained considerable strength, and his depression was lifting as he discontinued all medications. What was most remarkable was that a barium enema revealed that there was no trace whatsoever of an inflamed bowel. His regional ileitis disappeared and has not returned in over 20 years.

Gradually, the patient began to talk as he told his analyst the dreams he had while he slept in the office. Some of them were frightening in that he dreamed of monsters and other threatening figures chasing or attacking him. Nevertheless, he was proud of his new-found capacity to dream, and though the act of dreaming could be uncomfortable, he felt better because he saw himself more as a whole person. He believed it was important and helpful to perceive and experience feelings, impulses, and parts of the self that were lost to him as he was swallowed by depression, and his bowel seemed to express his inner chaos and destructiveness.

Before proceeding further with a discussion of how this patient's inner structure required precisely what the analyst provided, I wish to discuss how colleagues reacted to the presentation of this case. The analyst presented the
The patient can comfortably regress. To let this patient sleep comfortably represented the construction of such a setting. To have interfered with this regression would have been antianalytic. True, the patient was not free-associating but he was behaving autonomously in that he was doing what he apparently felt he needed to, and this was confirmed later in treatment.

The therapist was accused by his colleagues of encouraging the patient to act out by not stopping him. As we later learned, the patient was finally able to fulfill even the most rigid requirements of analysis; he was able to free-associate and developed a full-blown transference neurosis. Obviously, this would not have happened if he had run away from treatment.

Winnicott (1955) has emphasized that the treatment of borderline and psychotic patients requires management before analysis is possible. He was one of the first analysts who believed that these patients needed a support system, a holding environment, something that they lacked in infancy. The patient found a place where he could sleep without sedatives, a sleep that was restorative. He had been able to construct a safe haven, an effective holding environment. He could allow himself to be vulnerable and regress because he viewed the therapeutic setting as protective. But there was more to his early treatment than just the construction of a setting that the patient could trust.

By sleeping, he was in fact fulfilling the goals of even the most classical analyses if those goals involve making the unconscious conscious, an endeavor that Freud (1912) constantly stressed. Prior to treatment, the patient seemed to have no concept of an unconscious mind. As stated, he was concretely oriented and incapable of viewing mental phenomena from a psychological perspective. His approach was mechanistic and he could think only in terms of external sources to explain why he felt as he did. It seemed as if he were totally out of touch with his unconscious. He acted as if he operated only on the surface, as if he did not have an unconscious, and knew nothing about unconscious motivation.

Sleeping and dreaming produced profound changes in his mode of relating. His dreams indicated that he had an unconscious and that he was capable of getting in touch with it. He could now distinguish the inner world of the psyche from external reality and recognize that the sources of his pain and misery resided within himself, within his psyche. He was no longer as concrete nor as fragmented as he had been.

His previous psychic configuration has to be distinguished from splitting mechanisms, which have defensive functions. The patient was not reacting defensively. His concreteness and disjointed psyche were characteristic of his personality makeup and not a manifestation of splitting defenses. They were manifestations of faulty and traumatic development, but as such, they did not represent specific defensive reactions. Because he had faulty psychic structures, he had to construct defensive adaptations in order to be able to
relate to the vicissitudes of external reality. In a sense, he was defending himself against ego defects, rather than the splitting of the ego itself being a defense. I believe that many borderline patients who seem to be using splitting and projective defenses (Grotstein 1981, Ogden 1982) are in fact demonstrating a basic psychic configuration, as has been discussed.

This patient suffered from psychic discontinuity. He had no smooth continuum from primitive, unconscious primary-process structures to higher, reality-oriented, secondary-process ego organizations. He demonstrated a particular type of fragmentation in which various parts of the psyche were isolated from each other, islands without connecting bridges. This is still a split psyche, but the spaces between various psychic structures assume greater significance in the production of emotional disturbances than has been assigned to them. They are particularly important in the production of psychosomatic symptoms, as has been discussed and will be discussed further.

I have discussed elsewhere (Giovacchini 1979) a patient who somatically illustrated a similarly fragmented or a disjointed and discontinuous psyche.

The patient, a young adult, would suddenly and unexpectedly scream, twist his neck, and writhe as if he were experiencing intense pain. He would then continue free-associating without referring to this strange outburst. During one session he had about 20 such episodes. Some were so violent that he appeared to be having a grand mal seizure.

I finally called attention to this bizarre behavior and conjectured that, perhaps, he was warding off a blow that he was expecting from me. He indicated that he did not believe it was related to an interpersonal experience. Rather, he felt that something, a feeling or impulse, deep inside him was struggling to emerge. He referred to a Van de Graaf generator, which consists of two vertical electrodes with spheres on top. A current is sent through one of the electrodes until it reaches a certain potential, at which point a spark jumps across an empty space onto the other electrode. He also discussed a machine in a science fiction movie in which a scientist would somehow transmit raw feelings, such as anger or lust, and through the machine, they would be "refined" and elevated to the status of logical and, perhaps, abstract thoughts. On a final occasion some of the fuses within the machine are damaged, and as the scientist feeds his feelings into it, it explodes.

