CHAPTER 3

On Psychic Deprivation

CAN THE PSYCHE TRULY BE "deprived" of some element that once belonged to it? Psychoanalytic theory uses concepts such as repression, denial, disavowal and projection to describe the manifold ways in which bygone thoughts, feelings, memories, and fantasies have *disappeared* from consciousness. Yet these are not lost. They are still capable of recall under special circumstances or may find their way into our dreams, slips of the tongue, slips of memory, and sudden unaccountable fantasies; they may find expression in repetitive experiences, inhibitions, symptoms, and sublimations. These varied psychological events indicate that the psyche is never genuinely deprived of the thoughts, perceptions, sensations, or events that it has once experienced, even if, at a later time, these appear to be beyond conscious recall.

We are all unaware, much of the time, of what is occurring in our psychic reality. This is particularly evident in the unusual stories we create in the altered state of psychic awareness called dreaming, as well as in psychological symptoms of which we tend

to feel ashamed because they, like our dreams, often seem strange and illogical. In particular, those who undertake psychoanalysis come to discover that they have been conscious of only a small fraction of what composes their inner psychic world. As Freud, in his paper on "Contructions in Analysis" put it, the work of analysis "resembles to a great extent an archeologist's excavation of some dwelling-place that has been destroyed and buried . . . [but] the analyst works under better conditions and has more material at his command to assist him, since what he is dealing with is not something destroyed but something that is still alive" (p. 259).

The fact that our psyche functions, dynamically and economically, in ways of which we are unconscious, does not mean that the psyche is deprived. Few of us, for example, are conscious of our infantile sexual longings, with their inevitable procession of incestuous, homosexual, and pregenital themes. In the same vein, we are all relatively unconscious of childhood mortifications, with their quota of infantile rage, or of the envious and often murderous feelings that the child hidden within us still entertains towards those who were nearest and dearest to us in childhood. These primitive impulses all have a number of potential outlets in adult life. Ideally, our narcissistic, aggressive, and early libidinal strivings will find adequate expression in our sexual and love relationships and in our professional and social lives, as well as in so-called sublimated activities. Thus, when our primitive emotional states of mind are adequately invested and find expression in these different ways, all that lies behind our everyday experience is repressed from conscious memory.

However, when desires that are conflictual, forbidden, or impossible are only partially compensated or are suddenly blocked in their felicitous expression and subsequently find no adequate outlet, then repressed fears and longings may again come to the surface. When this occurs, they tend to give rise to neurotic symptoms or inhibitions that keep the troubling conflictual wishes from consciousness, thus permitting the individual to continue with his daily life. But this is only achieved by paying the tribute of mental suffering. The same may be said of psychotic symptoms, which frequently represent a delusional compensation for what has been

ejected from consciousness. Neurotic and psychotic symptom formations therefore take the place of what has been excluded, so that once again our psyche is not deprived—it has been compensated.

In spite of the individual solutions each of us has achieved in order to maintain psychic equilibrium, everyday life still provides many occasions for stirring up forbidden or frightening ideas. These may take the form of troubling thoughts, fantasies, or sensations that intrude upon the mind, or they may be nothing more than simple perceptions—the sight of a poster in the street, a flash of lightning, a sudden crash, an overheard conversation, or an unusual word—capable of mobilizing conflictual or painful mental representations. Nevertheless, we are usually able to put such psychic assaults "out of our minds" for the time being, sometimes so rapidly that we no longer remember them. They then become the potential furniture of dreams or perhaps the nodal points for artistic and intellectual creations. Or they may simply find discharge in daydreams. Whatever their fate, we are again compensated for what has been lost from consciousness. It should be emphasized that if we lacked this capacity to remove from consciousness troubling thoughts and perceptions, the continuity of our psychic lives in their conscious dimension would be constantly threatened. We would be bombarded with unwelcome anxiety or overstimulating wishes and therefore unable to go about our everyday lives. (This predicament occurs in the altered states of consciousness manifested, for example, in psychotic breakdowns or while under the influence of drugs.)

However, it may happen that, because of certain ways of mental functioning, the emotional impact of the external world (due to fleeting perceptions, traumatic events, conflictual relationships with significant others, or personal events such as births, deaths, or marriages) is excluded not only from consciousness, but also from the symbolic chain of meaningful psychic representations. The experience therefore goes *uncompensated*. In the same vein, the pressure of the internal world of instinctual demands—libidinal, sexual, and narcissistic deprivations, envy, rage, or continually unacknowledged aggression, and so on—may also fail to achieve mental representation. Thus these demands can be neither repressed nor subsequently used to form neurotic or delusional symptoms or character pathology.

