When Theories Touch – An Attempted Integration and Reformulation of Dream Theory

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As a background to concepts of trauma this paper presents a theory of development that attempts to provide concepts that promotes the theoretical integration of different theoretical positions. In addition there is a theory of endogenous stimulation that is put forth that is meant to be a new "drive" theory. This theory to some extent differs from each of Freud's drive theories. These new concepts allow for the discussion of various psychoanalytic bifurcations. One prominent dichotomy is whether humans are pleasure or object seeking. This dichotomy in the present context is viewed as relatively meaningless and there is an attempt to show some of the multifaceted aspects of human experience that relate to optimal as well as traumatic developments. To this end there is a discussion of Prescott's views on holding and Hrdy's compilations of different aspects of mothering. The chapter ends with a clinical illustration of the importance of understanding levels of endogenous stimulation or in other terms the sources of an individual's vulnerability to trauma.

A theory of endogenous stimulation

The presentation of this theory will be followed by how this type of theory relates to clinical concepts. Although we have amassed a reasonable amount of supportive experimental evidence, I do not think that the theory that will be put forth has been shown to be true or is largely accepted by the scientific community. It is a theory that I believe, but that is my metaphysics; there are alternative concepts, such as affective thresholds, that, to some extent, provide rough theoretical equivalents. In my view, the present theory presents greater explanatory power and greater heuristic value.

Theoretical summary

The model starts with the dream as the entry into a theory of endogenous stimulation. It is my view that the dream represents a person's attempt to deal with issues of survival (Ellman, 2000) that, in early development, directly involve issues of pleasure and unpleasure. The self, in some manner, is usually represented in the dream, and, even in early infancy, self and object representations are at least vaguely present. In the

dreams of children or adults, the self representations may be disguised or occur in symbolic form. My view of dream formation is closely linked to a theory of the function of rapid eye movement (REM) sleep (Ellman, 1992; Ellman & Weinstein, 1991). In this theory, REM is thought to (some may say has been shown to) activate pleasure pathways that are neural networks which are intimately tied to basic behavioral functioning necessary for a mammal to survive. In the rat, what I have called basic behaviors might include nest building, food seeking, courting, sexual behaviors, and, most fundamentally, aggression. Whenever a mammal goes into REM sleep, the intracranial self- stimulation (ICSS)[1] or pleasure pathways are activated and, in turn, are a factor in regulating basic behavioral areas. The memories associated with these areas are simultaneously stimulated. In humans, activation of these areas frequently (virtually always) activates memory systems that involve conflict, and, most typically, the dream (the mentation present in REM sleep) contains material about issues that are most important and/or most threatening to the individual. Under optimal circumstances, the dream provides some way of resolving a conflict, and the dream is forgotten. If the dream is particularly stimulating or anxiety provoking, the dream is more likely to be remembered. Anxiety dreams occur when the system is over-stimulated either psychologically or physiologically. The concept of over-stimulation, or too much stimulation, will be discussed later in this chapter. In traumatic dreams, the dreamer cannot envision a way in which threat can be resolved. These dreams are frequently repeated until some threat resolution is seen as possible. In traumatized patients, this may not occur, or only occur with good enough psychological treatment.

I have emphasized the survival nature of dream mentation, but I should point out that, in optimal or good enough development, the first dream is hypothesized to be a memory of a satisfying event. The infant in this state envisions satisfaction of a need state that is important to its survival, and this memory is in turn consolidated. In good enough development, the dream state is seen as adaptive rather than regressive. This theory leads to a revision of Freud's concepts of primary and secondary process. In this theory, if development is going well the first images of the infant are adaptive and self-enhancing, thus moving the infant to adaptive attachment behaviors. REM sleep is designed to facilitate a mutually gratifying interplay between infant and mother. However, even if Winnicott is correct in his

[1] A term used when an animal will work or perform a task, to receive electrical stimulation to a part of the brain, a phenomenon discovered in rats by Olds [1958]. The areas of the brain that will support this behavior are called pleasure centers.

view of absolute dependence, there will, of necessity, be conflict early on in the infant's life. No matter how dedicated the parent, optimal gratification will not always take place, and, to some extent, even the healthiest of infants will experience what Winnicott (1962a) called "falling to pieces", or annihilation anxiety. Thus, registration of anxiety-producing survival issues will enter the infant's dream-world early in life. The issues that are brought up in REM sleep mentation are survival issues that usually (virtually always) involve an element of the body–self represented in the dream[2]. Here, by body–self, I mean that the infant and developing child usually represent the self in terms of their bodily experiences or bodily functions. Are these survival issues wishes?

From my perspective, sometimes a motivating factor for a dream might be a wish that is seen by the dreamer as important for their well being; however, a dream could just as easily be motivated by a fear or some anxiety that is not related to a wish. In this theoretical statement, the adaptive and survival functions of the dream are the central postulates. It is important to recognize that because there was an attempt at an adaptive solution, it is not necessarily the case that the solution continues to prove to be adaptive. It is perceived to be the best solution available to the dreamer at a certain point in development. Given the repetitive nature of some conflicts, the perceived adaptive solution may come from a period that is early in the dreamer's life and no longer be adaptive. The idea that the solution is no longer adaptive is a perspective that comes from outside the dreamer (from another person).