These are graphic descriptions of a psyche that has no intermediary links or bridges between lower and upper levels of the psychic apparatus. These bridges are similar to transformers, psychic transformers, that process and modulate raw impulses as they move upward from primary-process to secondary-process operations. It is interesting that this patient had many dreams of collapsing bridges or of bridges just hanging in empty space without shores at either end.

This so-called empty space or lacuna requires further elaboration. Is it really empty? My colleague's patient had regional ileitis, a serious somatic disorder, alongside a concrete orientation that seemed to be the outcome of a lack of communication between the id and the ego, an inner lacuna between different psychic levels. When he was able to make contact with his unconscious, he no longer had regional ileitis. In other words, when he no longer had an inner lacuna, he was free of his somatic disturbance. Is it possible that, mentally speaking, the regional ileitis was related to these empty spaces and that it represented a psychic representation of the lack of connecting bridges?

Lacunae and emptiness point to the lack of psychological content rather than to total emptiness. I have described a prementational phase, a beginning stage of emotional development (Boyer and Giovacchini 1967, 1980, Giovacchini 1986), as discussed in Chapter 3. Disturbances of this stage can be detected in later psychopathology, and the data indicate that such disturbances are accompanied by somatic disturbances. Inasmuch as the prementational phase precedes psychological representation and the formation of psychic structures, it can be thought of as the center of a psychosomatic focus. The empty spaces that characterize psychopathology are somatically organized and devoid of psychic content. They occur as fixations on the prementational phase, a phase that has undergone an incomplete or defective development on its journey to the construction of psychic systems.

This defective development leads to what might be considered a lopsided psyche. I realize I am indulging in imprecise imagery, but I find it useful in making clinical assessments. When dealing with borderline and other severely regressed patients, clinicians are often struck by the lack of an orderly, sequential emotional development and the chaos arising from a lack of cohesive inner organization. Many of these patients are uncoordinated and physically clumsy, a somatic manifestation of psychic disjointedness.

Another patient, a woman in her early thirties, depicted her psychic structure in dreams. These are representational dreams that emphasize the architecture of the mind rather than id-ego compromises symbolically expressed. The latter elements are not necessarily excluded from these dreams, but they are simply not dominant. Freud (1900) referred to Silberer's "functional dreams," which illustrated various psychic activities. The dreams I am discussing here are similar to these functional dreams, but they encompass wider expanses of the psychic apparatus and their interconnections.

This patient dreamed of a group of islands surrounded by infested waters. Some of the islands also had small swamps and cesspools full of
rotten vegetation and decaying carcasses. The patient would find herself on an island that was in the center of this archipelago but she wanted to cross over to an adjoining one. There was no way of doing this except to swim over because there were no connecting bridges. She would not get into the water because it was so virulent that it would kill her.

For example, in one dream the island was overrun with rats, and she felt cornered because she could not escape to another island. She would awaken in a state of panic. But the themes of danger, lack of connections, and feeling trapped were constant in all of her dreams.

When she had such dreams, she felt totally unable to function. She felt trapped in her house, being able to leave only for her sessions. She was in a constant near-panic state, which was not affected by medications. At times, her distress assumed paranoid-like proportions, although her feelings were not as systematized as is seen in a full-blown paranoia. She might feel that she was so loathsome that her husband might want to kill her and for a few minutes she could believe that he was actually plotting her murder, but these moments were short-lived.

She also felt that she suffered from multiple personalities, although this belief was, in some measure, stimulated by some articles she had read in a popular psychology magazine. She was referring to different mood and behavioral states that fluctuated widely during the course of the day. They did not have the organization or cohesiveness required to label them as separate personalities.

In fact, she felt severely disorganized and described herself as being scattered. She did not have the subjective experience of feeling herself as a synthesized whole. In this mental state she tended to polarize her surroundings and persons in terms of good and bad, although most of them were in the bad category.

It was interesting that she viewed her body as a bad object. The soma became the enemy as she suffered from innumerable physical difficulties. She complained of aches and pains all over her body, which often localized in certain joints that were diagnosed as being arthritically inflamed. She also had intense migrainelike headaches, and she occasionally had rashes on both forearms, which were thought to be allergic. The rash itched intensely and reminded her of a festering sore, exuding pus. It was not, but the colors in the rash made it appear as if it were. She also had severe gastrointestinal symptoms—cramps, nausea, vomiting, and diarrhea—to the extent that her internist referred her to a surgeon.