When the psyche, either temporarily or in a quasi-continual manner, is unable to recover what has been excluded from consciousness through symptom formation, discharge in dreams, or in some other form of psychic activity, the mind may perhaps be described as in a *state of deprivation*. There is a void with which the psyche will try to deal, but its messages will be primitive and the mental functioning that results will tend to produce a reaction of a somato-psychic order, as in infancy. A child's immaturity and incapacity to use verbal thought render impossible the use of more complex ways of dealing with overwhelming affect storms and unmanageable excitement or mental pain. We see, therefore, that at this stage of existence what the psyche is truly deprived of are *words*, or more specifically, what Freud called word-presentations (1915b). Instead the psyche has access only to what he referred to as thing-presentations. These thing-presentations are dynamically powerful, unconscious elements expressed in the form of a perceptual or somatic registration of emotional arousal, which must then be decoded by the psyche and subsequently carried into action. This is precisely what happens when we are the victims of psychosomatic manifestations; a regression to infantile ways of psychic functioning is taking place. In other words, a short-circuit in the use of language and secondary process thinking has occurred. These regressive pathways are open to all of us throughout our lives, so that we are all capable of "somatizing" our emotional distress when external or internal pressures overwhelm our normal ways of thinking upon and reacting to situations that cause mental pain.

Psychic Repression Versus Somatic Expression

The practice of analysis offers frequent occasions for observing the somatic consequences of psychic deprivation. This is particularly revealing when it occurs with analysands who in general are not inclined to somatization as their predominant response to

stressful circumstances and the mental pain to which they give rise.

When clinical experience has allowed me to discover some of the underlying primitive roots and the preverbal significance of sudden psychosomatic events, this has led me to consider these somatic explosions as an archaic form of hysteria, in contrast to neurotic hysteria which, as classically defined, is predominantly dependent on language links and seeks to deal with anxiety concerning one's adult *right to sexual and narcissistic gratifications*. The substitute symptoms that the psyche creates are intended to take the place of, or act as a punishment for, libidinal wishes, whether these are invested in external objects or in the narcissistic self-image. The level of conflict that I am conceptualizing in using the term "archaic hysteria" with reference to psychosomatic phenomena is concerned more with protecting one's *right to exist* than with guarding one's right to the normal satisfactions of adulthood. Here we are dealing with the anxieties that are aroused when the sense of individual identity, or life itself, is felt to be threatened with extinction. As already emphasized in the previous chapter, the libidinal strivings of an infant may be thought of as vacillating between a wish for fusion with the mother-body and a wish for complete independence. Provided the mother's unconscious fears and wishes or the pressures of external circumstances do not render her incapable of modifying her infant's physical and psychological suffering, she will enable her baby to maintain, in times of physical or mental pain, the illusion of being one with her. When the infant is impeded in its attempt slowly to create an internal representation of a caring and soothing maternal environment and to identify with this "internal" mother, the lack of an internal protective figure persists into adult life. (The psychosomatic disturbance that gives rise to life-threatening infant insomnia is one manifestation of this lack in babyhood. The story of Sophie recounted in Chapter 5 exemplifies this.)

Somatic dysfunctioning in repsonse to stress of any kind might well be thought of as a symptom through which, as with classical hysterical symptoms, the psyche seeks to send messages that are interpreted somatically. The means are, however, more primitive

than in hysteria. Thus, in psychosomatic states, a body organ or somatic function might be perturbed for no organic reason, yet act as though it were called upon to take psychological action in a biologically threatening situation. For example, an individual's body might act as though it were trying to "get rid of" something poisonous (as in ulcerative colitis in which the body contents are brutally ejected), or as though it were trying to "hold onto" something (as in bronchial asthma, in which the patient frequently cannot expel his breath). Why would the bowel continue to empty its contents in the absence of any organic pathology? And why would anyone hold his breath, in fact almost stop breathing, without a physical reason for doing so?

