"ON THE FEELING OF BEING EMPTY OF ONESSELF"[1]

Mrs. Enid Balint

We often hear the expression that someone is "full of himself," which indicates a state of being proud and happy and self-identified. There are opposite related phrases like "not myself today," etc. These phrases appear to be related to the complaint sometimes presented by patients who feel they are empty or empty of themselves.

These expressions deal with the relationship between the ego, the body and the self, and the boundaries between may not always be sharp. Related concepts are Freud's body ego, Federn's ego experience and Schilder's body image. "Empty" people can be described as having some of the following characteristics: They are unable to be alone or to do things for themselves. At the same time, they dread human contact and are shy, inhibited and awkward. They are not satisfied with themselves. Although they sometimes can make an acceptable social adjustment, they may have to withdraw completely, which may lead to more confusion and even hospitalization. They are empty, yet they need contact with others but are not helped by it.

The early origins of this syndrome appear to lie in the paranoid schizoid position described by Melanie Klein and referred to in works by Ferenczi, Michael Balint, Winnicott, etc.

1. Summary of the scientific meeting of the Southern California Psychoanalytic Society in Idyllwild, Calif., June 2, 1963.

This paper will consist of clinical observations on possible psychogenetic elements in this syndrome. It appears to be related to the communications with the mother and her providing a feeling of time, growth and development for the child. The empty feeling seems to be seen more among women and may be related to the psychology of mothers. The patient is troubled more by a lack of herself rather than a failure to incorporate other objects. The question arises whether these people have ever felt "full of themselves."

This patient was a 24-year-old woman who saw herself as scorned and not recognized by her mother, who failed to observe the incestuous relationship which developed between the patient and her brother. The patient felt that the analyst would not recognize her in the waiting room and felt their relationship was meaningless. She felt in constant danger from animals and termites who might be undermining her. She never looked at the analyst and dreaded the world of her mother as an empty void. At one time during the analysis, it was necessary to hospitalize her for a three-month period when she became depressed, inert, schizoid and obsessive. During the analytic sessions, the patient was frequently allowed to draw, and the analyst retained these drawings as parts of the patient. As the analysis progressed, the drawings gradually became more complete and finally showed whole objects. It was only later in the analysis that the patient could refer to her body in any way. Much of the analytic work was done during violent

sessions when the patient would hit the couch, collapse and become incoherent, making sucking movements. After a period of this behavior, she would be able to speak coherently. Just as the patient feared the void of her mother's world, she dreaded the void of the transference when the analyst did not understand her. At these times, she felt empty of herself, as she did in other relationships. When she felt full of herself, the patient was afraid of her own hostility, and was safe from it when she felt empty.

After three and one-half years of analysis, a decision was made to terminate at six years. This was done for practical reasons. The analyst did not want to be involved in an interminable relationship, the relatives with whom this bizarre and regressed patient lived could not tolerate her indefinitely, and there was some evidence that the patient's family would not continue to meet the financial obligation. During the termination, there was an upsurge of violent aggressive and paranoid feelings. The patient worked on her relationship with her brother and her father, was able to start a secretarial course, and felt much anger and fear of losing herself again. She wrote occasionally to the analyst after terminating, was able to move away from her parents, got a job and seemed to be making progress.

The analysis could be seen in four phases: Phase 1 dealt with the feeling of being empty, the horror of living in the real world and her catastrophic mental activity. Phase 2

involved the patient's drawings which were accepted and saved by the analyst. Phase 3 showed the violent mood swings, the sucking movements and the first discussion of bodily feelings and genital symbols. Phase 4 dealt with paranoid and persecutory anxieties. In a three-year follow-up period, there was evidence of considerable developing adjustment to reality.

Historical features which emerged as important were the complete lack of understanding between the patient and her mother, the mother's preconceived ideas of what the patient felt, and a possible innately limited capacity for adaptation. The mother's inability to tolerate "bad" feelings on the part of the patient, leading to the patient's missing a sense of being accepted for all of herself and a total failure of identification with the mother were crucial. The mother showed an inability to provide a time for integration of the self of the patient. She felt her mother never saw her as she really was. Thus, there was no echo of herself from her mother, analogous to the phenomenon of feedback.

Ideally, there should be interaction of two active partners in the mother-child relationship. Children need acceptance, including their hurts, their defects and their bad feelings. This patient lived in a world where she felt threatened with an overwhelming upsurge of id material because of the lack of integration between her id, her ego and her "self." She was in a cycle of endless futile anger and despair with no feedback from her mother, and she was isolated by stunted

introjections and identifications. Ego development depends on interaction between the individual and the environment which should include as one essential element, the feedback from the mother. If this need is really disappointed, there develops (1) greatly increased aggression and hatred and (2) deficiency symptoms from the lack of a sense of self.

DISCUSSION

Dr. Franz Alexander: Mrs. Balint showed great patience during six years of psychoanalysis with this very regressed patient. The patient's mother did not have the equivalent amount of patience. The central phenomenon in this case appears to be related to the concept of sensory deprivation, which shows that environmental contact is essential for normal ego functioning. Maturation is not simply an endogenous phenomenon, but interaction with the environment is essential. It must be the right kind of interaction to avoid the intensification of the production of internal stimuli, leading eventually to hallucinations as seen in sensory deprivation.