The patient's reaction to her illnesses was terror. She felt overwhelmed by her body and was afraid she was going to die. She thought of her body as being polluted and, in her fragmented way, feared that it was determined to kill her.

It was interesting to note how she had personified the soma as if it were not connected to herself. She also believed it was the source of all her difficulties and, as she put it, it was tearing her apart.

I was particularly impressed by her descriptions of festering, pus-producing sores and her polluted body. Her body might have been represented in her dreams by cesspools and polluted bodies of water. Her soma seemed to be suffering from the same putrid decay as was found in the pools and the sea surrounding the pools. The fright she felt in the dreams of falling into the sea was similar to the terror she experienced when she feared that her body was going to swallow her up. In fact, she had difficulty breathing, perhaps a bronchospasm that made her feel as if she were drowning.

The sea determined that the lands it surrounded were islands. It represented the lacunae that I have discussed and was responsible for the psyche's fragmented state. As these dreams graphically illustrate, lacunae are not empty spaces, as was represented in the space between the two spheres of the Van de Graaf generator my patient described. The patient with Crohn's disease was conceptualized as having an intermediary space between the unconscious and conscious, an area that contained a psychosomatic focus, an area of turbulent somatic activity rather than a psychic vacuum. Similarly, this patient had many spaces between the islands of her mind but they, too, were not empty. They could be conceptualized in the same way as they were with the man who slept on the couch. They might be devoid of psychic content, but they contained all sorts of virulent matter, a pictorial representation of the turbulent, disruptive somatic processes that were expressed in her numerous symptoms and illnesses. Again, we can think of these premenstrual, or better stated, nonmenstrual, states in terms of a psychosomatic focus.

It is possible that some physical disturbances that have been considered to be psychosomatic might be associated with the fragmented psychic organization I have just described. Of course, psychosomatic illnesses cannot be so simply explained; there must be many complex variables involved in such complicated processes. Nevertheless, the characterological constellations of such patients must have some relevance.

The patients I have described, those with a psychosomatic focus, do not characteristically employ splitting and projective defenses. Their general psychic status quo is that of a split or fragmented self, a basic rather than a defensive organization. Again, this is not absolute, and the patient whose dreams I described used projective defenses, as evidenced by an inclination toward paranoid thinking.

I now wish to point to another group of patients who primarily use projective and splitting defenses as a reaction to uncontrollable inner and outer trauma, which, like an earthquake, causes fissures and cavities in the
psychic apparatus. They undergo tremendous stress, which tears them apart as their basic unity is destroyed. Splitting and projection are defensively used to introduce some order into what otherwise would be the total disintegration of psychotic collapse. These defenses produce an orderly disintegration, permitting the ego to split to a certain degree but no further.

In many ways these patients resemble the patients previously discussed. They may also present disjointed psychic states with lacunae and a lack of connecting bridges. This organization, however, represents a regressed psychic state, a defense against overwhelming trauma and painful inner feelings. These patients' backgrounds and infantile worlds have been unbelievably cruel, disruptive, and sexually abusive compared with those of other groups of patients.

Many of these patients are reputed to be suffering from multiple personality disorders, indicating that there has been a highly organized splitting or dissociative reaction to the early abusive behavior. I will not discuss multiple personalities per se, because I have never seen such a patient, but I have encountered patients who have been brutally abused, and whose psychopathology revealed badly damaged egos on the verge of collapse manifested by unbearable waves of terror and acute psychic pain.

The following vignette illustrates a peculiar combination of states of inner emptiness that are experienced as extremely painful and disruptive.

The patient, now in her fifties, had spent a good portion of her adult life in mental institutions. At times she was diagnosed as schizophrenic, but most of the time her reality testing seemed intact and she did not exhibit the bizarre thinking of a thought disorder. Rather, she was extremely agitated, most of the time verging on a state of panic.

Medications might temporarily help, but she usually developed a tolerance to the new drugs that were constantly prescribed. She would be hospitalized when she was helplessly nonfunctional and could no longer sustain herself in the external world. I found it odd that after she was discharged she did not seek, nor did anyone suggest, psychotherapy. She was simply maintained on a drug regimen, which eventually led to another hospitalization. A psychiatrist, a relative of hers in another city, insisted that she contact me for psychoanalytic treatment. Though she could have violent and turbulent reactions, she could also be unusually compliant, so she arranged an appointment.

When I first saw her, she was acutely agitated. She found it difficult to sit quietly, and she would pace back and forth in a small area of my office. She would wring her hands and frequently wipe the perspiration from her brow with her handkerchief. Before we started to look into her background she asked me, in a desperate voice, for a glass of water. I had no water in the refrigerator, so I put some ice in tap water and gave her a glass. She took a short, quick sip and then dipped her handkerchief in the water and continued wiping her brow. Then she took the ice from the glass and wrapped it in the handkerchief and once more rubbed it against her brow and temples. This was not always a gentle movement. Occasionally she struck the ice against various parts of her head and face with sufficient force that it must have been painful, and, in fact, she sometimes winced after such a blow.