Such somatic phenomena arise in response to messages from the psyche, as it attempts to deal with what are dimly perceived as threatening experiences; nevertheless, the individual concerned is frequently unaware of this aspect. Paradoxically, although the psychosomatic reaction is intended to protect the individual from psychological damage, it may in fact endanger his life. In archaic hysteria therefore, these phenomena do have a psychological meaning but of a presymbolic order, in that they are the result of a primitive attempt to deal with what we might well term psychotic anxieties, were they to be consciously recognized and believed to be imminent. But neither psychotic nor neurotic symptoms have been created to compensate for what has been ejected from consciousness, because the anxieties aroused have been unable to achieve a mental representation in a symbolic, verbal (i.e., thinkable) form.

The Unwanted Child

I shall illustrate some of the above ideas with a vignette drawn from the analysis of a man who was not a gravely somatizing patient. Nevertheless, he appeared to lack any trace of a maternal caretaking figure with whom to identify in his inner universe, and could thus be thought of, according to my hypotheses, as potentially vulnerable to either temporary psychotic or psychosomatic incidents. This analytic fragment also demonstrates the possible

relationship between psychosomatic phenomena and breakdown in dream functioning.

Christopher was a 40-year-old psychiatrist, married with two children. He and his wife, also a psychiatrist, were both reasonably successful and well-regarded in their careers. Christopher had already been in treatment for ten years with a well-known male psychoanalyst. "It was a typically Lacanian analysis. X . . . was almost totally silent throughout those years, but I tried hard to give him what I felt he wanted and did profound research into the signifying elements of my mental structure. My professional work improved considerably. Before that I was a mediocre student with little confidence in my ability to follow my chosen path." He then added, in a despairing tone of voice, "But my analysis was entirely an intellectual adventure. I'm still as ill at ease in my physical and my mental self as I was before I began—as though I don't really inhabit my own body nor my own self."

Christopher's symptoms, as well as his memories, all pointed to an extremely perturbed mother-child relationship. To begin with, Christopher, an only child, had been told all his life that he was unwanted and that his conception had obliged his parents to get married. He remembered that as a little boy he was always terrified of getting lost and that he would stick closely to his mother "in order to find his limits." He recalled vividly his fear when she went to the bathroom and locked the door behind her. He would hammer on the door, crying, frightened that he might begin to feel "lost" in her absence. According to his mother, everyone had believed, until Christopher was about 12, that he was somewhat backward mentally—until an uncle, of whom he was very fond, declared that even if Christopher whispered rather than speaking out, and tended to hide himself away from others, he was a highly intelligent little boy. Also in his twelfth year Christopher fell ill with pulmonary tuberculosis—a serious somatization to which reference will be made later. At this time he spent a year in a sanatorium where he developed both physically and mentally into an alert and active youngster. According to Christopher, the separation from his parents had been highly salutary.

The First Interview

In addition to the biographical details given above, and the brief account of his earlier analysis, Christopher explained that he sought analytic help at the present time because of the suicide of a woman patient whom he had been treating for severe delusional states. This woman, married with three children, brought about her death by setting fire to herself during her psychiatrist's recent vacation. Christopher had been very attached to this patient, had kept many notes on the progress of her therapy and had discussed her case extensively in group supervision with an analyst experienced in the psychoanalysis of psychotic patients. In addition to a feeling of narcissistic mortification in the face of his colleagues, he also felt extremely guilty, as though this tragedy were due to some irresponsibility on his part. He wondered whether his patient's unexpected and fatal act was linked to his own state of perpetual anxiety.

In both his professional and private life, Christopher felt "inadequate," "confused," "perplexed" with regard to the right course of action to take in many everyday circumstances. He claimed he was consequently overdependent on his wife, continually on the lookout for her judgments, seeking her approbation and fearing her disapproval. The theme of "loss" recurred incessantly. Christopher would become "lost" in his thoughts, as well as in his projects and his work. In the course of the analysis, his identity papers, his briefcase, his camera equipment, and his keys were regularly displaced and, as often as not, irretrievably lost. During his initial interview with me he recounted some of these facts in a muffled and sad tone of voice, like a man who had also lost all hope of being able to enjoy life. The suicide of his patient, now also lost to him, had reinforced his feeling of inadequacy in all areas of his life.

With regard to his physical self, Christopher mentioned in passing two symptoms with psychosomatic overtones. He talked of an irritable bowel condition for which no organic cause had been detected, but this was a rather intermittent occurrence and troubled him little. He was more concerned about his frequent insom-

nia, since he often had difficulty in falling asleep and would sometimes wake up feeling anxious but with no memory of any dreams.

My overall impression was that Chrisopher seemed to have little insight into his state of depression and narcissistic depletion. In addition, he paid little heed to his childhood experiences and the relationship with a mother whom he had nevertheless presented in a rather cruel light.

