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A Comparison of the Symbolic Function in Delicate Self-Mutilators with Joyce Mcdougall's Conceptualization of the Symbolic Function in Psychosomatic Illness and Sexual Perversion

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A COMPARISON OF THE SYMBOLIC FUNCTION IN DELICATE SELF-MUTILATORS WITH JOYCE McDOUGALL'S CONCEPTUALIZATION OF THE SYMBOLIC FUNCTION IN PSYCHOSOMATIC ILLNESS AND SEXUAL PERVERSION

by

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Abstract

A COMPARISON OF THE SYMBOLIC FUNCTION IN DELICATE SELF-MUTILATORS WITH JOYCE McDOUGALL'S CONCEPTUALIZATION OF THE SYMBOLIC FUNCTION IN PSYCHOSOMATIC ILLNESS AND SEXUAL PERVERSION

by

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Advisor: Professor I.H.Paul

The syndrome of delicate self-mutilation is reviewed with emphasis on the psychoanalytic interpretations that have been offered to explain this behavior. These interpretations generally find a symbolic meaning in this symptom, while also noting the pre-verbal level of development that is a marked aspect of these patient's functioning. The alternate hypothesis is offered that delicate self-mutilators suffer from a deficit in their capacity to create symbolic symptoms.

The work of Joyce McDougal with patients manifesting

sexual perversions and psychosomatic symptomology is reviewed. She hypothesizes that these patients suffer a deficit in their capacity for symbolic functioning, and she coins the notion of the "action symptom", which is a 'sign' rather than a 'symbol', to explain this deficit.

The 'sign' and the 'symbol' are distinguished with respect to both psychoanalysis and philosophy.

McDougal's notion of the action symptom is then related to the differing functions of the 'sign' and the 'symbol'.

Finally, the population of delicate self-mutilators is compared to the population described by McDougal with respect to their capacity to create symbolic symptoms. The considerable similarity between these populations is found to warrant consideration of the hypothesis offered in this dissertation.

CHAPTER I

INTRODUCTION

Delicate self-mutilators

There exists a group of patients who mutilate themselves 'delicately': that is, their act is not life threatening nor is it intended to be. This 'delicate self mutilation' takes the form of delicate, rather than coarse, slashes of the wrist, arm or body which usually require minimal medical treatment. In the psychoanalytic literature, this act is seen as one which functions to restore a sense of self from a state of depersonalization brought on by the experience of loss. It appears that there is an element in the act of cutting one's self, of seeing and feeling the flow of blood from within, of eliciting and/or manipulating the attention of others, which leads to a communing in some unusual way with one's self, and is restorative.

This dissertation will attempt to add to this existing literature a perspective which has not yet been applied to this population: the theoretical conceptualizations of of Joyce McDougall. This dissertation will extend McDougall's theoretical conclusions, based on her work with sexual perversion and psychosomatic personality, by applying them to delicate self-mutilators. The focus for applying

McDougall's work to this population will be her conception of deficits in symbolic functioning rooted in pre-verbal trauma and noted in her patients. It is hoped that the application of this conceptualization will both enhance the understanding of this particular population while, at the same time, it will provide one way of categorizing self-mutilators not dependent upon behavior but upon developmental level of symbolic functioning.

Hypothesis

The hypothesis I wish to explore in some detail in this dissertation is that delicate self-mutilators can be meaningfully conceptualized as suffering from deficits in their capacity for symbolic functioning. While this point has been made before (Doctors, 1979), it has not been a primary focus of attention. What I wish to specifically explore is the following conceptualization: Because delicate self-mutilators suffer from deficits in their capacity for symbolic functioning, they are deficient in the capacity for unconscious symptom formation. Delicate self-mutilation is thus an act which takes on the function of an unconscious symbolic symptom in relieving psychic tension.

Background for hypothesis

Briefly, for the moment, what I am asserting is this: The hallmark of the neurotic symptom is that it carries meaning, is a metaphor, is symbolic of a repressed in-

stinctual striving. The symptom is a transformation; it is the "return of the repressed" in a transformed state which, in its new form, is not recognized by the ego as the original repressed instinct. With this "return", some diminished form of satisfaction (of the repressed instinct) may be experienced. Thus, the secondary "after pressure" of the primary repression is relieved.

In psychoanalysis the "visissitudes" of instinctual transformations have been carefully studied from the standpoint of psychopathology. From psychopathological states one is often able to infer normalcy. However, while transformations of instinctual strivings have been followed serially, from the unconscious instinct to its eventual derivative in consciousness, the actual process of transformation: the function of symbolizing, has been an a priori assumption of psychoanalysis. It has remained something of the 'black box' of psychoanalytic theory.

A general aim of this dissertation, then, will be to attempt to examine the contents of this 'black box' by using the symbolic function as a more central focus from which to view psychopathology. Joyce McDougall has examined two forms of psychopathology, sexual perversion and psychosomatic symptomology, with this idea as an important aspect of her conceptualization. I will apply her conceptualizations to another population: delicate self-mutilators. My

intention is to show that McDougall's ideas concerning the symbolic function can be meaningfully applied to this population.

Introduction to The Symbolic Function

Before continuing further I should like to make a few introductory remarks on the notion of both 'symbols' and the 'symbolic function'. (This subject will be covered in detail in Chapter V.) In the widest sense of the meaning of a symbol,

> ...the subject is seen to comprise almost the whole development of civilisation. For what is this [civilisation] other than a never-ending series of evolutionary substitutions, a ceaseless replacement of one idea, interest, capacity, or tendency by another? (Jones, 1919; p.87).

It is this idea of "substitution" and "replacement" that captures the major function of the symbol. For example, the English vocalization "chair" functions to substitute for the thing which is a chair in linguistic communication. The word 'chair' replaces the need to have the thing 'chair' present in order to communicate the idea of it. More subtly, words may function to enrich meaning by evoking more subjective, or emotional, experience. These uses are found in metaphor, simile, conotation, etc. These add shadings of subjective experience to the basic, objective denotative meaning of words. An example of this use of words would be

the phrase "sea of troubles", which adds uniquely individual associations to "sea" (deep; stormy; limitless; etc.) to the idea of "troubles". It can be seen, then, that symbols function in a variety of capacities; there are levels of symbolic activity, from basic substitutions of one thing for another to the figures of speech which enrich linguistic communication to the creative acts of the artist.

In psychoanalysis the symbol has a narrower and more technical definition. According to Jones (1919) the "true" symbol is the unconscious product of repression. From this perspective, only what has been repressed may be called a symbol. Thus any conscious use of symbols, as noted above, may not be called a "true" symbol. Although Jones' definition has been critisized as being too restrictive (Rycroft, 1956; Kubie, 1953), it will serve as a good starting place for the moment. In Chapter V I will examine the notion of the symbol in greater detail.

I shall organize what follows in this way: I will first present two early case studies which describe different forms of self-mutilation: delicate and course. The differing ways each form is conceptualized will be helpful to begin making distinctions about how self-mutilation may, or may not, be symbolic. Next, I will review the psychoanalytic literature on delicate self-mutilation. My focus will

be first on the common characteristics of patients who delicately self-mutilate which justify calling it a syndrome. Next, I will focus upon the psychoanalytic interpretations which have been offered to explain this behavior. Following this, I will then present the work of Joyce McDougall which relates to deficits in the symbolic function she has found in patients with psychosomatic illness and sexual perversions. Finally, I will apply the concepts put forth by McDougall concerning psychosomatic illness and sexual perversion to the population of delicate self-mutilators.

CHAPTER II

TWO CONTRASTING CONCEPTIONS OF SELF-MUTILATION

Introduction

Before reviewing the literature on delicate self-mutilation and in order to acquaint the reader with two contrasting conceptions of self-mutilation which will be central to my hypothesis, I will first present two early papers on the subject. The first, The Case of Miss A, (Emerson, 1913) will introduce an important diagnostic issue concerning delicate self-mutilators. The second, a comprehensive article by Karl Menninger (1935), will put forth a clearly stated conception of the symbolic meaning of the act of coarse self-mutilation. The difference in these two conceptions will be seen to be consonant with the fact that coarse and delicate self-mutilators are indeed different populations.

The Case of Miss A

The first reported case of self-mutilation in the literature, The Case of Miss A, (Emerson,1913) is a psychoanalytic study of a 23 year woman who presented with "twenty-eight or thirty" self-inflicted cuts on her left arm, breast and right calf. There was no question of suicidal intent in these injuries; rather, the cutting was a means of gaining relief from headaches, and from a "queer feeling" which she could not describe.

Miss A's father was a "cruel man" who thrashed his sons unmercifully, often stripping and tying them to a bedpost. Miss A lived in terror of him, although she was not thrashed herself. What she feared most was being stripped. Because of this fear, an uncle was able to blackmail her into allowing him to "do as he liked" with the promise not to reveal to the patient's father an infraction of hers that would have angered him. Thus, the patient was masturbated daily by this uncle for "five or six" years until the age of fourteen.

The patient's menses began at the age of thirteen, and were irregular. She was told by friends that this could be the cause of consumption or insanity. She believed this because she was having severe headaches and she attributed them to her irregular menses.

The first incident of self-cutting occurred when Miss A. was about twenty years of age. While she was cutting bread a cousin attempted a sexual assault. The patient scuffled with her assailant and was cut. Two results of this immediately followed: the cousin left her alone; a headache which the patient had had, disappeared. After this incident the patient continued deliberately cutting, as stated earlier, as a means of relieving her headaches and her "queer feeling". Although the cutting offered her relief, her attitude about it was ambivalent. In her own words,

> Then another time I had another crazy headache. I had tried hard to control myself...but I had a fight at home, my mother was nagging me....I cut myself with a safety razor-blade four times before it brought any relief (p.47).

Emerson comments on the difficulty of diagnosis in this case. He maintains that it is "doubtful" that this case could be called one of hysteria because of the lack of repression. The patient was clearly able to remember her childhood psycho-sexual traumas. However, similar to hysteria, according to Emerson, the patient was unable to bear mental distress. Emerson distinguishes between Miss A.'s ability to bear mental and physical pain.

> The patient was not afraid of [physical] pain, but she was unable to bear mental anguish. To a certain extent she chose [physical] pain (p.49)

Again in the patient's own words:

> The next time I was with Y- and he would not believe what I told him, so I took up my knife to show him. I just stuck it into my arm, he wouldn't let me rip the scar open. I was indifferent. I felt still and baffled. I knew I must give up the idea of having a child [with Y], and it hurt, but the pain was numb (p.47).

Emerson's comments on the treatment follow:

> It was assumed that the patient has considerable psychic power, only introverted. She was encouraged to believe in her

> own capacity. Each step in the analysis was explained and discussed with her. She was told some of the theories and was asked if she corroborated them in her feelings and thoughts. If not, they were revised to fit the facts. In this way she analyzed her own complexes and thereby gained much self-control. And most important of all, opportunity for sublimation was obtained for the patient, and she was given a chance (p.53).

Emerson states cautiously that the patient responded well to treatment, having gone fourteen months without a relapse.

Menninger's Conception of Self-mutilation

Menninger (1935) in a comprehensive article on differing forms of self-mutilation, excluding delicate self-mutilation, states the problem in the following way:

> We must try to determine the reason for the increased power of the destructive element and the reason for its direction back upon the self; we must also study the significance of the sacrifice and why a particular part of the body is selected for this function (p.408).

The neurotic uses "substitutive and symbolic" forms of self-mutilation while the psychotic "makes no effort at such concealment". Menninger understands neurotic self-mutilation as a compromise formation: the mutilator punishes him/her self because of the guilt incurred by a forbidden indulgence, while the punishment itself

> actually permits the continuance of forbidden indulgences and in this way becomes in itself a kind of indulgence (p.415).

The "forbidden indulgence" for Menninger is masturbation. Menninger sees neurotic and psychotic self-mutilation as similar in structure but dis-similar in the neurotic's ability to "disguise" the method of self-mutilation in such ways as injury at the hands of another party, or unnecessary surgical operations. In both, however, it is a compromise device which saves the personality from the direct assault of the instincts or the conscience.