Her speech was as agitated as her behavior. Her flow was rapid and the tone of her voice was tremulous. She pleaded with me not to make any demands of her because she was afraid she would collapse.

During the main part of the first session she presented herself as a helpless, panic-stricken infant. In the last 10 minutes, however, there was a dramatic change in her demeanor. She became querulous and challenging. What made me think that I would be able to help her? No one had ever been able to make her feel better, not even the most powerful drugs in the world.

She then barraged me with a series of questions regarding my qualifications and experiences with difficult patients such as herself. She also had a typewritten sheet describing various situations that might occur between patient and therapist, and in each case she wanted to know how I would react. She was asking about the limits of my tolerance. Apparently my responses were moderately satisfactory in that she was willing to continue our relationship.

Her background was so horribly traumatic that it seemed unbelievable. To this day, I wonder about the balance between fact and fantasy, but in view of her vulnerability, anxiety, and rage, there must have been considerable fact interwoven with the fantasies. She reported that as far back as she could remember, around the age of 3, she was brutally beaten by both her mother and father. She also had memories, presumably dating back to age 7, of a group of people dressed in black robes standing in a circle with her in the center, bound hand and foot. The men in the group approached her one by one and stuffed her erect penises in her mouth, almost choking her to death. Then the women would beat her across the abdomen with leather thongs. When discussing this presumably satanic ritual, she screamed, cried, and convulsively sobbed. At one point she actually fell off the couch and started coughing and choking as if she were drowning.

Her infancy was described in terms of one horror after another. Between the ages of 6 and 16, she was repeatedly raped by her father and then beaten by her mother. The mother frequently participated in these sexual violations by pinning her daughter so her father could enter her
with the least exertion. She recalled many instances when her parents, on the maid's night out, would be gone for many hours, leaving her alone but chained in a dark closet. There were other occasions when she claimed that she was kept in that closet for days at a time.

During her adolescence her father drowned in a boating accident. Because he was an alcoholic it was assumed that he was drunk. Her mother is still alive, living the life of a grand dame in an expensive style. She is also an alcoholic and can be counted on sober only before lunch. Before passing out at night she tends toward violence, and the servants have to protect the furniture. This family is quite wealthy, a factor, I believe, that kept the patient from being committed.

Although the patient was practically nonfunctional, she managed to live alone in an apartment. She also had considerable musical talent and was able to practice long hours. On occasion she would make public appearances. It was hard to reconcile the image of virtuosity with the helpless, tearful panic states that characterized most of her behavior in my office or on the telephone.

During the first year of her treatment, she presented herself primarily as a terrified woman. She vehemently accused me of hating her, and of feeling that she was a vicious worm that should be stepped on and crushed. She would feel worse after each session, and frequently she would go directly home and spend the rest of the day screaming. Partly, this was because she actually felt physical pain—sharp, jabbing pains throughout her whole body and hot flashes that made her feel she was being burned alive. Even more disruptive was her mental anguish. She stressed a pervasive and invasive sense of emptiness that reduced her to a state of "agitated nothingness" and caused her to disparage herself emotionally and physically. As with the previous patient, she despised her body. Furthermore, she felt herself to be a completely worthless person who should be eliminated from this world as expeditiously as possible. She was able to project these attitudes in the transference and was frightened that I would attack her.

I had to be very careful with my interpretations. If I remained silent, she despaired because I was abandoning her and would not talk because I loathed her. If I made interpretations, she would accept them only as criticisms and attacks. For example, if I tried to correct some distortion about my feelings, then I was indicating I had no respect for her judgment and capacity to perceive. This was even true of her most negative and disruptive feelings and attitudes, which she attributed to me. I might be feeling quite cheerful and grateful to her because I believed I had learned something from her that was clinically useful. Then, she might misperceive

my mental state and insist that I could not stand her presence and wanted to kill her. Calmly, I would point out that since she perceived the entire world as blatantly destructive, it was not surprising that I, as part of the world, be experienced in the same fashion. She immediately took what I said to mean that she was so stupid that she could not distinguish her feelings from her perceptions. I had no faith in her judgments and evaluations; therefore, I loathed her.

Eventually I became aware of feeling some irritation. Everything I tried to do was, from her viewpoint, an attack, whereas I was trying to be helpful. I could understand her lack of trust and her anticipation that she was the target of external destructive forces, but her accusations were beginning to wear me down. I felt there was nothing I could do for her that would not be misconstrued as an attack.