It is not my intention to give a full account of this lengthy analysis (in which the psychosomatic elements did not play a major role), but simply to illustrate a certain type of mental functioning which in my opinion increases psychosomatic vulnerability (among other possible symptomatic outcomes). Such mental structures appear to become organized in early childhood, when the mother-child relationship has *failed* to give rise to an internal representation with caretaking functions (with which the child needs eventually to identify if he is to aquire the capacity for both physical and mental self-care). The image of the mother in these cases tends to be split. On the one hand, there is an idealized, inaccessible, and omnipotent mother-image, potentially able to take away all suffering and satisfy every wish; however, this plays a persecutory role in that the child can neither deserve nor attain this grandiose ideal. On the other hand, there is a rejecting and death-bearing image of the mother with whom the child, once he has become an adult, will identify, consequently behaving in similar manner to his own child-self. When, in addition, the father appears to have played a rather muted role in the child's life, being therefore represented in his inner world as someone indifferent to his child's well-being, such patients act as shockingly careless parents towards themselves. They tend to look either to the world of others or to addictive substances to repair their sense of damage. These combined factors contribute to a disturbed sense of subjective identity with a concomitant lack of distinction between self and object. This favors the persistence of unrecognized psychotic anxieties regarding one's bodily and psychic integrity and eventually facilitates psychosomatic expressions.

Before coming to a dramatic somatization that occurred during the analysis, I should like to mention briefly the somatic event

mentioned by Christopher during his first interview—the sudden onset of pulmonary tuberculosis when he was 12 years old. This period of his life had given rise to many memories and associations among which we discovered certain psychological factors that may have contributed to Christopher's falling ill at this specific time. All his childhood memories led him to believe that he was an extremely sad and withdrawn little boy. He linked this to his conviction that his mother did not love him. Consequently he turned to his father in search of support for his narcissistic self-image. Shortly before the appearance of the tuberculosis, his father not only had suffered a serious setback in his professional activity but had also had a grave physical accident. Christopher remembered seeing his father bleeding, and his concern that he might die. The knowledge that his father had lost his employment redoubled his anxiety. We came to the conclusion that these events, which coincided with the stresses of puberty, may have greatly exacerbated Christopher's already existing depression and increased his vulnerability to infection.

A Somatic Drama on the Psychoanalytic Stage

The analytic fragment which follows is drawn from two consecutive sessions in the fifth year of Christopher's analysis with me. I had taken these notes, as I frequently do, following a vacation break.

CHRISTOPHER Our vacation wasn't too great . . . because of the new boat. I couldn't seem to control it . . . and most of the time I couldn't even get it started. Then I also spent a terrible night which left a searing impression on me. I'd been asleep about an hour and I suddenly woke up in great pain. My whole abdomen was monstrously swollen. I had fantastic diarrhea and explosions of stomach gas that lasted for hours. It was something spectacular. And the pain was atrocious. Even after I had the pain under control with medication I couldn't get back to sleep for the rest of the night. In fact, the diarrhea is still going on. Truly I don't understand what happened to me that night.

Over the years I have learned to treat somatic events of this order, when recounted in a session, as "communications" of a mute or infraverbal kind with an underlying significance of both a dynamic and an economic order. I approach them much as I would the account of a dream, searching, for example, for some glimpse into day residues. I asked Christopher, therefore, whether anything in particular had occurred the day before his terrible night.

C Well . . . yes . . . all day I'd struggled with the boat . . . impossible to get it started. After about two hours my wife said, "What we need is a *man* to help us!" At the time I agreed fully, yet now I come to think of it, her remark was quite shattering. Talk about being castrated! And on top of that she had gone on again about wanting a third child. I still feel threatened by this . . . it's too much . . . too soon. I can't face it.

JM It seems you hadn't "digested" your wife's remarks very well that night. Do you think that your body, instead of your mind, was reacting to all that had happened in the day?

(There followed a long pause.)

C Perhaps I was trying to make a baby for her . . . that monstrous swelling . . . and it was something like giving birth.

Although I did not say this to Christopher, I thought to myself that, if his interpretation were accurate, his somatic staging of the pregnancy theme resembled an abortion rather than a birth. Then I also wondered, in view of the material from previous sessions, whether Christopher's interpretation of his somatic illness expressed unconscious envy of the woman's capacity to bear and to give birth to children. If this hypothesis were correct, then Christopher would seem to be expelling such unconscious wishes, giving to the incident an hysteric overtone.