In one case cited, a psychotic woman who had killed her own child with her right arm later put the same arm on a railroad track so that the oncoming train would amputate it. According to Menninger, she then made a rapid and complete recovery and has been well since.

> What this woman did, therefore, was to substitute a self-mutilation for suicide; instead of offering up her life she offered up her arm, which was quite logical since it was the guilty organ. It was logical if one assumes the personification or autonomy of various organs of the body (p.412).

Menninger posits this mechanism as an unconscious device for relieving guilt. In another case cited, the self-mutilation was neurotically disguised, taking the form of extremely severe nail-biting. Although the biting resulted

in tearing off of nails and infection, no pain was experienced. Menninger sees this indifference to pain as similar to that seen in hysterics

> who can be moved so strongly by psychological motives as to be unmoved by physical sensation accompanying their self-mutilative acts (p.414).

To summarize Menninger's conception of self-mutilation, he posits a continuum from a disguised (neurotic) symbolic substitute to an unconcealed (psychotic) destruction of an offending part. The power of the destructive element is turned back upon a part of the self. In this way, the part is sacrificed for the whole. This compromise saves the whole (differentiating self-mutilation from suicide) while relieving guilt through the punishment of the part. The mutilated part symbolically represents the act for which the guilt has been incurred.

Comparison of the Concepts of Emerson and Menninger

The different views expressed in these two early papers highlight the primary focus of this dissertation, which is the role of the symbolic function in relation to symptom formation in delicate self-mutilation. Emerson noted a diagnostic dilemma in attempting to fit his patient's symptoms into a model of hysteria (the return of repressed material in symbolic somatic form: conversion reaction)

First, there did not appear to be repression of the traumatic events: Miss A. clearly remembered these events. Second, she experienced continued build-ups of tension which hysterical patients were able to avoid through their symptoms: "la belle indifference". Her headaches and her "queer feelings" did not serve to relieve tension. Relief from tension was accomplished by an additional and consciously deliberate act: delicate self-mutilation. Included in this was an unusual relationship to pain: she appeared to chose physical pain over mental anguish. Further, her response to physical pain was expressed in terms difficult to comprehend: "I felt still and baffled. ... it hurt, but the pain was numb."

Emerson's treatment, which he appears to have sensitively geared to the capacities of his patient, resulted in "opportunity for sublimation" and in symptom remission. This capacity for sublimation is of interest, since the functional properties of sublimation and symbolic symptom formation are parallel: the symbolic displacement of instinctual urges. In neurosis, the displacement is to a symptom, while in sublimation it is to a socially acceptable activity (Freud, 1905). In both, however, a symbolic activity has occurred. This means that Miss A. left treatment with some capacity for tension release through symbolic activity and, at the same time, was free from her

symptom of delicate self-mutilation. This allows the inference that there is a connection between her ability to symbolize, and her symptom remission.

In Menninger's formulations, based on neurotic and psychotic patients, the symbolic significance of the acts of coarse self-mutilation are clear. The offending part is mutilated because it is symbolic of the act for which guilt has been incurred. This is the classic neurotic mechanism of symptom formation. In psychosis, as well, the symbolic function operates. The difference, as Menninger states, is that the substitution is not disguised.

The contrast between Emerson's and Menninger's cases and formulations serves two purposes for this dissertation. First, it discriminates two different populations: coarse and delicate self-mutilators. This distinction is consonant with the current literature (Doctors 1979; Scheftel, 1985), and nothing further will be said about coarse self-mutilation. Second, Emerson's questions about diagnosis; his noting the capacity for sublimation in connection with symptom remission; and his inability to find a symbolic significance to his patient's symptom, all can be seen to lead to the hypothesis that the symptom was not symbolic in Menninger's sense. This latter hypothesis is not consistent with the literature on delicate self-mutilation, as will be seen in the following review of the literature.

CHAPTER III PART 1

REVIEW OF THE LITERATURE ON DELICATE SELF-MUTILATION

Terminology

While there is little agreement in the literature upon terminology, there is much agreement about many aspects of those patients who repeatedly mutilate themselves in such a way as to cause minimal physical harm. Many terms have been applied to this population: self mutilation (Offer and Barglow, 1960; Simpson, 1976; Carroll, 1980); the syndrome of the wrist cutter (Graff and Mallin, 1967); wrist slashing (Grunebaum, 1967); wrist-cutting (Rinzler et al, 1968); the syndrome of delicate self-cutting (Pao, 1969); self-cutting (Novotny, 1972); repeated self-cutting (Siomopoulos, 1974); and the deliberate self-harm syndrome (Pattison and Kahan, 1983). The term "delicate self-mutilation" will be used in this dissertation.

Characteristics of Delicate Self-mutilators

The characteristics found in common among delicate self-mutilators are the following: predominance among young intelligent women; early traumatic experience; symptom-free childhood; first self-mutilation after menarche; history of substance abuse; poor parental relationship; inability to verbalize affect; difficulty with sexual identity; periods of normal adjustment alternating with psychotic episodes. There is a regular sequence of events leading to self-

mutilation consisting of separation or loss; buildup of tension; depersonalization; lack of pain when self-mutilating; relief after self-mutilation.

The existence of these characteristics which are regularly found among delicate self-mutilators has led a number of workers in this area to apply the term "syndrome" to this population (Graff and Mallin, 1967; Doctors, 1979; Pattison and Kahan, 1983).

I will now review the literature for each of the characteristics noted above.

Predominance Among Intelligent Young Women:

Graff and Mallin (1967) reported on 21 patients, 20 females and 1 male. The male was excluded from the study because they felt he was atypical. Rosenthal et al, (1972) omitted 11 men from their study because the findings were so different they decided to present them in a separate paper. Unfortunately, this paper has not been published. Of Pao's (1969) 27 patients, 23 were female. Similarly, Graff (1967), Grunebaum and Klerman (1967), Rinzler and Shapiro (1968), McKerracher et al, (1968), Rosenthal et al, (1972), Simpson (1975), Doctors, 1979, Carol et al, (1980), and Schaffer et al, (1982), have reported a predominance of females in their studies.

However, Pattison and Kahan (1983) indexed 56 individual cases in the literature and found "no significant

difference" in gender. They do note that this may be an artifact of their method of case retrieval, in that the literature contains confusions between low-lethal self-harm and highly lethal suicidal behavior as well as being inconsistent in psychiatric case detail. Bach Y Rita (1974) has reported on self-mutilation in habitually violent male inmates who exhibit many of the components of the syndrome outlined above. However, since this population consists of imprisoned criminals, the stress of imprisonment and confinement, as well as the fact of their anti-social behavior add psychological variables not found in the population of delicate self-mutilators here being studied.

As to intelligence, Phillips and Alkan (1961) reported the case of a young woman, 'Alice', with numerous signs of self-inflicted injury: a seven inch scar on her face, several smaller ones on her right temple, two large scars on her neck, multiple scars on her right hand and wrist, several on her upper left arm, evidence of deep gashes from her left wrist running all the way up her forearm, an incision on the bottom of her left foot, and an old wound beneath her left arm. The woman was a college graduate of superior intelligence who never had any academic difficulty. Graff (1967) described the chronic wrist slasher as an attractive, intelligent woman who has usually been a top student in high school and has attended college. Similarly,

Grunebaum and Klerman (1967), Rinzler and Shapiro (1968), Siomopoulos (1974), and Simpson (1976) report above average intelligence in this population.

Early Trauma

Emerson's report of Miss A (1913), above, documented a history of continued sexual abuse, while Grunebaum and Klerman (1967) report histories of both incest and other forms of early trauma, concerning such events as a patient watching her mother being raped, or another patient having her father throw knives at her. Schaffer et al (1982) reported greater frequency of child abuse in self-mutilators, as have Carroll et al (1980), Green (1978), Roy (1978), and Novotny (1972). A history of early illness or surgery is reported by Siomopoulos (1974) and Simpson (1975); major separations by Carroll et al (1980); and Kafka (1969) reported a case with such severe dermatitis as a child that handling was impossible. Rosenthal et al (1972) reported that 60% of their population of cutters had had surgery, hospitalization or lacerations requiring multiple sutures before the age of five.

Relatively Symptom-free Childhood

Despite the high incidence of early trauma these patients are apparently symptom free during childhood (Docter 1979). Phillips and Alkan (1961) note that their patient (Alice) spent her childhood in boarding school where

she always appeared to adjust well. They state, further, that there was no objective evidence of illness prior to the patient's first self-mutilation. They do observe, however, that her self-image was poor and that she adopted the role of the clown among her peers. Graff (1967) states that people are usually impressed with the wrist-slasher's abilities, but that she is often a loner and acts like one, thus compounding the problem. Rinzler and Shapiro (1968) report that the family of one of their patients was unanimous in describing her development as unremarkable in any way, and Pao (1969) states that his patients were relatively free from major symptoms before puberty although he also notes that an expert could have detected them as troubled. Burnham (1969) speaks of childhood difficulties but believes that these patients have the skills and intelligence to negotiate difficulties until puberty evokes a regressive symptomology. Although histories of eating disorders (Asch, 1971; Simpson, 1975; Novotny, 1972; Pao, 1969; Rosenthal et al., 1972) and anxiety (Crabtree, 1967) are reported without specific reference to age of onset, Graff and Mallin (1967) do state that difficulties suggesting a high degree of childhood pathology, including night terrors or uncontrollable tantrums, were noted in their patients.

From this evidence it appears that most, but not all, of these patients experienced a lack of overt symptomology in

childhood, even in the presence of clear evidence of traumatic experiences.

First Self-Cutting After Menarche

This finding is virtually universal in the literature: no report has come to the attention of this writer which does not report the first episode of delicate self-cutting in women to have occurred before the onset of menstruation. No information about the age of first incident of delicate self-mutilation is available for the few male patients reported. Other types of self-mutilation are reported to have occurred before menarche in girls who later became delicate self-cutters. For example, Rosenthal et al (1972) reported that none of his patients cut themselves before menarche, "...although several had histories of other types of self-mutilation by then" (p.1364). The "other types" were not specified.

History Of Substance Abuse

In Pattison and Kahan's (1983) recent index of 56 case histories found in the literature of "deliberate bodily self-harm of low lethality" (p.867), they report that drug and alcohol abuse was a "major predisposing factor" (p.869) to this syndrome. They found that while 36% of their sample were drug or alcohol abusers (20 of 56), when the under 30, non-psychotic group was examined, 95% (19 of 20) were substance abusers. It is this latter group that most close-

ly resembles the delicate self-mutilators relevant to the present study. Graff (1967) discusses a predilection for alcohol or drugs in order to relieve anxiety. "When the patient is on leave from the hospital, many times she will head for the nearest bar and get drunk" (p.62). Rinzler (1968) observes a "desperate search for stimulation, with an increasing pressure of activity leading to a crescendo of apparent hedonism involving sex, sky-diving or LSD trips". Burnham (1969) describes a patient: "With her husband away on a trip she drank and overate. When deprived of her hours with me as well, at weekends, the tension became too much and she burned herself" (p.226).

Poor Parental Relationship

Every study which has gathered information on parental relationships for this group of patients has spoken of long standing difficulties with one or both parents, or of gross deprivation. The prototypical parental couple consists of a cold, domineering mother with a retiring, distant father (Crabtree, 1967; Graff and Mallin, 1967; Pao, 1969; Asch, 1971; Simpson, 1976). Phillips and Alkan (1961) state their patient's parents were "...wealthy [and] were quiet and emotionally unapproachable, encouraging [the patient] to withdraw to the end of the room to color or draw" (p.425). Another type of parenting was found by Grunebaum and Klerman (1967). They found their patient's early lives

and parental relationships to be unstable, with illegitimacy and foster care placement common. They also found that the most striking feature of parental behavior was the open display of sexuality and aggression. In their study, the father was "seductive and unable to set limits. He is intermittently indulgent, often inadequate at his occupation, and frequently alcoholic". Homes broken by divorce or death and a striking history of maternal deprivation is reported by Rosenthal et al (1972).