I finally decided that I would try to interpret on another plane than that which focuses on projections of internal reactions to the infantile milieu. I wanted to go one step beyond her feelings, because I was not able to get her to accept their transference significance. She believed they were realistically based, and this could be viewed as a transference psychosis. As gently as I could, I pointed out that she had difficulties in availing herself of potentially helpful experiences. Before I could go on, she barked that I saw her as defective. Although she thought this was true, she felt I was being sadistically cruel in shamelessly confronting her with her senseless handicaps.

Inasmuch as everything I said or any experiences she had were viewed as an attack, her orientation was paranoid, and clinicians know how futile it is to directly confront paranoid patients. The traditional paranoid splits internal objects into good and bad and then projects the bad objects into the external world, which is then filled with persecutors.

My patient's paranoid phenomenology did not have the fixed delusional rigidity of paranoid characters or paranoid schizophrenia. Her infantile world was in fact persecuting and assaulting, and she has incorporated these experiences as hostile introjects. Her view of the world, however, was less based on projections and more determined by generalizing the infantile environment, to include the current setting, a process I call externalization (see Chapter 4). In other words, she viewed reality as an extension of her early environment. Actually, up until puberty, there was little to distinguish infancy from adolescence, presumably because her parents continued to attack her. Thus it was understandable that she would generalize these experiences to practically all contemporary interactions, leading to a paranoid stance. However, the impact of the external world was the predominant
factor in shaping her attitudes, rather than internal forces distorting her view of the world. There were such distortions, but they received tremendous support from repeated traumas.

Borderline patients have suffered assaultive traumas and abuse; and to understand the manifestations of psychopathology it is useful to assess to what degree the impingement of reality contributes to distortions created by hateful introjects. There is a reciprocal interaction, an interplay, between internal and external forces. Insomuch as external forces dominate, the psyche is more severely disturbed in terms of structural defects and fragmentation. This can be stated as the obvious sequence: the greater the trauma, the greater the damage.

What was most striking was her sharply contrasting moods. To repeat, she could be submissive, compliant, and almost totally self-obliterating. On the other hand, she could be contemptuous, mandatory, to some degree even arrogant, to the extent that I felt controlled and immobilized. Apparently she had succeeded in projecting her helplessness into me. In any case, there seemed to be little connection between these two states, and for a long time I found them unpredictable.

After 3 years of treatment, she admitted that I was really trying to help her, but because of her vulnerability and lack of trust, she could not accept whatever I had to offer. She recognized, with my help, that she was operating within the context of a vicious circle. Consequently, she had organized her life around a core of anger, and behaviorally she was overwhelmed by the manifestations of splitting mechanisms.

Affects have a binding function (Giovacchini 1975a, 1990), as discussed in Chapter 2. Anger in particular gives structure to internal chaos that is the outcome of an amorphous ego organization. This patient's early life was filled with violence, and her chief adaptive modalities were infused with anger. She could, to some measure, soothe herself by being angry, in that such an ego state helped overcome her feelings of extreme vulnerability. It also helped fill a feeling of miserable emptiness.

To attack was better than being attacked, and this was finally realized as it occurred in our sessions. In fact, this was the first observation or interpretation that she was able to accept. As described earlier, she would often begin her sessions in a whimpering fashion, emphasizing her helplessness and weakness, and then, toward the end of the session, she would abruptly change and viciously attack me for being useless, unempathic, and sadistic. This sequence was pointed out to her, and, uncharacteristically, she elaborated that anger was a pacifier and also furnished her with a protective robe.

This is an example of an interpretation that has a minimal threatening potential. It refers to a general movement in the analysis, a description at the phenomenological level of macroscopic aspects of the patient’s behavior. As such, it is a nonintrusive comment and therefore difficult to view as assaultive. Of course, paranoid patients can view any phenomenon or statement as an attack, but it is much more difficult to do so when interpretations do not make reference to feelings, defenses, or parts of the self. It was not giving meaning to behavior either; rather, it was simply a description of certain shifts of ego stances such as shifting from a passive to an assertive attitude (see Chapter 12).

She again emphasized that she was struggling against painful emptiness, and when anger failed she felt as if she were falling apart. This is where splitting mechanisms entered the picture, something that happened fairly frequently at the beginning of treatment.

Her ability to proceed from passive vulnerability to active counterattacks was evidence of some ego strength. By being angry she was protecting herself as well as filling a painful inner void. Over the next several years she learned that she did not have to murderously retaliate to survive the dangers of the traumatic external world of the past, which at times was represented by the analytic setting. Being active and aggressive became equilibratory experiences.

In the past, anger had become involved in a self-destructive cycle, a vicious circle. She began this cycle by contemptuously depreciating practically everybody. For example, in the transference she used me as a target, but first she would go into endless detail how corrupt, stupid, and insensitive were various analysts she had met socially. If a psychiatrist became involved in a scandal that made the newspapers, she would cut it out and gleefully show it to me. She had a sizable collection of such clippings.