It is noteworthy that Mrs. Balint did not refer to the work of René Spitz, which would seem to have some bearing on her paper.

The concept of emptiness could also be described as a lack of ego identity or a state of ego diffusion. The results in this psychoanalysis appear to be due not to a cognitive

understanding, but really to a new mother-child relationship which had the effect of correcting the damaging relationship from the patient's childhood. Mrs. Balint was the opposite of the patient's real mother. This raises the question as to whether or not a simple supportive and accepting environment for the patient could have accomplished as much for her as her years of psychoanalysis.

Our method of working with our patients involves cognitive exchange, but this may not be the crucial element in our work. We attempt to make correct interpretations which may help, not through cognitive insight but through giving the patient a feeling that he is understood, and this sense of being understood may be the basis of any therapeutic benefit. This loosens frozen developmental processes and allows the patient's development to continue. Only the organism can heal itself; we can only free it to do so.

Mrs. Marie Briehl: It is noteworthy that the period of six years which this analysis lasted is the crucial time of childhood, the information about which we obtain almost entirely from the mothers. These are the crucial years. The patient's trauma from the incestuous relationship with her brother, during the years 6 to 12, probably had the effect of stopping the integration which should have been occurring during her latency period. This resulted in a destruction of her identity during her latency period, which finally broke down in adolescence.

Dr. George Frumkes: It is striking to note the con-

trast between the rather concrete title of this paper and the somewhat vaguely described pathology. The process of communication is stressed in many areas of life at the present time, and the emphasis appears to be now on process rather than on structure. This patient could be called an ambulatory schizophrenic, who felt that her self had disappered rather than the world. One is reminded of Descarte's familiar quotation, "I think, therefore, I am."

Dr. Sydney L. Pomer: This paper raises the interesting possibility that patients could be selected for their analyzability by a particular analyst through an effort to determine the analyst's suitability for providing the necessary echo for the patient. Freud pointed out that analysis speeds up the life process of maturation, and it is doubtful that 6 years of benevolent hospital care or similar ideal environment would have provided the same advance that this patient's psychoanalysis did.

Dr. Gerald Jacobson: This paper revives some thoughts from Dr. Michael Balint's paper on benign and malignant regression. It may be that a therapist providing what the patient needs in order to mature or to cope with his situation may foster the occurrence of a benign regression; whereas, if the patient wants the therapist to be a parent just for the infantile gratifications involved, the regression may become a vicious cycle and a malignant regression. In this psychoanalysis, the question must be raised as to the effect of setting the time limit, and what bearing this had on preventing a

malignant regression in this case by setting a definite limit.

Dr. K. V. Rajan: Emptiness is a vacuum, and this patient did not want to be close. I wonder if this was interpreted to the patient. It is essential that the analyst examine his own response and concept of what the patient means when she says she feels empty.

Dr. Richard Alexander: I agree that the concept of a corrective emotional experience is the crucial thing in this case. This patient must have built up strong masochistic needs for rejection, and one wonders how this was handled. It is clear that an environmental change is not enough to deal with such material. The parent's refusal to pay for the last year of analysis is interesting, and I wonder if it was related to some change in the patient at that time.

Dr. Clyde Miller: Much of the material about this patient and that in Dr. Michael Balint's paper on malignant and benign regression would seem to refer to a type of patient in whom hospitalization is a frequent necessary adjunct to the therapy. Some comment on the value of hospitalization, and adjunctive personnel would be helpful.

Dr. Harvey Strassman: In this case, it appears that the malignant regression occurred before the treatment rather than during the treatment when the defenses had been broken down. When this occurs, the psychoanalyst must become a patient therapist, like Mrs. Balint.

Dr. Albert Schrut: Just as these patients showed

two characteristics; an inability to be alone and yet an inability to be with people, they need both a treatment relationship and an accepting environment.

Mrs Enid Balint: The psychoanalysis provided the patient with the feedback which she needed and had failed to receive during her childhood. I emphasized this aspect, but it was not all that she needed and not all that occurred during the analysis. Much of the early work in the analysis involved helping the patient reach and understand her feeling of emptiness, and become able to verbalize it. She had to become able to be angry with this empty feeling, and to be dissatisfied with the treatment and with me. Thus, she had to be able to experience bad feelings and to have them accepted as her mother could not.

Masochistic elements were very strong in this patient, but a feeling of an awareness of her "self" had to appear first. Interpretations of her wish to stay away from me were made frequently. Many times, these patients erect a false self and achieve false relationships; whereas, they need meaningful relationships and experiences. Some regression is needed in working with this type of patient, but it can be limited and benigh. In this patient's development, she abandoned efforts to be compliant and acceptable to her mother, and her self was almost totally made up of horror and fear.

Hospitals are very useful for such patients, and this

patient was hospitalized several times, particularly at times when it was neeessary for me to be out of the country for several weeks. This type of patient needs, at many times, a hospital or an accepting hospital-like environment, as was given her by her relatives.

It is my feeling that self-realization is a better term than ego identity for the phenomenon being dealt with in this material. It is as though this patient had no good to get back to but only bad, similar to the concept of the basic fault.

John S. Peck, M. D., Reporter