Inability To Verbalize Affect

Offer and Barglow (1960) conducted a series of structured interviews with patients five days after they had self-mutilated. After being interviewed, one of these patients went to the bathroom and made superficial cuts on her forearm.

> When discovered she smiled and said: "Oh, I really didn't want you to find out about it. It's really nothing. I feel much better." She couldn't verbalize her feelings. "I just cry and get hysterical when I try to talk" (Offer and Bargalow, 1960)

Graff and Mallin (1967) state that the goal of therapy with this population is to assist the patient to "...utilize words rather than more primitive gestures" in important relationships (p.41). They believe that these patients resemble pre-verbal children in that they treat words as

"soothing acoustic phenomena" and so cannot derive comfort from verbal messages but only from physical ones. They report that the patient was often not aware of what their therapist was saying to them, and that they only heard his voice, with its tone and affect providing the needed contact with him. Thus these authors understand the phenomenon of self-mutilation as a "manifestation of a breakdown in this developmental system" (pp.39-40). Grunebaum and Klerman (1967) characterize these patients as inarticulate and state that they cannot or do not verbalize the extent of their tension. They state that their ability to communicate discomfort is a critical variable in determining whether a slash will occur. One of their patients described delicate self-mutilation in this way: "It's like vomiting -- you feel sick and spit out the badness". These authors characterize this act as a "self-prescribed treatment that does not involve verbalizing feelings..." (p.529). Crabtree's (1967) patient, a 13 year old girl soon after menarche, began to scratch herself on the arms, legs and face when she became interested in an older male teacher. After confiding her behavior to this teacher, she said, "At first he seemed very understanding but then he became angry and I did it all the more -- I don't know why but this scratching did have something to do with my feelings about him" (p.93). For Podvoll (1969) the

act of self-mutilation has two goals: an internal goal, which is the relief of tension (see below for discussion of this) and an external goal, which is a restitutive attempt at changing the interpersonal field. It is this latter goal which, for Podvoll, is usually least within conscious awareness and most difficult to verbalize. Pao (1969) notes that after the act of cutting the patient shows neither the ability nor desire to study the events or the conflicts that precipitated the act. One of his patients said of a young man for whom she had previously felt longing, "I thought no more about him; if I thought about him I'd feel hurt. ... I cut off the thought that related to my feeling abandoned but the feeling of being abandoned stayed with me" (p.204). Simpson (1975), in a controlled study of 24 wrist-cutters in a hospital setting, found that 18 cutters and only two controls showed clear difficulties in verbalization.

Difficulty With Sexual Identity

Considering the history of poor parental relationships, described above, the present finding may come as no surprise. Whichever of the two predominant types of families discussed: the cold and domineering mother with a distant, uninvolved father, or the open displays of parental sexuality and aggression witnessed by these patients, one might expect any identification with parental figures to be prob-

lematic. This expectation is clearly borne out by the data which addresses these patient's sexual identity. Graff (1967) and Graff and Mallin (1967) found sexual behavior to be an " all-or-none proposition": At least half of their patients were openly promiscuous while a large number had little or no sexual contacts. In addition, the promiscuous patients often complained of a lack of fulfillment in sexual relations. They described an almost unbearable tension which could be relieved only by being held in someone's arms, or by slashing. Pao (1969)states that the female patient's "repugnance toward female sexuality" is an identification with their mother's attitude or a result of parental preference for male siblings (p.197). Asch (1971) discusses their "characteristic promiscuity" as a "[desperate] need to maintain contact and closeness with their objects at any price" rather than a true genital sexuality (p.604). Rosenthal et al (1972) note that 65% of their population had had a negative reaction to the menarche (feeling unhappy, disgusted or frightened), and that almost half had always had irregular menstrual periods. However, their study did not confirm Graff and Mallin's finding of an "all-or-none" stance toward sexual relations. Twenty-five percent of their patients had not had intercourse but had engaged in some sexual activity. And only 3 of 24 could be considered promiscuous. Never-the-less, several of their

findings did point toward confusion of sexual identification. Half of their female cutters drew a male figure first on the Draw-A-Person Test, and 65% said that they felt more like their fathers than their mothers. Novotny (1972), in one of the few specific reports of male self-mutilators, notes that two of his male patients mutilated while intoxicated. For one of them the act was precipitated by anxiety-producing fantasies with passive homosexual content. This patient felt that cutting himself proved him to be a man "...since he could stand pain". For the other, the act was preceded by a disappointment connected with a girlfriend. According to Novotny this patient frequently was very frightened by intrusive homosexual thoughts. Siomopoulos (1974) interprets the disgust these (female) patients express about adult sexual relationships as an "expression of their psychosexual arrest which excludes 'the other' from any sort of sexual gratification" (p.90). In Simpson's (1975) group of 24 wrist cutters, substantial sexual disturbance and distress was seen in 16, and promiscuity in 10. Pattison and Kahan (1983) found that homosexuality was associated with the young, male, non-psychotic patient who self-mutilated a single time in response to situational anxiety.

Periods of Normal Adjustment Alternating With Psychotic Episodes

Again, this finding might be inferred by inspection of the data already presented: the intelligence, symptom-free childhoods, school achievement and high functioning parents of some of these patients do give them the appearance of normality. This appearance is in marked contrast to the symptom of delicate self-mutilation. This contrast is seen also in their day to day functioning. Graff (1967) states, "Following admission ...they may do well for several weeks, and suddenly burst into a new episode of slashing for no [discernible] reason" (p.61). Grunebaum and Klerman (1967) state that they appear normal except when periodically overwhelmed by inner emotional tensions. Pao (1969) remarks that diagnostically these patients should be categorized as severe borderline states. Characteristically, the cutters went in and out of psychosis in a split second.

> When psychotic they demonstrated ... primary process experiences. ... Nevertheless, when not psychotic they could even pass as being normal and were capable of responsible work (Pao, 1969; p.196).

Other studies which have specifically noted this phenomenon are Burnham (1969), Asch (1971), and Simpson (1975).

Regular Sequence of Events Leading to Self-Mutilation Consisting of Separation or Loss; Buildup of Tension; Depersonalization; Lack of Pain When Self-mutilating; Relief After Self-mutilation

This last finding is perhaps the sine qua non of the syndrome of the delicate self-mutilator in experiential terms, and is reported by the majority of clinical investigators. This sequence of events will help to understand an act that, at first, appears to defy an unspoken basic self-preserving principle of human nature. This unspoken principle maintains the boundary between two contrasting views of ourselves: one, from outside, as an almost unbroken, contoured and shaped surface of warm, smooth and sensual skin. The other, from inside, as a mostly unfathomable image of independently pulsing organs, acidic digestive juices, a skeleton which makes an appearance only in severe injury or derisively on Halloween, and a slimy convoluted mass beneath the brow which is said to coordinate all of these. This boundary between inside and outside, and often between life and death, is violated by these patients in the absence of a wish to die.

For these patients, the act of self-mutilation is self-preserving. A sequence of events which begins with loss or separation ends with relief. It is in their response to this sequence of events that the necessity for this behavior may be found.

Separation and Loss

Grunebaum and Klerman (1967) state that generally these patients slash their wrists when they face the loss of a meaningful person or an impasse in their personal relations. Pao (1969) concluded that, while conflicts over aggression precipitated acts of self-cutting, conflicts over being abandoned and being left behind must pave the way. This conclusion was based upon the treatment of a patient who cut herself in connection with the analyst's vacation, with the departure of staff members, and whenever she felt abandoned. It was observed that the abandonment need not come from outside, but could be actively created by the patient, herself, by refusing to join in group activities, forced feelings of self-sufficiency, etc.

The idea that aggression plays a major role in this symptom is noted. Asch (1971) believes that these patients cannot be separated from objects without either experiencing extreme anxiety or a profound apathetic state. Most of their behavior, according to Asch, consists of attempts to cope with violent thoughts and impulses which threaten to break through. Podvoll (1969) describes the inner experience of a patient as a flight from deeply dependent, even symbiotic, wishes toward a primitive love object to the reliance upon auto-erotic use of one's own body.

Build-up of Tension

With the experience of a separation or loss, and the resonance this creates with their own early experience, as well as their inability to verbalize, to release these feelings to others or to themselves, a build-up of tension occurs. In Graff and Mallin's (1967) study the reasons given by patients for cutting was a build-up of tension until they could no longer control it which followed a minor reversal (p.38). The "mounting stress" observed by Grunebaum and Klerman (1967) has many similarities to depression, and the patient may use the term 'sad' or 'dejected'. Never-the-less, these authors distinguish this state from depression because the feelings of anxiety, anger and sexual tension experienced by these patients are not repressed, but conscious. They state further, that in their experience anti-depressant medication does not provide relief. Crabtree (1967) makes the same point about medication (p.93). Pao (1969) described the build-up of tension in his group of hospitalized patients in this way:

> For reasons not known to the patient, she felt very tense; following a period of tenseness she decided to be by herself; while alone, the tension mounted; then all of a sudden, she discovered that she had already cut herself (p.198).

Depersonalization; Lack of Pain; Relief:

The build-up of tension leads to an altered state of

consciousness during which the actual self-mutilation occurs. Awareness, and a feeling of being alive, returns in connection with a sensory experience of the new wound. Pain usually is absent, and the tension has been relieved.

For Graff (1967) there is a constellation of symptoms which comprise this behavior pattern. These include not only the slash, but sexual promiscuity, addiction, the altered state in which the patient appears detached or psychotic, and the immediate recovery after completion of the act. One of his patients stated that she was unable to tell that she was alive during states of stress, and reassured herself by cutting her arms so as to draw blood. For Graff, the important part of this act is the self-stimulation that occurred. In Graff and Mallin's (1967) study, patients not only reported a lack of pain during self-cutting, but five actually noted that it was pleasurable. The lack of pain is related to "a special form of isolation or dissociation" by Grunebaum and Klerman (1967), who see the patient's urges as the need to feel or experience something real, a need to end a painful state of having no feelings often described as emptiness and unrealness. They also report that most patients report a sense of relief.

The term 'anhedonia' has been used by Rinzler and Shapiro (1968) and by Asch (1971) to describe these patients. The term was originated by Glauber (1949) for patients who

"fear ego impoverishment and annihilation". Rinzler and Shapiro (1968) see these patients as "devoid of meaningful object relations", failing to find pleasure except with the strongest stimulation, and readily complaining of "feelings of emptiness" (p.485). Asch (1971) sees the 'anhedonic' state as " a primitive form of depression" (p.603). However, they do not experience depression but rather are not able to experience any affect except recurrent and severe anxiety. As noted earlier, Asch believes that these patients have an urgent need to deny hostility in the outside world as part of their continuous and desperate attempt to control their own violent impulses and fantasies. When these impulses can no longer be defended against, they "exhibit the specific and characteristic defense mechanism of depersonalization". For Asch, this phenomenon has two sources: First, massive unneutralized aggression causes an ego regression from an original position of poorly delineated self and object representations, leading to further dissolution of boundaries. Second, defensive denial and repression results in further confusion of the self image, since that image is based upon 'feeling' and the repression of feeling removes even further the experience of 'self' from the patient. The affect of this is an increased tendency to depersonalization, and to feelings of being 'empty' or

'dead'. It is at this point that cutting occurs, and usually continues until the sight of blood produces a relaxed and even pleasurable feeling.

In the study conducted by Rosenthal et al (1972) the patients appeared to be aware of exactly what would end their depersonalized state.

> For some, it was a degree of pain; for others, it was the sight of blood; and for a third group it was the wound -- seeing what was inside. Each of these acts can be thought of as a primitive way of combating the feelings of unreality and emptiness. ... For these patients ... depersonalization was a frightening experience that they brought to an end by cutting themselves, a nonsuicidal gesture (pp.1366-1367).