Although such revelations made her feel momentarily triumphant, they eventually caused her to become even more depressed and miserable because she felt desperately isolated and her painful inner emptiness intensified. As a consequence, her anger would increase because of the rejecting, corrupt surrounding world, and, in turn, she would react with further feelings of helplessness and emptiness, the final outcome being painful splitting experiences.

In conclusion, instead of being protective and adaptive, anger had been one of several factors that prevented her from receiving and internalizing potentially helpful experiences such as the therapeutic interaction. This maintained fragmentation and discontinuity and led to an intensification of her feelings of emptiness.
EMPTINESS, PSYCHOSOMATIC RESOLUTION, 
AND FRAGMENTATION

I have emphasized how spaces within the psyche devoid of psychological 
content—psychic lacunae, as I have called them—often become the locus of 
somatic disruption, a psychosomatic focus. The patient I have just discussed 
stressed how painful such emptiness could be, often causing her to feel that, 
psychically speaking, she was disintegrating.

My patient, both in the consultation room and in her apartment, 
usually in the evening, would feel "as if she were falling apart." At times she 
had the experience of feeling outside herself, an intense feeling of depersonal-
ization. Simultaneously she felt dead, but this in no way deadened her pain. 
On the contrary, she would moan and scream. When I witnessed several such 
episodes, both in my office and on the telephone, I was struck by the 
bizarreness and animal-like nature of her crying, moaning, and grunting. At 
first, I also found these episodes distressing because I surmised that she was 
going through a disruptive splitting experience in which she was losing what 
little psychic unity she had. Later, I learned that there were other meanings 
and purposes to this behavior.

After 4 years of treatment, she admitted that when I was with her, either 
at the office or on the telephone, she usually felt better after such outbursts, 
provided I did not interrupt them. I was prepared for this disclosure because 
of other patients I had encountered and whom I described in Chapter 5. 
These were, as discussed, attempts to achieve integration.

During these quests for cohesion, these patients are able to form 
connecting bridges between various parts of their psyche as they reintegrate 
lost and split-off parts of the self.

A fragmented psyche can be viewed as a loose organization with many 
empty spaces between various parts of the self. Again, we are faced with 
lacunae and a lack of psychic continuity. The latter can be associated with 
psychosomatic symptoms and the feeling of painful emptiness. To fill up this 
emptiness can be a painful experience, as discussed in Chapter 5.

The therapy of patients suffering from psychosomatic symptoms can 
have painful moments, not only when the patient is undergoing states of ego 
disintegration. They can also occur when the patient is attempting to 
reintegrate lost, traumatized parts of the self in order to achieve psychic 
cohesion, as discussed in the previous chapter, but here I am referring to 
episodes when the patient is not particularly regressed. This striving for 
unification, that is, to no longer be fragmented, has a significant influence on 
the course and persistence of psychosomatic symptoms.

McDougall (1989) has wondered about unexplainable changes that are 
related to the appearance or disappearance of psychosomatic symptoms.

Patients in psychoanalytic treatment sometimes become asymptomatic for no 
apparent reason. The patient who had regional ileitis is an example of a 
dramatic remission of a potentially life-threatening disease. His improvement 
could be correlated with increased psychic cohesion from a discontinuous 
state in which there was little connection between the unconscious and 
conscious, a severe type of fragmentation. In other patients it is difficult to 
understand what has happened within the psyche to explain why psychoso-
matic symptoms have disappeared.

A 23-year-old single male first saw me in the spring. When discussing 
the schedule he alerted me that he would have to be gone for a month 
toward the end of summer. He had such severe allergies that he had to 
leave the city to seek a ragweed-free environment in the Southwest. Besides 
his hay fever told him about many symptoms and character traits that 
indicated he was a schizoid personality as described in Chapter 4. For the 
most part he felt alienated and he withdrew from the external world.

He was, at times, concretely oriented, but there were many sessions in 
which he demonstrated keen intuition and a capacity for insight. He 
related that he had many different facets to his personality that operated 
independently of each other. Like the other patients described in this 
chapter, this patient was psychically fragmented and his behavior was 
determined by the discontinuous aspects of his character structure, but he 
was not particularly disconnected from his unconscious, as occurs in many 
concretely oriented patients. Nevertheless, he did not feel as if he were a 
well-put-together, whole person. He felt isolated and complained about 
loneliness and the lack of emotionally meaningful relationships.

He often felt hopeless because he believed that he did not fit in the 
current milieu. He did not believe he had the social skills required to move 
comfortably in the surrounding world, and he despaired of ever learning 
them because of being psychically damaged. He also believed that he was 
physically unattractive and no amount of therapy could change that.