At the following session Christopher recounted a dream.

C Last night I had a horrible nightmare. I had a newborn baby in my hands and I was getting ready to roast it. I put it on a spit and watched over the cooking carefully, without a trace of concern or guilt. Then I began to eat it, starting with its hand. And I offered its arm to someone, maybe my wife. At that moment I became suddenly aware of the tiny stump of an arm and I began to feel afraid. The thought came to me in the dream, "My God, you've committed a crime! It's forbidden to eat children. When he grows up he'll be crippled. I've damaged him for life." I was flooded by a feeling of horror and my mounting panic woke me up in the middle of the night. I was sweating and trembling and couldn't get back to sleep again for thinking about the dream.

The similarity and at the same time dissimilarity of the nightmare and the nightmarish vacation experience recounted at the preceding session immediately captured my attention. But not Christopher's. His first association was to a dream that his *psychotic patient had made* shortly before her suicide. She dreamed that she took her youngest child (the third) and boiled it until there was nothing left "but its little heart beating in her hand." In the dream she rushed to her psychiatrist for help, asking him to make the child whole again.

In listening to Christopher's associations the following thoughts went through my mind: First, Christopher had frequently referred to this woman's ambivalence toward her youngest child; his inability to understand this particular dream, in which she specifically appealed to him for help, had also left him feeling ill at ease when it was first recounted. At one point I had said, because of the context in which he had recalled his patient's dream as well as his continuing determination to understand it, that we could imagine that the "little heart that continued to beat" perhaps also represented the patient's own childlike heart. Now it seemed to me that the same fantasy might apply to the eaten arm of the baby in Christopher's dream. Perhaps the infant Christopher had become "a cripple for life." Was not he the crippled child, incapable of securing his mother's love and equally incapable of managing a boat and thus gaining the esteem of his wife? Perhaps he was offering his arm (a gift of castration) to his mother or wife as a survival technique?

But was there not also an underlying fantasy that his own greedy

aggression might be responsible for his woes? For we find on this particular dream stage Christopher-the-cannibal who eats other people's babies. Possibly he projected onto his mother his own damaging oral love. Christopher was an only child and no doubt unwanted, as his mother claimed, but these very facts made him fearful that another might arrive who would be more worthy of her love. He had once said he felt "burned" by his relationship to his mother since she seemed perpetually unloving and out of reach. Was he getting rid of these imagined babies by eating them, burning them or "boiling them up"? (Clearly, the patient's dream of boiling her baby had made as lasting and perhaps as traumatic an impact on her psychiatrist as the horror of learning later that she had deliberately burned herself to death. It is not surprising that he subsequently found himself unable to use the dream and to further his patient's insight into her own deep conflict.)

Christopher felt he had been a "bad mother" to his patient and in his own dream he is no doubt identified not only with the damaged child but also with the terrifying mother. The dream-script reads: "Look, mothers cook and eat their babies." His association to the psychosomatic explosion recounted at the previous session seemed to read: "Mothers wish to abort their babies." To what extent was he identifying with a "killer-mother"? Christopher's earlier dreams and fantasies concerning women and their pregnancies led me to feel that one potential interpretation might be directed toward the fantasies of getting rid of unwanted children and another to his envious feelings towards women coupled with the fear of identifying with the woman as a baby-murderer. In addition, Christopher's firm refusal of his wife's request for another child seemed to follow the same pattern. I limited myself to the remark that "not all children are wanted."

This intervention led Christopher to connect the dream theme, for the first time in this session, with his wife's insistent demand for a new baby. Then he added that she had actually brought the subject up once more the preceding night.

C But I can't bear to think I made this dream. The very thought makes me feel ill.

Indeed, thoughts of this order, if excluded from consciousness, might well have contributed to Christopher's digestive illness during the vacation, particularly since they had not found expression in a dream or in some other form of mental activity. We might also propose that, when a frightening fantasy cannot find expression through a dream, this suggests that the psyche does not have access to the words required for this particular fantasy. Words are remarkable containers of feeling and may prevent highly charged emotional experiences from seeking immediate discharge through the soma or release in action.

C I'm as psychotic as my patient. I understand now why she committed suicide! I feel such hatred for myself. I can't tolerate this dream.