CHAPTER III PART 2

PSYCHOANALYTIC INTERPRETATIONS OF DELICATE SELF-MUTILATION

Introduction

Now that the syndrome of the delicate self-mutilator has been described, I will report in more detail the specific psychoanalytic interpretations which have been put forth to explain this behavior. Most of these conceptualizations speak to the manner in which sexual and aggressive drives are repressed, distorted or displaced by taking into account the patient's early identifications, or 'object relations'. Doctors (1979) summarizes these interpretations as follows:

> ... the best known analytic formulations ... draw on traditional psychoanalytic formulations which link self-mutilation or self-injury with symbolic self-castration and concommitant symbolic sexual gratification (p.30).

The important aspects of these interpretations for this dissertation will be the symbolic significance imputed to the act of delicate self-mutilation, because these take as their unquestioned starting place the ability to create symbols that represent repressed instinctual gratifications. The hypothesis of this dissertation questions that assumption. After I have reviewed several interpretations I will briefly comment on them, so that the reader may begin to see the how the hypothesis of this dissertation differs

from the symbolic interpretations now being reviewed.

Psychoanalytic Interpretations

For Crabtree (1967) delicate self-mutilation is a particular form of sadomasochism in which the core instinctual issue is expressed initially in a self-enclosed way so that the patient takes his own body as an object. Aggressive fantasies are connected with castrating or mutilating fantasies originally directed towards parents or siblings. The chief unconscious benefit is the relief from guilt, even while the patient secretly enjoys the crime for which she should earn condemnation. The early goal of intensive psychotherapy, then, should be the translation of this form of mutilation into a object-oriented dilemma by the establishment of a "transference psychosis for which a way out can then be sought".

A Contradiction Regarding Repression

Grunebaum and Klerman (1967) in a similar vein discuss aspects of depression, a part of which is usually conceptualized as an attack upon the self. They make two apparently contradictory statements concerning their patient's ability to use the defense of repression. I will use this contradiction to briefly highlight the alternate hypothesis being offered in this dissertation.

After noting open displays of sexuality, rejection and

aggression in these patient's families, they hypothesize that the latter experiences

> ... led to the development of ego defects in the patient, involving particularly the repression of these impulses (p.528; italics added).

Later, in discussing the similarities and differences from depression seen in these patient's affect, they state the following:

> While the emotional state experienced ... has many similarities to depression ... these feelings are characterized by a number of features which are phenomenologically different from those of depression. Feelings of anger, anxiety and tension are usually conscious. (p.528; italics added).

It appears contradictory that "ego defects involving particularly the repression" of aggressive and sexual impulses can become conscious in a state otherwise resembling depression. In Freud's (1917) description of melancholia he stated that the exciting causes were

> ...countless single conflicts in which love and hate wrestle together are fought for the object ... These single conflicts cannot be located in any single system but the UNC ... (p.168).

Freud goes on to state that it is only after depression lifts that the ambivalent conflicts can become conscious.

Further, the process of depression involves the regressive (sadistic) identification with a lost object. As will be seen in Chapter V, the process of identification is central to the process of symbol formation. Thus I would make two points about Grunbaum and Klerman's analysis, in anticipation of a full discussion of my hypothesis in Chapter VI. First, their description of repression in this group of patients is unclear. Emerson (1913), as we have seen, is clearer about the confusion in diagnosis because of a lack of repression. The question about the occurence of repression is important; it implies that other processes have occurred that provide material for repression. Second, and connected to this latter idea, I would question Grunbaum and Clerman's hypothesis that the ego defects in these patients primarily involve repression of experiences at all. These patient's experiences with their parents can be hypothesized to have led to a lack of identification rather than a repression of those identifications. This line of thought will be detailed in Chapter V and Chapter VI.

Further Interpretations

To continue with the psychoanalytic interpretations of delicate self-mutilation, Graff and Mallin's (1967) decision to add touching to their therapy with these patients is informed by the hypothesis that the pathology seen in these patients is linked with the pre-verbal level of

development. Thus, there is a lack of ability to communicate conflictual issues verbally. For Graff and Mallin, this pathology originates with maternal deprivation resulting in the regressive use of oral means to relieve anxiety, such as alcohol abuse and eating disorders. Delicate self-mutilation serves to elicit therapeutic action from others, to attack the introjected punishing mother, and to provide needed self-stimulation to make up for the lack of outside stimulation. The pleasurable feeling derived from cutting is the joy of punishing the deprivor: the introjected mother.

For Pao (1969) delicate self-mutilation is conceptualized as an altered ego state to be compared with other such states, especially depersonalization and derealization. It is comparable to fugue in the surrendering of autonomous ego functioning to an impervious urge which is a drive derivative. A subsystem takes over selected ego functions. Unlike fugue, there is no amnesia for the event. What is amnestic are the experiences connected with conflicts leading to the event. "Cutting seemed to be a symbolic expression of the denied, yet accepted, castration" (p.202), which explains the prevalence of this symptom in women. Pao sees conflicts over separation as a major factor.

Asch (1971) conceives of delicate self-mutilators as

suffering from a primitive form of depression called 'anhedonia', with the wrist cutting as a response to depersonalization. Separation from important objects produces a severe panic and profound depression. The delicate self-mutilation is seen as masochistic: unacceptable aggressive thoughts are turned against the self. These patients attract sadistic partners for the same reason. They require a reassurance of existing, which is found in the necessity of continuous feeling of immediate sensation, since they cannot retain this memory.

> While depersonalization has the aim of warding off destructive impulses toward important objects, the cutting represents the return of the repressed. It is an actual acting out of those impulses (p.612),

but with two modifications. The cutting is an attenuated version of the impulse, and the aim of the drive has been turned back on the self. Asch speculates upon the possible symbolic meaning of the cutting as an attempt to bring on displaced genital bleeding. The relief in seeing the gaping, open wound may similarly be a part of the re-creation, through an identification with the aggressor, of some conception of menstruation as a helplessly and passively experienced genital mutilation. He sees menarche as a double loss of mother: the loss of the anaclitic mother-child relation, and the revival of the Oedipal conflict. Unlike

the boy, the girl must now give up her mother. Because she is essentially narcissistic through identification, to give up her mother is a threat of loss of her own identity. Therefore she uses wrist scratching to "create the representation of the self as a bleeding person" (p.614). Bleeding then could represent the "magical attempt to regain the lost object, the bleeding woman, the mother, through identification" (p.614).

Novotny (1972) presents a case of incidental self-mutilation occurring before menarche: a patient who from the age of 8 picked her navel until it bled and then became a delicate self-mutilator after menarche. For him, self penetration represents symbolically the wished for and feared penetration by the father. The sexual wish for father is repressed because of castration fear and penetration fear. A fear of injections is also noted in his patients. The intensity of oral conflicts is so great that Novotny wonders if oral conflicts are disguised in symbols from a higher level of psycho-sexual development.

Siomopoulos (1974) notes excessive masturbatory experimentation before puberty, which ceases at age 14 or 15. For him, self-cutting follows renunciation of these activities. Siomopoulos views masturbation as an outlet for gratification of unconscious incestuous fantasy in that the urge to do violence to oneself in these cases is a "symbolic sub-

stitute for the masturbatory act". A lack of maternal handling during infancy leads to self-cutting in order to meet the need for outside stimulation. Auto-erotic activity fulfilled this need in the past. Thus, self-cutting is a

> distorted form of auto-erotic activity. Autoerotic impulses are repressed at puberty and emerge as a distorted form of self-cutting. ... the self-cutter opens up symbolically ... multiple little female genitals ... which become available for uninhibited touching, handling and ... manipulation (p.90).

The dissociative process makes the continuance possible by eliminating from memory pain and infantile wishes and fantasies.

Summary of Interpretations Relevant to Symbolization

As can be seen, repression, identification and "symbolic" processes are prominantly mentioned in these conceptualizations. These are the traditional psychoanalytic formulations put forth to explain neurosis. However, also prominently mentioned are primitive and pre-verbal modes of dealing with tension which are not usually connected with neurosis, but with borderline or psychotic conditions (Kernberg, 1975). In the latter areas, symbol formation and symptom formation are different from those processes seen in neurosis. This has been noted often in psychosis (Arieti, 1955) and is just now being explored in borderline

conditions, the diagnostic category most often assigned to delicate self-mutilators.

Two descriptions of delicate self-mutilators more in line with the latter are Rinzler and Shapiro (1968) and Graff (1967). For Rinzler and Shapiro (1968) these anhedonic patients fear "ego impoverishment and annihilation". These authors see a severe disorder of ego functioning with disturbances in object relations and failure of early identificatory processes, resulting in poor judgement, depression, and feelings of emptiness. Their inability to refer to a meaningful introject is seen in their rejection of the maxim, "I think, therefore I am" for "I feel, therefore I am". Confronted with anxiety they affirm the integrity of their body and ego in concrete ways: by proving that a person who bleeds is alive and will be cared for. The symptom is in fact an effort to avoid depersonalization and psychosis. Graff (1967) interprets this behavior as satisfying a need for relief of anxiety through direct physical stimulation which is related to the most primitive oral cravings. He states that these patients are "truly little infants" whose needs have not been met by the world. Therapy aims at helping the patient to handle anxiety through verbal expression rather than through the non-verbal self-stimulating way of the infant.

To summarize the psychoanalytic interpretations of deli-

cate self-mutilation, most authors reviewed used traditional psychoanalytic formulations of neurosis, in which sexual and aggressive drives are repressed and/or displaced, leading to the hypothesis that the cutting represents some aspect of the return of the repressed in symbolic form. Along side of these interpretations was prominently noted pre-verbal and primitive drives and defenses, more in keeping with Pre-Oedipal psychopathology.

The hypothesis of this dissertation is that delicate self-mutilators can be meaningfully conceptualized as suffering from deficits in their capacity for symbolic functioning. As I noted briefly, above, the capacity for symbolic functioning in psychoanalytic terms requires at least the capacity for identifications and the mechanism of repression. In the next chapter, I will review the work of Joyce McDougall who has studied these processes in patients who exhibit perverse and psychosomatic symptoms, as well as marked deficits in their capacity to symbolize. McDougall's presentation relies heavily on clinical descriptive material, and does not succinctly define just what a "symbol" and and "sign" might be. To supplement this, in the chapter following my review of McDougall, I will discuss in detail the definitions and functions of symbols and signs. In the final chapter, I will synthesize this material and discuss how McDougall's notions can be mean-

ingfully applied to the population of delicate self-mutilators.

CHAPTER IV

REVIEW OF JOYCE McDOUGALL'S CONCEPTUALIZATION OF THE SYMBOLIC FUNCTION IN SEXUAL PERVERSION AND PSYCHOSOMATIC ILLNESS

Introduction

Joyce McDougall's position within psychoanalytic theorizing combines the 'object relations' school, represented by Melanie Klein (1932) and D.W.Winnicott (1975; 1980), with early Freudian 'drive theory' (Freud, 1905; 1911; 1915). For her, the early caretaking relationship is vital for the structuralization of the child's psyche, as asserted by the object relations school. At the same time she holds to the early "energic" formulation of Freud, in which psychic regulation of instinctual energy is the focus. To this framework McDougall adds the role of the symbolic function and, connected with it, a new idea: the "action symptom".

McDougall's Notion of the Symbolic Function

In the most general sense, McDougall's notion of the symbolic function is broad: she connects it to the maintenance of biological life itself. For her, pain and loss lead to "the ineluctable demand to create psychic objects that will compensate". For McDougall, symbolic (psychic) objects function as a substitute for objects-in-the-world. Without them, pain and loss would be directly and overpo-

weringly experienced. The structuring of the psyche, then, in response to physical or emotional pain is a "creative process" which provides a bulwark against this pain.