Actually he was a rather plain-looking person, short and with a 
somewhat stooped posture. He was not particularly appealing but he was 
not at all as ugly as he claimed. It was true, however, that it was unlikely 
that anyone would spontaneously reach out to him.

Nevertheless, as the months went by I found him less lugubrious and 
more open. At first he would hardly talk, and I felt myself struggling to 
keep the therapeutic dialogue flowing. By the end of the second year of 
analysis, he spoke quite freely and was quite engaging. As I found myself 
becoming immersed in his material I realized that he had never taken a 
leave at the end of the summer, as he had announced during our first 
session.
I wondered about his hay fever, so I asked him why he did not leave for the Southwest at the end of two summers. He replied that since he began analysis, he no longer had hay fever, an allergy that he had had for over 10 years. Racking my memory, I was not able to point to any psychodynamic shifts that had occurred between the spring and summer of the first year of therapy. I attributed this partly to the length of time that had elapsed between the disappearance of his allergic symptoms and my awareness of his improvement.

I was both disconsolate and amused because the analyst is often the last person to learn about the patient’s improvement. I should have asked him why he was not leaving for the Southwest that first summer. It simply had not occurred to me. Still, he did not volunteer anything and it would seem that being rid of such a chronic and unpleasant condition as hay fever might have been worthy of comment. When I confronted him with his noncommunicativeness, he had nothing to say. He did not find it unusual that he had not commented about the disappearance of his somatic symptoms. In fact, he did not think much about it himself. I regretted that I had lost the opportunity to study this interesting turn of events about a psychosomatic phenomenon. I felt that 2 years later the material was too stale to allow reaching any meaningful conclusions.

The analysis continued for 6 more years, and he had no further somatic symptoms. He had made significant improvements. Vocationally, he had discovered that his mind was capable of a keen understanding of computer concepts, and various companies eagerly sought his services. Apparently he was considered somewhat of a genius in this area. He also started a relationship with a former beauty queen and eventually married her. What was most striking was that he was low-keyed about his accomplishments. In fact, he did not even consider them to be accomplishments. This was striking in view of his attitudes and insecurities at the beginning of treatment when he viewed himself as inadequate and so ugly that no woman would want to have anything to do with him, especially a beauty queen. Now he saw nothing unusual in his marrying such a comely person or in that he was a very special person in the world of computers.

I do not believe it is relevant to discuss what occurred in the analytic interaction. I simply want to call attention to certain character configurations that might have been associated with his recovery from hay fever and which might be considered unexplainable if we remained in a psychodynamic context. In any case, because of the passage of time, it is not possible to reconstruct the unconscious currents that might have been involved with somatic processes that reestablished the integrity of the immune system.

What was most impressive about this patient was his low-keyed reaction to fundamental changes and improvements in areas that had previously been highly disturbing. He had dreaded the onset of the ragweed season, and he bitterly lamented his inability to have a heterosexual relationship because he was so unattractive that no woman would have anything to do with him.

Furthermore, other than possessing a basic core of inadequacy he had felt as if he had no identity sense. He had a dream early in treatment where he was flying over different European countries, beginning with the one from which his parents had emigrated. He left his head there, letting it parachute to earth. He left his arms, legs, and body in other countries. In conjunction with this dream, he stressed how scattered and disjointed he felt.

His orientation had reached a degree of concreteness that made me wonder, at times, whether he was psychotic. He described a fragmented psychic state but he believed that what he lacked was certain hormones and anatomical structures that would bind him together. He was literally attributing his sense of fragmentation to somatic defects, which he insisted were due to a poor genetic endowment.

He also viewed his hay fever as the consequence of a lack of unity and as a manifestation of the disjointed functioning of the respiratory system, which he believed was operating independently of the other elements of the breathing apparatus. Inasmuch as the nasal mucosa and other sites involved in hay fever were not under the control of the respiratory system, these regions would, according to the patient, “go on a spree,” that is, react in a wild, uninhibited manner manifested by the symptoms of hay fever. A fragmented part of the self or soma would not be subjected to regulatory and modulatory influences that are characteristic of a state of cohesion and unity.

When he first started treatment, everything was considered a calamity. In spite of being withdrawn, he was constantly agitated. He was tense and anxious and would cause others to withdraw from him because they found themselves absorbing his disruption (see Chapter 3). I recall that at the beginning I was not exactly at ease during his sessions. I did not look forward to them and was sometimes relieved when he occasionally canceled a session. Undoubtedly, I had absorbed some of his agitation.

As so often happens under these circumstances, the patient begins to feel somewhat soothed. After several months he was no longer as intense as he had been. In retrospect, I now believe that he was gradually beginning to achieve some degree of cohesion, that he was no longer as fragmented, and that he was not as agitated or hyperactive. He had achieved a modicum of calmness. He still had a long way to go, as attested to by his many years of analysis, but he may have achieved a sufficient amount of unity that was reflected in the soma.