JM There are two people speaking at once in you at this moment—the adult who treats himself as psychotic and hateful, a child murderer, and the infant who tries to communicate his distress through this dream. This is a child terrified that others may come and take his place and he will then feel "damaged for life." He must eat up any others that threaten his existence. Your wife's insistent demand for another baby is perhaps as threatening as would have been your mother's wish for another baby. You become once more the small frightened child you have so often told me about. The adult in you can't tolerate this distressed child, doesn't want to listen to him, and may even want to kill this helpless, monstrous baby-self.

C The unwanted child! Yes, *I* don't want him either!

JM The killer-mother?

C That's what I was to my patient, an incapable, murderous mother. And we were both killer-mothers in our dreams!

I then reminded Christopher that at our last session he had recounted a quarrel, during the vacation with his wife, that had been followed by "monstrous" diarrhea and a night of insomnia. This time there is no somatic explosion but an explosive dream that was also followed by insomnia. This proved to be an important turning point in Christopher's elaboration of his relationship to

the anxious child-self whose messages he had tried to stifle for so many years. It also heralded the possibility of analyzing his ambivalent love-hate feelings toward, and homosexual envy of, women. These themes occupied many succeeding sessions and brought many new associations into Christopher's psychoanalytic discourse.

From the material contained in this short vignette I would make the following hypotheses: The events of the day preceding Christopher's massive gastric perturbations had mobilized in him extremely primitive fantasies which had never been put into words and which would have evoked affects connected with distress, rage, envy, and oral sadism. But Christopher was totally unaware of this archaic dimension. I would suggest that my patient's body had reacted as though it had been poisoned because he was deprived of the knowledge of wordless fears and the primitive fantasies that were just becoming capable of verbalization.

The horrifying themes expressed in the dream are closer to psychotic fantasies than the fears associated with neurotic organizations. But in Christopher's case the foreclosure from the psyche of certain important mental representations, accompanied by the loss of the associated affects, was not recovered by delusional formations, as in the psychoses. Instead, a radical split between body and mind had occurred. Messages sent by the psyche were not transmitted through the symbolic chains of verbal thought and word-presentations; rather, short-circuiting the links of language, they were registered only as *thing-presentations*, provoking a direct somatic response, such as we observe in small infants. The persistence of this kind of mental functioning, reveals frequently, in the course of analysis, its roots in the early mother-child relationship. The mother's unconscious problems or stressful circumstances may prevent her from providing a sheltering space in which her small child can develop a more mature form of psychic organization when in the throes of primitive emotional states. Innate vulnerabilites, such as neurological impairment or cognitive disorder, may also hamper the *infant's* ability to take in and process the mother's empathic response. Whatever the cause, there has not been a "good enough" mother-child relationship.

This deduction in Christopher's case is supported by his other psychosomatic complaint—his severe insomnia. Lewin's research (1946, 1948) led him to propose that manifest dreams are like a technicolor motion picture projected onto a blank screen that is the dream representative of the breast, and that "blank dreams" represent the refinding of the early breast relationship. If these hypotheses are accurate, then one might question the capacity of certain patients, who have had a perturbed mother-child relationship, to fall asleep with ease and "regress" to the blank-screen state. If the breast-mother was experienced as unreliable or incoherent in her relationship to her nursling, this might impede the ability to dream at all. Thus the normal discharge that unconscious conflict, highly charged with emotion, seeks through fantasies and dreams is often lacking. (I have found similar disturbing representations of the mother in a number of analysands suffering from insomnia. These patients frequently seemed to behave like Ferenczi's "wise babies" (1931). In a sense the "babies" must be parents to their own nursling selves. Incapable of reliving the primary fusion with a supportive maternal introject, they must stay awake so that no harm comes them.)

Christopher's constant fear of separateness and loss, coupled with his difficulties in sleeping, led me to the assumption that, for obscure reasons, his mother had failed to ensure the basic maternal function of shielding against overwhelming stimuli both from within and from without. The sleeping tablets he took constantly no doubt played the role of a transitional object, since he appeared to lack an inner maternal object capable of permitting him to fall safely asleep. As Winnicott (1951) pointed out, experiences of overstimulation consequent upon the mother's failure to provide a screening function, if often repeated, will contribute to the creation of a "false self." In Christopher's case this took the form of pseudo-deficiency in his intellectual functioning and, later, of character defenses against the psychotic anxieties with which he was constantly threatened. These served to mask a persecutory representation of his mother, while keeping at bay considerable depressive affect associated with infantile rage and oral aggressive fantasies.