> In the long run, in man's psychic creativity may well lie an essential element of protection against his biological destruction. (1982, p. 340)

In a more specific sense, the capacity for symbolic functioning is the "coping mechanism" which mediates the inevitable physical and mental pain encountered in human life. This inevitable mental pain arises from two major sources: the narcissistic mortification connected with the primal scene, and the earlier pre-verbal "definitive loss of the magic breast-mother." The former loss is connected with the oedipal conflict and gives rise to anxiety related to social and sexual integration. The latter loss is connected with the pre-verbal period; as such it is a more global menace which serves as the prototype for later castration anxiety. Early loss becomes a 'global' menace because frustration, anxiety and conflict have not yet become attached to the sexual organs. That is, the psychic representation of the sexual organs do not play a symbolic role in mediating frustration, anxiety and conflict. Rather, these emotions remain directly and primally connected to anxiety about biological life. McDougall's position is that when the sexual life is <u>symbolically</u> represented, a

'layer' or 'buffer' has been formed between anxiety over actual destruction and anxiety over sexual identity. Anxiety over sexual identity is less threatening than anxiety over actual destruction.

Importance of Pre-verbal Period

It is during the pre-verbal period that symbolic structures begin to form in response to pain and loss. In this important period, the sensate nature of human contact is seen by McDougall as "despatializing". By this she appears to address what Spitz (1965) has termed "coenesthetic" reception, which is neither localized nor discrete but takes place in terms of totalities and responds to non-verbal expressive "signals". This despatializing factor, in McDougall's terminology, sets in motion the early psychic mechanism of projective identification, which dominates until language "spatializes and limits the psychic structure". Just how psychic mechanisms are set in motion during this stage is well explained by Klein (1930) and will be discussed in the following chapter.

For McDougall, language is a major force which delimits the child's inner and outer world. It is at this moment, according to her, that the infant begins to inhabit its soma. Traumatic disturbances before this moment may place the patient

> on the edge of an abyss that cannot be represented mentally, run[ning] the risk

> of precipitating himself into acts such as automutilation or toxicomania, with suicide on the horizon as the final solution. (1982, p. 12)

Although McDougall does not cite references when making this statement, it appears to be consistent with Freud's ideas concerning the difference between a conscious and an unconscious idea. For Freud (1915b), the unconscious idea is "that of the thing alone" while the conscious idea consists of the concrete idea "plus the verbal idea corresponding to it" (p. 134). Through this linking a "higher organization" in the mind makes it possible for primary process thinking to be succeeded by secondary process thinking (Freud, 1911).

Regulation of Psychic Tension

McDougall distinguishes several means of tension regulation with respect to the capacity for symbolization. The least pathological is repression with subsequent symptom formation, the hallmark of neurosis (Freud, 1915a). In neurotic symptom formation a symbolic transformation occurs in which a repressed instinctual impulse "returns" to consciousness in a transformed state which symbolizes the original repressed instinct and allows tension release.

A qualitatively different way of regulating psychic tension is by use of the "action symptom", a term coined by McDougall to point up the difference between it and the

neurotic mechanism just outlined. The "action symptom" appears where repression would appear in the neurotic, and serves to release psychic tension through action rather than through repression and the consequent process of neurotic symptom formation.

A related method of tension regulation is the psychosomatic sign, also an action symptom. An example would be ulcerative colitis. A psychosomatic sign is distinguished from a neurotic symptom by McDougall: it is "the antithesis of a neurosis" in that, in the absence of the capacity for psychic tension regulation through repression, tension is neither transformed (by repression) nor released through action. Rather, psychic tension is transmitted directly to the soma with an effect which may be "devastating". The psyche has failed to mediate psychic tension through the use of repression and symbolic symptom formation; the "action symptom" has not asserted itself, and so the soma itself must provide the bulwark against pain. McDougall asserts that the laws of the psyche and the laws of the soma are different; thus the psychosomatic manifestation cannot be conceptualized as symbolic.

While all of these means of tension regulation are seen as an attempt at self-cure, McDougall notes that for some of the "difficult" patients whose disturbances originate in the pre-verbal period of their lives, defensive operations

serve the function of protection against de-differentiation and loss of identity rather than against Oedipal conflict. Restrictive and "crazy" as these symptoms may appear, they will not be given up easily, for they make survival possible. In this respect McDougall emphasizes repeatedly that these symptoms are "creative" and life-affirming, in that the alternate solution could well be psychosis or suicide.

In order to understand more fully these distinctions I will summarize McDougall's presentations of cases of sexual perversion and psychosomatic symptomology. Her focus is twofold: first, the meaning of these symptoms for the individual; second, the meaning of these symptoms from the metapsychological perspective of the capacity for symbolization itself. As will be seen, from the latter perspective qualitative differences are asserted to exist for symptom formation in the neurotic, the sexual pervert and the psychosomatic patient.

Sexual Perversion From the Perspective of the Symbolic Function

Professor K. was an apparently well functioning academic. He viewed life as a game in which he constantly fooled his public into believing him competent. His presenting complaint was a work disturbance in completing a book. He also revealed in a tantalizing manner a highly detailed and ritualistic sexual perversion which entailed beating his

girlfriend on the buttocks with a whip. He called these his "favorite games", but it soon became apparent that their function was to bypass the ever-present terror of being unmasked and condemned for an unknown act or crime.

An important aspect of Professor K's games was an imaginary and anonymous onlooker. It was essential that the onlooker watch, and equally essential that the onlooker be duped. This ritualized, compulsive fantasy was an indispensible thread to the patient's games. The scene always consisted of the punishment of an innocent victim who was publicly whipped. The fantasied onlooker was doubly fooled: the meaning of the scene which purported to be a punishment was the very condition of sexual excitement to the victim; the onlooker unknowingly was an accomplice since the fantasy of his presence was necessary for the orgasm which ended the drama.

A screen memory reveals to McDougall the source of the patient's perversion: Professor K.'s mother had often told him of a scene in which her father, a writer who she openly idealized in comparison to her own husband, had chased her through a garden with a whip in his hand. At the age of nine Professor K. already spent hours daily imagining this scene in minute detail. It is this scene which served as the basis for his later sexual perversion.

McDougall speaks of perversion as an avoidance of the

oedipal conflict by the building of essential illusions which must not be changed in any way. The presence of these illusions brings into question what may be considered "real" for these patients, and with this question a further one concerning diagnostic category: While the pervert or fetishist may lead a seemingly 'normal' life, within the area of their perversion their 'normalcy' appears to give way to bizarre acts not easily conforming with rational motivation.

Diagnostically, McDougall asserts that organized perverse formations differ from either neurotic or psychotic personality structures. She classifies them as "action symptoms". McDougall sees the perverse act as an essential feature in the maintenance of these patient's psychic stability, functioning to keep alive their necessary illusions which protect them from oedipal conflict. A factor which characterizes the pervert is that he or she has no choice; sexuality is fundamentally compulsive. Because the dominant factor here is self-reparation and omnipotence, no choice is conceivable. Connected with this is an often seen "singularly impoverished fantasy life", as well as an ego structure which cannot regulate a compulsion to carry into immediate action whatever may be imagined.

> That which is missing in the internal world is sought in an external object or situation, for there is a vital lack or

> blank in the ego structure of the subject, and this in turn is due to a failure in symbolization. (1982, p.60).

The failure in symbolization is, for McDougall, related to a loss of meaning: The meaning of both the primal scene and the role of the father's penis. That is, the primal scene and the father's penis have been denied psychic representation: They have not been symbolized. Thus, in this circumscribed area the weakening of associative links to these Oedipal issues tends to weaken the individual's relation to reality, leading to a circumscribed "psychotic solution". Additionally, the erotization of this solution allows for instinctual discharge.

McDougall asserts that certain elements of this case are, in her experience, essential and invariable in personality structures whose balance is maintained through perverse sexuality. She maintains that the Oedipal situation, with all of its accompanying anxieties, have never been faced but have been circumvented. The two major defenses used for this purpose are disavowal, and

> ...the disguise of "play". These serve[d] to deny the primal scene through inventing a counterfeit couple and also to convert castration anxiety into its opposite by treating it as a game (1982, p.41).

In a personality structure of this kind the paternal

imago is given a negative value, while this is counter-balanced by an ambiguous maternal imago which is invested with the condensed attributes of both sexes. The mother becomes both seductive and forbidding at the same time.

> For the child, she is contradiction itself, the very image of perversity (1982, p.42).

Because he is deprived of the solution to the Oedipal conflict which allows of paternal identification, he sees himself as the true object of of his mother's desire. Using McDougall's metaphor, he gets a fradulent diploma

> on condition that he never uses it. Nevertheless the fraudulent diploma, stolen from a repudiated father, is the only reference that permits him to avoid the "solution" of psychosis. A paper king with an imitation scepter, he must thereafter protect his identity and convince others that his illusory world is real. Of necessity, he must deceive them -- the public, his sexual partner, and, finally himself -- in the same way that, in fantasy, he deceived the father. ... The menacing father is thus ejected from his inner world ... while in the intimate erotic world he is endlessly duped and humiliated (1982, p.42-43).

The lack of identification with the paternal imago is seen by McDougall as resulting in a "total failure to symbolize a valid representation of the father's phallus". Without this representation Oedipal conflicts are not surmounted, but avoided. The avoidance of these conflicts

leads not to neurotic symptomology, which is a solution to anxiety which threatens sexual identity, but to highly circumscribed areas of psychotic-like symptomology, which is a solution to anxiety which threatens existence itself.

To summarize McDougall's argument, the failure of normal identifications with the paternal phallus in sexual perversion results in a symbolic deficit. This deficit, in turn, is associated with the lack of important neurotic symbolic structures which are vital to coping with anxiety. In neurosis, defensive measures, such as repression, are routinely directed against against conflictual affect connected with these normal identifications. In this way, the defensive measures are able to divert the threat of anxiety to the arena of sexual identity. Without the normal symbolic identifications, actual objects from the environment must replace missing symbolic ones. The anxiety about the loss of these replacement objects is experienced as a threat to actual biological survival rather than a threat to sexual identity (castration).

Psychosomatic Illness From the Perspective of the Symbolic Function

Psychosomatic creations, for McDougall, are the "antithesis" of neurotic or psychotic manifestations and of the psychoanalytic process. In neurotic and psychotic manifestations a story may be decoded in which the patient is seen

as the "guilty victim of forbidden wishes who has met setbacks on the path to desire". In psychosomatic transformations no such symbolic story may be found.

> Indeed, it is frequently when [neurotic and psychotic processes] cease to function that the psycosomatic (as opposed to psychological) illness declares itself. ... It is when we fail to create some form of mental management that psychosomatic process may take over (1982, p.341).

McDougall finds a "methodological error of some dimension" in psychoanalytic formulations of the symbolic significance of psychosomatic symptoms. She quotes Garma (1950), who speaks of gastric ulcer in a patient as a "vengeful bite" connected with the patient's need to punish himself for his infantile wish to bite his mother's breast. In Garma's formulation, the future ulcer patient selects harmful food in order to assuage his unconscious guilt by procuring for himself an introjected bite to both his soma and his psyche.

McDougall objects to the causal relationship ascribed to the unconscious guilt and the ulcer by citing another example, a patient whose mother is black and father is white. In psychoanalysis, McDougall points out, fantasy productions tend to attach themselves to somatic events with ideas involving both castration and the early mother-child relationship. This patient lived his physical prob-

lem, black skin, as though it was a visible sign of castration. He attached to the physical fact of his black skin fantasies of a dangerous persecuting mother responsible for his psychic suffering. Though these fantasy productions were helpful within the treatment,

> ...it would be absurd to hold that the castration anxiety and the early persecutory anxieties were the cause of the black skin (1982, pp.352-353).