If we view the soma in the same way we conceptualize the psyche, we may again think in terms of cohesion and fragmentation. As the patient
described, his upper respiratory apparatus was not in synchrony with other somatic processes, and the hay fever represented a disruption of a somatic homeostatic balance. To paraphrase Freud (1930), there was a split from the main somatic currents. Relatively quickly, that is, before much unity occurred in the psyche, there was a comparatively early readjustment and cohesion at the somatic level. I suspect that at the first hay fever season the patient was feeling fairly comfortable during his sessions, because to some extent the therapeutic setting had established a holding environment.

I have given many clinical examples of fragmentation in this and the preceding chapter. As I have generally emphasized, faulty psychic structure is characteristic of concretely oriented patients and others who belong to the borderline spectrum. The patient just presented differs markedly from others I have described in that he did not experience painfully regressed episodes as he was trying to establish some degree of psychic and somatic integration. Quite to the contrary, his symptoms quietly disappeared, whereas other patients were loud and bombastic as they painfully struggled to bring lost parts of the self back into the main psychic current or to gain some relief from disruptive somatic disturbances.

I believe that in some measure these contrasting phenomena can be ascribed to different infantile backgrounds. This patient was, for the most part, neglected by his caregivers. His mother was a frail, depressed woman who was anxious when trying to nurture her son. The father left the house when the patient was 3 years old, so he hardly knew him as a child. As an adult he occasionally sees his father and views him as a passive, ineffectual person.

His infantile environment was characterized by what I have called errors of omission, as contrasted with errors of commission (Giovacchini 1979a). The former refers to neglectful, incompetent caregivers, whereas the latter corresponds to an assaultive, violent atmosphere that characterizes the childhood of fragmented patients I have described who were massively traumatized. Obviously, when dealing with clinical phenomena, clinicians cannot make hard and fast distinctions. There is usually considerable overlapping, but there are clinical examples that will emphasize one element of their background, particularly massive trauma. The patient I have just discussed stressed the incompetence and frailty of his background and downplayed assaultive intrusions. He described periods of understimulation and abandonment rather than disruptive impingements from the external world. He described a low-keyed setting rather than an atmosphere of uncontrollable and dangerous violence.

I believe that these qualities of the infantile milieu are responsible for how patients react differently to both regressed episodes and attempts to achieve psychic and somatic integration. The patients hitherto described emphasize how painful it was to re-integrate lost, trauma-encapsulating parts of the self, whereas this patient experienced a quiet internal rearrangement and synthesis as he was freed from a psychosomatic disability.

There are significant differences in the character structure and types of fragmentations that characterize these two types of patients. Whatever the psychic structure of massively traumatized patients, the early assaultive environment battered away and undermined the basic foundations of the mental apparatus. These patients had to construct splitting defenses, no matter how fragmented their personality may already have been, in order to survive. The patient suffering from hay fever did not have such horrible and violent experiences. He was, as was also true of his mother, fragilely put together. There was a general lack of cohesiveness, not as a response to repeated assaults but as the consequence of a generally depleting environment, one that failed to meet his basic needs. In retrospect, it would not be surprising that he would gain some unity and synthesis when he was able to react to the holding-environment aspects of the analytic relationship.

Clinical explorations reveal that there are different types of splitting mechanisms. Kohut (1971) wrote about horizontal and vertical splitting, obviously a spatial or geometric distinction. A closer look reveals that horizontal splitting is simply a rephrasing of the familiar process of repression, which basically is not a dissociative phenomenon associated with a fragmented psyche. Vertical splitting refers to ordinary fragmenting processes. The geometric perspective, as emphasized by such adjectives as horizontal and vertical, adds nothing to our clinical understanding of emotional development and psychopathology. In fact, these formulations give the false impression that they explain different types of dissociative phenomena just by drawing lines through the psychic apparatus.

Freud (1923) drew a horizontal line, although it was slightly slanted, through his model of the mind to indicate the repressive barrier. This was merely a graphic depiction and was not meant to be taken literally. It also emphasized a dynamic interaction between different parts of the psyche, primarily the id and the ego, and did not indicate that there is any disturbance of the unity of the mind when repressive defenses are active. According to Freud (1926), the aim of all defenses is to achieve repression in order to maintain cohesiveness. The only exception is splitting itself, which is designed to prevent further fragmentation.

I have stressed that lack of psychic unity can be the outcome of faulty development or a defensive, as well as a disintegrative, reaction against massive trauma. There is a reciprocal relationship between these two states in that the less organized the psyche is, the more it will fragment when traumatized, as might be expected. These distinctions are important for the understanding of psychopathology and the problems therapists have to face when treating these patients.