Psychosomatic Character Pattern

McDougall prefers to conceptualize psychosomatic illness along the lines of the theoretical model of the Paris pychosomaticians (Marty, et al, 1963). According to McDougall, they propose an economic theory of psychosomatic transmission as well as a concept of a psychosomatic personality structure which is opposed to neurotic, psychotic or perverse structures. Their economic theory is closely related to Freud's early theory of the 'actual neurosis' in which urgent instinctual discharge is blocked in the present. According to Freud, this kind of neurosis was not amenable to psychoanalysis (McDougall, 1982, p.346; Strachey, 1959). For the Paris psychosomaticians, the emphasis is upon an impoverishment in the capacity to symbolize instinctual demands, rather than upon the fact of the blocked discharge itself. They see blocked discharge in

relationship to deficient representation and diminished affective response. Their model, like Freud's 'actual neurosis', is in complete opposition to the hysterical model of conversion reaction.

The failure to represent instinctual conflict symbolically leads to a specific mode of mental functioning and may determine a "psychosomatic character pattern". This pattern includes five characteristics: 1) Unusual object relations notably lacking in libidinal affect; 2) operational thinking, which refers to thoughts which are pragmatic in the extreme and have a psychotic resonance in the absence of any other manifestations of psychotic ego functioning; 3) A marked lack of neurotic symptoms or character adaptation; 4) Facial movement, bodily gestures and physical pain appearing where neurotic manifestations would be expected; 5) Preliminary interviews characterized by inertia because of a lack of associative material concerning the patient's relationships, life experiences and illness.

In related research on babies suffering from serious psychosomatic illness, Fain (1971) has concluded that these babies have a tranquilizing rather than a satisfying mother. Autoerotic activity is blocked in these babies because their mothers have failed in their function as a protective shield "precisely through overindulging the exercise of this function". Instead of developing a primi-

tive form of psychic activity akin to dreaming these babies require the mother herself to be the guardian of sleep. At the other extreme, Fain has found babies who create prematurely autoerotic objects which enable them to dispense with their mother. Here, the mother's absence is totally disavowed through the baby's precocious creation of its own protective barrier. Nevertheless, there is a serious symbolic gap, in that the mother's absence is in no way compensated for psychically.

McDougall, following this line of thought, states that she has found her patients with psychosomatic symptomology to have had both types of mothering, and describes these mothers as performing "an addictive function". Their babies come to need the mother as the addict needs his/her drug. McDougall notes that she has seen similar imagos in patients who show acting out behavior other than addictions and psychosomatic "acts", most often in perversion and character patterns marked by discharge patterns.

> In trying to come to terms with the substructure of all "action disorders", including psychosomatic "acts", we are in the area of transitional phenomena and are witness to the attempt to make substitute objects in the external world do duty for symbolic ones which are absent or damaged in the inner psychic world. (McDougall, 1982, p.370).

Summary

For McDougall both perverse and psychosomatic symptoms are to be conceptualized as "action symptoms". Unlike either neurotic or psychotic symptoms these 'acts' do not tell a symbolic story. Rather, they signify the existence of a symbolic deficit. This sign function is an important distinction, and will be discussed in the next chapter.

In the perversion, the symbolic deficit is circumscribed and relates to a specific symbolic deficit in the representation of the primal scene and the paternal phallus. In the psychosomatic patient the symbolic deficit appears to be more globally related to early experiences of psychic deprivation, resulting in a more general deficit in the capacity to use symbolic structures to regulate psychic tension. In this case, psychic tension is directly transmitted to the soma.

CHAPTER V

THE RELATION OF THE SIGN AND THE SYMBOL TO McDOUGALL'S CONCEPTUALIZATION OF THE ACTION SYMPTOM

Introduction

The action symptom for McDougall is a sign, rather than a symbol. This is an important distinction. In order to fully understand this distinction it will be helpful at this time to look more closely at what has been written about the sign and the symbol as separate aspects of the symbolic function. An important idea relevant to this discussion is the relationship of the symbol to mental activity. This will be discussed first. Next, the developmental progression from action to thought will be briefly reviewed in order to set the stage for discussion of the distinction between the sign and the symbol. This distinction will be seen to be closely related to certain forms of activity, and will lead us to a clear understanding of the diagnostic value of the 'action symptom' with reference to the symbolic function. In Chapter VI the population of delicate self-mutilators will be re-examined from the perspective of the action symptom.

The Relationship of the Symbol to Mental Activity

In their book, Symbol Formation, Werner and Kaplan (1963) put forth the premise that there is not a world out there which is represented by symbols, but that symbols

themselves partake in the formation of the world of objects. For them, becoming familiar with the environment is not a simple mirroring; in the activity of 'knowing', symbolizing enters directly into the mental construction of cognitive objects. The inherent duality of the symbol, in its function of representation, implies the conscious awareness that the symbolic vehicle and the referent are in substance and in form totally different entities. It is this awareness that distinguishes the directed, form-building activity inherent in the symbol from the passive reception of meaning as it is presented in what Werner and Kaplan label the "protosymbol".

The awareness that vehicle and referent are different entities develops over time, and is lacking in both normal childhood and in schizophrenia. In these, Werner and Kaplan distinguish the "protosymbol" from the true symbol. The protosymbol lacks the "intentional act" of representation, but is extremely important in the genetic processes of symbolization. Protosymbols become true symbols by progressive differentiation of vehicle and referent, as happens in childhood. Conversely, true symbols may regress to protosymbols through de-differentiation of vehicle and referrent, as happens in schizophrenia.

It should be noted here that Werner and Kaplan's definition of the "true" symbol is diametrically opposed to

Jones' (1916) definition, noted in the Introduction. For Jones, from the psychoanalytic perspective, the "true" symbol is one in which the meaning is unconscious. For Werner and Kaplan, the "true" symbol is one in which the distance between symbolic vehicle and referrent is clearly and consciously understood. This difference in definition is specifically mentioned by Werner and Kaplan in a footnote (1963, p.467). They attribute the difference in definitions of a "true" symbol to the difference in their material from that of psychoanalysis. They see their focus of study to be language while, for them, the psychoanalytic focus for the study of symbols is dream imagery.

To return to the relationship of the symbol to mental activity, the importance of this relationship lies in the understanding that a human directedness partakes in the active construction, or re-presentation, of an external thing or event by the formation of a symbol. In distinction to this, the meaning of the protosymbol, or sign, may be thought of as being presented, or given, by the undifferentiated vehicle/referent itself. That is, the 'distance' between vehicle and referent is missing.

The idea that symbols are intentional and expressive acts is echoed in the work of Piaget (1969), who states that in development the child's first symbols are "motivated", in that they present some resemblance to the thing

signified. He goes on to observe that the essential instrument of social adaption, language, is not invented by the child but transmitted to him in "ready-made, compulsory" forms. The child, however, needs a means of <u>self</u>-expression, needs a

> system of signifiers constructed by him and capable of being bent to his wishes. Such is the system of symbols characteristic of symbolic play. ... [Symbolic play is] an assimilation made possible (and reinforced) by a symbolic "language" that is developed by the self and is capable of being modified according to its needs (pp.58-59).

Rycroft (1956) emphasizes that symbolic and imaginative processes underlie the development and maintenance of the sense reality just as much as they do neurosis. He notes that the antithesis between phantasy (Segal, 1974) and reality, between imagined ideas and objects in the external world, tends to break down in the experience of the infant who fantasies satisfaction which is then actually received from the mother (Winnicott, 1945).

> Repeated experiences of this overlap of illusion and reality will tend to attach the individual positively to external reality without disturbances ... Although frustration may lead to acceptance of reality, only satisfaction can lead to love of it (Rycroft, 1956; p.139).

Melanie Klein (1930) has stressed the importance of

phantasy in the infant's ability to develop a relationship to reality through the symbolic function. For Klein the motivating factor in symbol formation is the anxiety resulting from the subject's own sadism directed against the contents of the mother's body. Defenses set up at early periods -- the periods characterized by McDougall in the last chapter as "de-spatializing" -- are directed at both the sadistic impulses and the objects of the sadism. The child's "dread" makes him equate the contents in question with other things which, owing to this equation, themselves become objects of anxiety.

> ... and so he is impelled constantly to make other and new equations, which form the basis of his interest in the new objects and of symbolism. Thus, not only does symbolism come to be the foundation of all phantasy and sublimation but, more than that, upon it is built the subject's relation to the outside world and to reality in general (Klein, 1930; p.26).

A philosopher who has emphasized the differing aspects of the symbolic function is Ernst Cassirer. He has written a three volume work, The Philosophy of Symbolic Forms, (1955) in which he exhaustively examines the symbols of science, language and myth. Beginning with science, he asks whether its symbols exist merely side by side with those of language and myth, or whether they are not "diverse manifestations of the same basic human function" (1955, p.77).

If the latter is true, then Cassirer asserts that philosophy must formulate the "universal conditions of this function and define the principle underlying it." While the scope of Cassirer's goal is far beyond that of this dissertation, I wish to point out that his notion of the diversity of manifestations of the symbolic function, encompassing apparently incompatible realms such as science, language and myth, appears to allow as well for diversity in individual variation of the capacity and motivation to symbolize. This idea is consistent with the hypothesis of this dissertation.

Cassirer emphasizes that cognition is only one of the many forms that in which the mind can apprehend and interpret being. Others too, can be designated to be modes of "objectivation". However, their methods are entirely different from logical conception and logical law.

> Every authentic function of the human spirit has this decisive characteristic in common with cognition: it does not merely copy but rather embodies an original, formative power. It does not express passively the mere fact that something is present but contains an independent energy of the human spirit through which the simple presence of of the phenomenon assumes a definite "meaning", a particular ideational content. This is as true of art as it is of cognition; it is as true of myth as it is of religion. All live in particular image-worlds, which do not merely reflect the empirically given, but which rather <u>produce</u> <u>it</u> in accordance with an indepen-

> dent principle. Each of these functions creates it own symbolic forms which, if not similar to the intellectual forms, enjoy equal rank as products of the human spirit. (1955, p.78)

Cassirer sees this diversity of symbolic forms as being directed toward the goal of

> transforming the passive world of mere impressions, in which the spirit seems at first imprisoned, into a world that is pure expression of the human spirit (pp.80-81).

Following the sense of these authors, then, the symbol can be seen to be an element of purposeful mental activity, whether it is activity directed toward knowing or wishing; whether it is an activity which is a pure expression of the human spirit or one which is the unconscious result of anxiety. This activity takes place at the psychological boundary, the 'skin', of the organism, between that which is within and that which is without. The symbol is an individually unique and creative integration of these two poles of experience (Kubie, 1953). This activity can be seen in its formative stage in what Winnicott (1953) has called the "transitional object", which exists at the border of "me" and "not-me", and is the creation of the child alone. The function of integrating this duality is reflected in the very structure of symbols, having an objective pole in the thing to be represented and a subjec-

tive pole in the choice of representational vehicle. The use of symbols is, in a broad sense, an integral part of that which distinguishes humankind from the animal world (Langer, 1942). The lack of differentiation of vehicle and referent in symbol formation, in the narrow sense, has been seen to be normal in childhood, and indicative of extreme pathology, as in the de-differentiation between vehicle and referent observed in schizophrenia.

The Developmental Progression From Action to Thought

Now that the purposeful mental activity inherent in symbol formation has been discussed, I wish to continue to the second idea I introduced: a brief review of the developmental progression from action to thought. This discussion will lead us to the relation of signs to symbols, and will form the basis for fully understanding the implications in McDougall's notion of the "action symptom", and to applying it to delicate self-mutilators.

A complete review of the developmental progression from action to thought is far beyond the scope of the present work. This idea is a central one to all developmentally oriented branches of the social sciences. Therefore I will briefly review the work of several representative theorists before discussing the distinction between the sign and the symbol in this developmental progression.

Piaget (1962) traces the transformation of action to

thought by meticulously following two separate developmental lines, play and imitation, from their infantile beginnings in reflex activity to the "internalization" of action into fully representational and symbolic thought. For Piaget, assimilation and accommodation are two complementary functions which integrate and modify internal "schemas" of action to both the demands of reality and of fantasy, the latter in the form of symbolic play. Piaget specifically notes the "internalization" of action schemas and the consequent delay between perception and action indicative of representational thought. These ideas are central to psychoanalysis as well.

For Freud, the delay between sensation and action is mediated by language and thought. Freud wrote that

> Restraint of motor discharge (of action) ... was provided by means of the process of thought, which was developed from ideation. Thought was endowed with qualities which made it possible for the mental apparatus to support increased tension ... (Freud, 1911; p.16).

A philosopher, Sussane Langer, (1942) has studied this progression from the specific vantage of role of the symbol. For her, by the interpolation of symbols into the gaps and confusions of direct experience man is able to synthesize, delay, and modify his reactions. For Langer, man's "conquest of the world" rests upon this supreme develop-

ment.

> The basic need, which certainly is obvious only in man, is the need of symbolization. The symbol-making function is one of man's primary activities, like eating, looking or moving about (p.32).

For Langer, symbolization is an act necessary to thought and prior to it. She conceptualizes the function of the brain as a transformer rather than a switchboard. For her, the brain transforms the current of experience which passes through it into a stream of symbols, and these symbols are transformed into ideas; a typically human function thus finds a typically human form of overt activity.

Distinction Between Sign and Symbol

The distinction between the sign and the symbol which I will use is taken in large part from Langer's (1942) work, to which I have already referred. There is not full agreement in the literature as to this distinction. For alternate views see Piaget, (1962); Alston, (1967); Reichbart (1983).

For Langer the sign is "something to act upon" while the symbol is "an instrument of thought" (1942, p.51). A sign indicates part of some larger process in which the sign is part of the referent. This reminds us of Werner and Kaplan's distinction between 'symbol' and 'protosymbol', in which the awareness between symbolic vehicle and referent

is missing in the protosymbol. This implies that for an act of representation the subject must be taken into consideration. For the sign, there are three essential terms: the subject, the sign and the object. The 'meaning' of the sign for the subject is the existence of the signified. The sign is thus the basis of animal intelligence, in that a sight, smell, sound, etc. signals the existence of the rest of the situation. For an animal, the smell of humans signifies part of an existing situation, for example, the danger from hunters. The sign is a signal of the existence of the rest of the situation. It signals the existence, past, present or future of a thing, event or condition. The misinterpretation of a sign is the most simple form of mistake, leading to the experience of disappointment. As a corollary to this the sign is, itself, the most simple form of knowledge.

A term used symbolically, rather than signally, "...does not evoke action appropriate to the presence of its object" (p.48). Symbols are not proxy for their objects, but are vehicles for the conception of objects. In talking about things we have the conception of them, not the things themselves in mind. Behavior towards conceptions is what words normally evoke; this is the typical process of thinking (p.49).

For the symbol there must be four essential terms: the

subject, symbol, conception, and object. This is, strictly, a different function than the sign. Thus, the perception of the word "Napoleon" does not evoke action consonant with the past, present or future existence (appearance) of Napoleon, but evokes the conception of Napoleon; no overt action is called forth. The 'action' is an act of conception, not of overt motility.

> Symbols are not proxy for their objects, but are vehicles for the conception of objects. To conceive of a thing ... is not the same thing as to "react towards it" overtly, or to be aware of its presence. In talking about things, we have conceptions of them, not the things themselves; and it is the conceptions, not the things, that symbols directly "mean". Behavior toward conceptions is what words normally evoke; this is the typical process of thinking. (p.49)

Application of the Distinction Between the Sign and the Symbol to the Action Symptom

In McDougall's latest writing concerning "neosexualities" (perversions), action symptoms are described as

> ... psychic organizations that attempt to resolve the conflicts in the inner world by some form of action in the external world. This obligation to act indicates a certain failure in symbolic functioning ... action takes the place of containing, feeling, and thinking (1985, p.279).

This action which replaces "containing, feeling, and thinking" and is symptomatic of a "failure in symbolic function-

ing" can be seen to fit well with Langer's distinction between the sign and the symbol. McDougall's action symptom is a sign, in Langer's sense, in that it functions to signal the existence of conflict in the inner world rather than to transform that conflict into a conceptual act of thought which can contain and delay action in the outer world. For McDougall, the conflict which is signaled is pre-verbal and importantly connected with the earliest relationship between the child and the mother.

> In the first years of life the child communicates through signs, chiefly cries and gestures, rather than through language. And in fact he can only be said to communicate by means of these signs to the extent that they are understood by Another who treats them as communications. From this point of view it may be said that a baby's earliest reality is his mother's unconscious. The traces of this early relationship are not inscribed in the preconscious as are those elements that have become part of the symbolic verbal chain; they have a different psychic position from representations contained in the form of repressed fantasies, and thus have little chance of seeking partial expression through neurotic symptoms. ...psychic suffering at this presymbolic phase is indistinguishable from physical suffering, a fact that is evident in ... many psychosomatic manifestation (1982, pp.252-253).

McDougall thus distinguishes between the action symptom as a sign and the neurotic symptom as a symbol. The neurotic symptom is a transformation of a conflict into a con-

ception which functions to delay and mediate the activity connected with it. If activity does ensue (compulsive thoughts or actions; hysterical conversion reactions; phobias) it has become a transformation of the conflict; that is, symbolic of the conflict, and not merely a signal of the existence of conflict. It is a "true" psychoanalytic symbol in that the relation between the symbolic act and the symbolic activity is not known to the subject.

On the other hand, the action symptom as a sign is part of what it signals. It lacks the differentiation between vehicle and referent which is the sine qua non of the symbol. An important implication for this distinction is that the content of the action symptom, being a sign and not a symbol, is not interpretable in the same way as is the content of the neurotic symbolic symptom. Here, the use of speech

> ... has little in common with the language of free association. ...[Language is used] as an act rather than as a symbolic means of communication of ideas or affect. ... Once the nascent thought of feeling has been ejected, [the analysand] will frequently plunge into action of some kind in an attempt to ward off the return of the unwelcome representation and mask the void left by the ejected material. Economically speaking such action assures a certain discharge of tension, and might be called an "action symptom". In this way talking itself may be a symptomatic act and therefore an "anti-communication" (1982, pp.253-254).

In McDougall's presentation, this is most clearly seen in her description of the psychosomatic character pattern and the "meaning" of psychosomatic symptoms. She states that psychoanalytic processes are the "antithesis" of psychosomatic processes. She reminds us of Freud's distinction between conversion hysteria and actual neurosis. The former Freud considered symbolic of the sexual conflicts of early childhood, and the physical symptoms retained their symbolic significance as an unconscious substitute for instinctual satisfaction. The latter Freud saw as related to present sexual problems; as such, he considered them "devoid of symbolic meaning" (McDougall, 1982; p.346).

McDougall classifies the psychosomatic symptom as an "action disorder", in that she conceives of it as an

> attempt to make substitute objects in the external world do duty for symbolic ones which are absent or damaged in the inner psychic world (1982, p.370).

In psychosomatic structures important representations are simply "decathected without compensation" with the result that there is little psychic binding through symbolic activity, but a tendency to "inappropriate somatic discharge" instead. Although this type of psychic functioning is similar to fetishism, it is not synonymous with it, in that the psychosomatic patient rarely achieves the genitalization of global primitive anxiety about castra-

tion. Thus, McDougall is not surprised to find a similarity in Oedipal constellations between psychosomatic and perverse patients. In psychosomatic symptoms, then, transmission of psychic tension to the soma occurs without the mediation of psychic structures to transform that tension into symbolic symptoms. And McDougall reminds us that

> somatic processes and psychic processes are governed by different laws of functioning (1982, p.354).

In perversion the meaning of the perverse act as an action symptom is more subtle and complex because a number of other defensive processes are at work, such as projective identification, splitting, and disavowal. In relation to the symbolic function in perverse structures, there is an avoidance of Oedipal conflict by means of a lack of symbolization of the paternal phallus. In these cases, the symbolic deficit is in a focal and delimited area, although one that is central to the development of a stable Oedipal structure able to regulate the psychic economy. The failure of symbolization leads to a failure in the capacity to regulate tension, and to the appearance of the action symptom. Here, the action symptom functions to regain from the external world what is lacking in the inner world: in the case of the male pervert, the paternal phallus. It is still more a sign than a symbol in that it is the same

phallus which is sought in the external world as is missing in the internal world. Little transformation has occurred; little conception has occurred; it is simply a matter of replacement of one for the other.

CHAPTER VI

DISCUSSION OF THE ACTION SYMPTOM IN RELATIONSHIP TO THE SYMPTOM OF DELICATE SELF-MUTILATION

Introduction

This discussion will take as its starting point the idea of "multiple function", first introduced by Walder (1936), which limits the logical difficulty of the psychoanalytic notion of over-determinedness. Before Walder's introduction of this concept, there was no principle of psychoanalytical hermeneutics that could set a limit upon how far over-determinism reached for any given psychic act. "Over-determinism opens onto infinity, as it were" (Walder, 1936; p.51). The principle of multiple function limits the determinedness of each psychic act to eight groups of problems, based upon Freud's (1923) delineation of the 'structural theory'.

> Consequently, each psychic act can and must be conceived of in every case as a simultaneous attempted solution of all eight problems (Walder, 1936, p.49),

even though the attempted solution may be more successful for one group than another. Because the complete and simultaneous solution to all eight problems is impossible, the character of each psychic act is seen to be a compromise.

In this chapter I will discuss the possible meaning of the act of delicate self-mutilation from the standpoint of

the action symptom. Following Walder, this discussion is intended to complement, rather than substitute for, the existing hypotheses and interpretations in the literature. My hypothesis looks at this unusual act from another perspective than has as yet been reported in the literature. The basis for attempting to find another perspective is viewed from the standpoint of the multiple function inherent in the over-determinism of each psychic act. I will put forward a modest suggestion as to how the symbolic function can begin to be fit into Walder's principle at the conclusion of this chapter.

Comparison of Delicate Self-mutilators With the Patients Described by McDougall

I will begin my discussion by comparing the characteristics of the patients McDougall describes with the literature already reviewed on delicate self-mutilators.

A syndrome of characteristics describing delicate self-mutilators has been reported in the literature (see Chapter 3). Their act has been conceptualized primarily in the language of neurotic psychopathology, along with references to pre-Oedipal conflicts such as early trauma and disturbed early parental relationships. An important precipitant of their act is the experience of separation or loss, which is followed by a build-up of tension and the absence of the capacity to verbalize their affective state. Delicate self-

mutilation occurs in conjunction with a form of depersonalization in which pain is usually not felt. The act of delicate self-mutilation, in phenomenological terms, is restorative.

For McDougall, the capacity for symbolic functioning is the "coping mechanism" which mediates the inevitable mental pain encountered in human life. She sees two events importantly configuring later psychic development in terms of symbolic functioning. The first is the loss of the "magic breast-mother" in the pre-verbal period, which results in anxiety of a global kind, connected with biological survival. The second is the loss related to the narcissistic mortification of the primal scene during the Oedipal period, which gives rise to anxiety connected with social and sexual integration. Early traumatic loss becomes a global menace because anxiety is not mediated through the symbolic representation of the sexual organs. Rather, anxiety remains directly connected to somatic and biological existence. Later loss is felt as anxiety concerning castration, a comparatively lesser danger, which is mediated by the symbolic representation of the sexual organs.

From McDougall's perspective, the early traumas and severe disturbances in parental relationships reported in delicate self-mutilators is grounds for hypothesizing a possible deficit in the capacity for symbolization, with

concomitant disturbances in a sense of self and, of course, in a sense of sexual identity. It is from a population with similar histories of early loss and severe disturbances in parental relationships that McDougall's cases of perversion and psychosomatic character types come.

McDougall distinguishes three types of tension regulation: repression; the action symptom; and (also a type of action symptom) the psychosomatic sign. Repression removes from consciousness impulses which would lead to unacceptable actions. The return of the repressed is a symbolic transformation of these impulses into thoughts and actions more acceptable to the ego. Because of the symbolic equivalence between the repressed impulse and the symbolic thought and/or action psychic tension is released. The action symptom releases tension through an action which not the result of the transformation involved in repression, but appears where repression would appear in the neurotic. It is a <u>sign</u> rather than a <u>symbol</u> of a psychic disturbance. The psychosomatic sign, a somatic <u>sign</u> of psychic disturbance, occurs when psychic tension is directly transmitted to the soma without mediation of psychic structures. McDougall notes that the action symptom serves as protection against de-differentiation and loss of identity in the absence of a symbolic bulwark to act as protection. In repression, which is symbolic, the defensive operation

protects against loss of sexual identity, such as fears of castration. Action symptoms are life-affirming and restorative; the alternative to them is suicide.

All reports of delicate self-mutilation remark upon the tension releasing function of the symptom as well as its restorative function in the absence of the ability to verbalize affect. As to the latter, the frequent reports of these patient's feelings of "emptiness" along with the paucity of their object relatedness leads one to speculate about whether they lack the ability to verbalize affect or whether they lack the normal experience of affect. Perhaps connected with this are the confusions, noted in Chapters 2 and 3 about these patient's capacity for repression. Affect is, after all, clearly stated by Freud to be the more important target of repression (Freud, 1915a). In the absence of these normal (neurotic) affects there would be no need for repression.

McDougall sees the perverse act as an essential feature of her patient's psychic stability, as well as noting its compulsive and inflexible aspects. It is this latter dimension that prompts her to state that Freud's dictum that "perversion is the negative of neurosis" (Freud, 1903) is not a sufficient explanation of that condition. McDougall also notes the lack of fantasy life in both her perverse and psychosomatic patients. She sees the fetish as a sub-

stitute for the lack of representation of the paternal phallus, stating "that which is missing in the internal world is sought in an external object". This must be sought externally because of a "failure in symbolization". This distinguishes McDougall's interpretation from the more usual psychoanalytic interpretations which see the fetish and perverse acts as substitutes for the missing maternal phallus (Freud, 1927; Wulff, 1946; Roiphe and Galenson, 1973. See also Chasseguet-Smirgel, 1985, for an argument in support of McDougall's position.)

Delicate self-mutilators are characterized as being on a merry-go-round in that each act of self-mutilation leaves them once more in the same place, having made no gains psychically and remaining as vulnerable to loss and recurrence of the symptom as before. Their act functions to restore their immediate psychic stability in the face of mounting tension without real change in their overall psychological makeup. In addition, the act is compulsive, although it appears to have more plasticity than the perverse scenario described by McDougall. That is, it is not essential that the same object, or even the same type of object, is used. In addition, the type and site of the cut can vary. However, it has been noted that the object is often secreted away, much in the manner of a transitional object, suggesting a relationship involving primitive af-

fect. Defense against primitive affect "differs fundamentally from ... repression" (Klein, 1930).

For McDougall psychosomatic creations are the "antithesis" of neurotic manifestations. Unlike neurotic and psychotic symptoms in which a story may be decoded, McDougall finds no such story in psychosomatic symptoms. Rather, she describes a psychosomatic character pattern, in which object relations lack libidinal affect, thinking is "operational", there is a lack of neurotic symptom formation, physical pain appears where mental pain would be expected, and there is a marked lack of associative material. Further, as babies, these patients have had either a "tranquillizing" or an absent mother, with resulting disturbances in their later ability to self-regulate.

Comparing this character pattern with delicate self-mutilators we do find an inability to verbalize a 'story', and have already speculated on whether they do, in fact, have the usual affective experiences to verbalize. Their overwhelming response to separation and loss, however, does not speak to the lack in libidinal affect noted in the psychosomatic character pattern. Rather, their libidinal affect appears to be intensely and pathologically focussed on non-responsive objects, these often being reminiscent of parental figures, and leading to the many interpretations of masochistic aims noted in Chapter 3. Their lack of

childhood neurotic symptomology, and their dirth of associative material is also well documented. While physical pain does not appear to replace neurotic manifestations, the act of delicate self-mutilating can be seen to function as a replacement for a missing mechanism for tension release. Also, the experience of normal physical pain which has been associated with the differentiation of self and other (Schilder, 1935; Hoffer, 1950) is often attenuated, and impulsive dangerous acts leading to painful injury are not unusual.

Delicate Self-mutilators From the Perspective of a Symbolic Deficit

It appears from this comparison that the population of delicate self-mutilators has much in common with the population described by McDougall. I wish now to look at the behavior of delicate self-mutilators from the vantage of McDougall's idea of the existence of a symbolic deficit, specifically with reference to the distinction between sign and symbol in symptom formation (see Chapter 5).

From a linguistic perspective delicate self-mutilators may not use language normally because of a deficit in their ability to reliably distinguish linguistic vehicle from its referent (Werner and Kaplan, 1963). This would help to explain their use of language as 'acts', as well as imply a degree of magical thinking as is found in a normal young

child. This magical thinking is implied in reports that delicate self-mutilator's expect to be understood without their effort to verbalize (see Chapter 3 above).

Further, if the "directedness" inherent in the formation of symbols should be missing, this would imply a passive role in the way in which they internalize their environment. This confluence of passivity and impulsive behavior is strikingly similar to, from another framework, David Shapiro's (1965) well known explanation of poor judgement in impulsive behavior as a cognitive style which is "deficient in certain active processes" (p.149) as well as being "concrete".

In terms of sign and symbol, the use of signs rather than symbols implies the passive reception of meaning from undifferentiated signs rather than the active creation of unique and individual symbols. This could also go further in explaining delicate self-mutilator's magical thinking, in that 'meaning' for them <u>is out there</u>, in signs, rather than within them, in the form of symbols. One would wonder how elaborated their symbolic play was as children. In adolescents, Doctors (1979) reports that her patients used graphomotor means of expression often, but produced only cliched and stereotypical images. That is, they would copy rather than "embody an original, formative power" (Cassirer, 1935).

A lack of relatedness to their caretaker in infancy would forestall their development of fantasy, thus creating disturbances in their relationship to reality (Rycroft, 1956; Winnicott, 1945; Klein 1930). Their inability to delay action implies a lack of internalized thought processes (Freud, 1917; Piaget, 1962) particularly conceptual ones. "Symbols are not proxy for their objects, but are vehicles for the conception of them" (Langer, 1942). In Langer's terms, the four essential terms for the symbol: subject, symbol, conception and object are not present. What is missing is the conception.

Without full conceptual ability the meaning of action, like the meaning of words, may be undifferentiated from its referent. Rather than standing for, and apart from a referential meaning, the act and the meaning, the word and the meaning, are partially merged. Thus, too, the act of delicate self-mutilation and the meaning of this act may not stand separate, as the symbol and its referent, but may be as the sign and the signified, partially merged. This would imply that the meaning of this act must then be sought close to the act, rather than at a symbolic distance from it. If the act is thought of as a sign, rather than as a symbol, following McDougall, one then needs to find 'meaning' in the act, rather than at a symbolic distance from it. This act is thus categorized as conforming to different

rules than does the neurotic or psychotic act, both of which use symbols to express wishes and conflicts. Calling the act of delicate self-mutilation an action symptom classifies it outside of the neurotic framework, and outside of the usual analytic modes of interpretation.

Implications For Further Clinical Investigation

By categorizing delicate self-mutilation as an action symptom and removing it from the neurotic framework and the interpretive tools connected with that framework we are forced to decide which analytic tools would be appropriate to such a population. We have seen one report (Graff and Mallin, 1967) in which touching was added to therapy with these patients in order to overcome their inability to use verbal means to symbolize their psychological conflict. Graff and Mallin state that the cutter's means of anxiety relief are "physical, pre-verbal messages". They conclude that for therapy to reach these patients it, too, must be through physical, pre-verbal messages.

Another investigator (Grand, 1982) has explored the relationship of the role of early body experience to the lack of distinction between thought and action in schizophrenia. He reminds us that Freud regarded the ego as "a mental projection of the surface of the body" (Freud, 1923), and describes treatment of autistic and schizophrenic children that focuses upon tactile experi-

ences in order to shift the function of self-stimulation from arousal to "an instrument of intentional and organized activity" (Grand, 1982, p.333). He notes that the idea of somatosensory stimulation as essential to the development of the body image and a cohesiveness in the experience of self has often been noted.

> What has not been so frequently recognized is the role of <u>self-generated</u> somatosensory experience in the process of bolstering a failing sense of self and body integrity (p.335).

Under these conditions self-stimulation serves to prevent "fragmentation of the body core of the ego" (p.335).

This description, from an investigator who has studied neither delicate self-mutilators nor perverse or psychosomatic personality patterns, sounds remarkably similar to the descriptions reported about those latter patients. It would appear to be consistent with the idea that in an action symptom a basic developmental task connected with the psychological integration of the soma has failed.

The question then of the relative efficacy of words in the treatment of this group needs further exploration. As well as her explicit reference to her patient's difficulties expressing their affective state, McDougall implicitly addresses this in her reliance on counter-transferencial responses. Her patient's inability to contain or psychical-

ly elaborate affect in moments of tension necessitates this non-verbal, or unconscious connection as a means of communication. Rather than verbalize affect, these patients tend rather to "evacuate" it by unconsciously attempting to have the analyst experience the affect instead of themselves. McDougall states about a patient of this type:

> She did not suffer alone. My own counter-transference was sorely tried (1982; p.267)

Another area for further study is the idea of the distinction of the sign from the symbol in other forms of psychopathology. For example, eating disorders such as bulimia and anorexia involve acts with problematic relationships to consciousness, as do delicate self-mutilation, sexual perversion and psychosomatic manifestations. From McDougall's point of view, these do not fit comfortably with classical psychoanalytic symbolic interpretation. It may be that these disorders, involving as they do a dirth of affect and verbalization, may be better conceptualized from the vantage of the action symptom. To various degrees this may be true as well of the addictive disorders, which have been seen to be associated with delicate self-mutilation.

At the opening of this chapter I discussed Walder's principle of multiple function. At this time I would like

to suggest that accommodating the idea of the symbolic function to this principle is another area for further thought. Walder defines eight problems connected with the functioning of the ego. Four of them are placed before the ego by the outer world, the compulsion to repeat, the id and the superego. The other four problems the ego assigns to itself in its active, incorporating aspect toward these four agencies. As a beginning to fitting in the symbolic function to this principle of multiple function, I would suggest that the symbol, as was elaborated in Chapter 4, is attached to the ego's active aspect in assigning itself problems, where as the sign is more connected to the ego's passive role as the solver of problems assigned to it. As Walder himself states, however, it is only by abstraction that these separations may be made.

The last suggestion to be made for further investigation is the most general and perhaps the most difficult. If the symbol does indeed distinguish humankind from other forms of life, as Langer (1942) suggests, then the psychoanalytic study of the formation of symbols may do much to help explain the elusive concept of 'self'. This could very well be attempted from the already important field of psychoanalytically informed infant observation and research, and would be the psychoanalytic counterpart to the work of Piaget (1962) and Werner and Kaplan (1963). Already the

academic synthesis of the work in symbol formation of Freud and Piaget has been attempted by Furth (1983). The value of the investigation I am suggesting would be to add additional empirical support to the field of psychoanalytic symbolic interpretation, as well as to clarify the nature of the difficult concept of the symbol itself.

One last word is in order about the theoretician who inspired the hypothesis of this dissertation. Joyce McDougall excells at involving the reader in the very human interactions between psychoanalyst and patient, and her attempt to frame these in theoretical terms results in thought-provoking ideas which emanate concentricly rather than linearly. While this may, indeed, parallel the complexity of human interactions, it also adds complexity of its own, and makes comprehension difficult. This dissertation has attempted to clarify only one of McDougall's ideas. It is to be hoped that she and others will continue the attempt to theoretically clarify the important human processes upon which she has chosen to concentrate.

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