To finish this theoretical summary, in this conceptualization, REM sleep is one form of endogenous stimulation. In addition, the same mechanisms that caused REM to be activated every 70–90 minutes during sleep are also activated during waking hours. (This hypothesis originated with Kripke and Sonnenschein [1973] and Globus [1970].) This endogenous rhythm tends to periodically activate mammals. Thus, whales that have REM sleep every 120 minutes would be activated with this REM periodicity, whereas a human would be activated every 90 minutes (humans' REM periodicity). The difference between REM activation and waking activation is that, during REM sleep, there is an active inhibition that stops the organism from moving. This active inhibition is not present at birth. (The inhibition occurs at the level of the pons, where motor impulses are blocked

[2] These issues are not always brought up in a painful manner; the infant may dream of successfully eliciting gratifying experiences. Nevertheless, this success, at some level, is perceived as necessary for well-being or, to use Winnicott's language, going on being to continue.

at this level. If an impulse gets through at the level of the pons, there is a further inhibition at the level of the spinal cord (Ellman,1992).) At birth and for several months after birth, the infant is moving its limbs and sucking vigorously during REM sleep. Parents frequently mistake early REM for waking.

Before we leave this theoretical summary, we might ask the question: how does this theory differ from Freud's drive or instinct theory? Freud's theory saw instinct as the main determinant of an individual's psychological world. The present theory pictures endogenous stimulation as one factor in an individual's development. For some individuals it may be an important factor, and for others relatively inconsequential. The present theory also sees endogenous stimulation as a factor to facilitate attachment, rather than as a factor that induces regression (in the sense that Freud used the term in *The Interpretation of Dreams*). Freud (1900) saw the infant first hallucinating the object and, at least for a short period of time, being satisfied with the hallucination or the visual experience of the object. It is our view that the infant, when activated by need, probably first responds with a genetically pre-programmed response (crying) to elicit a built-in response from its parents. If it is sometimes the case, as Freud posited, that the infant first visualizes the satisfying object, then we would assume it does this to adaptively remember the source of comfort or pleasure. What is primary in this model is the adaptive aspect of endogenous stimulation; this internal stimulus is programmed to obtain a response from the infant's care-givers. The interaction with care-givers is not simply around need, but is present for a range of interactions that allow the infant to begin to cathect, or affectionately represent, the main care-giver (usually the mother).

Freud's view was that pleasure is associated with drive reduction, and he came to that perspective for a variety of theoretical as well as historical reasons. Pleasure can occur in a variety of ways, and we can say unequivocally that there is a good deal of evidence that indicates that drive reduction is not the only pathway for pleasurable experiences. Given these views about endogenous stimulation, it is apparent that we see the primary, or first, process that the infant goes through as one that provides signals to its care-giver(s). It is only if (or when) the care-giver does not respond to the infant's signals that the infant might resort to producing memories of the satisfying event. If this happens in a continuous manner (memory instead of real satisfaction), the memory will become aversive rather than satisfying and, if not responded to, the infant may fail to thrive. Here, the main point is that the primary activities are the infant's signals to its mother; secondarily,

the infant may produce memories of satisfying events as a way of soothing or reassuring itself.

Although one might say that the first modes of communication between infant and mother are through pleasure and unpleasure sequences, I would agree with Fairbairn (1951), Mitchell (1988), and Bowlby (1969, 1973, 1980) that the overall function of these modes of communication is to bind the mother– infant pair into a libidinal unit (which is, of course, a Freudian way of describing the unit). In the present theory, this is in order to insure the survival of the infant. Here, then, we might say that for the health of the infant, both mother and infant eventually have to be object seeking. This is an aspect of early development that Freud barely mentions, and when he does, his most important statement is in a long footnote (Freud,1911). However, if we look at the infant at birth, Fairbairn's dictum that humans are object seeking rather than pleasure seeking seems out of touch with an infant who is mostly sleeping, eating, and needing a variety of biological functions to be monitored. Moreover, in a sense, both object seeking and pleasure seeking seem out of touch with an infant that needs mostly to receive and be held. Although the infant is certainly more active mentally than one might have imagined in 1900, it is still primarily sleeping (10–17 hours a day), eating, and needing to be changed and comforted (held). Winnicott's description of absolute dependence (Ellman, 2009) seems to me the most accurate description of the activities between the mother and the infant. Winnicott is not merely describing the interaction, but also picturing the internal state of the infant. He assumes these internal states need to be anticipated (object presenting) by the mother in such a manner that the infant experiences the environment as providing for it when a need arises, or even slightly before a need arises. This is Winnicott's meaning of natural omnipotence, the sense of an infant that its experienced needs (no matter how inchoate the experience) are quickly gratified by the environment. In Winnicott's terms, this is good enough mothering. Although I agree with Winnicott that the infant will be well taken care of with what he calls good enough mothering, I believe good enough mothering is hard to do.

Pleasure or object seeking, or a different vehicle

Let us return to a question that we seemed to have answered: is the infant object seeking, pleasure seeking, or both in its first few days of life? I have intimated that the dichotomy is a false one, but I have also implied that perhaps neither theoretical postulate talks to the infant's primary needs. As Prescott states (2001) what is crucial in mother–infant contact is newborn/infant carrying [which] is another "infra-human primate maternal universal" that has been largely lost to homo sapiens mothers. In [my] view,

body movement (vestibular–cerebellar simulation) is the external umbilical cord—the primary sensory stimulation in utero—that conveys continuing basic trust and security to the newborn/infant. (2001, p. 227)

If Prescott is correct, then the prime issue for a newborn infant is not pleasure or object seeking, but a continuing sense of basic trust and security that makes the new environment more manageable and lessens the probability that birth and its immediate after effects are traumatic. It seems that a prime way the mother makes contact with the infant is through comfort first of all. This is object seeking by the mother and undoubtedly pleasurable for the infant. If one wants, this can be called object or pleasure seeking, but, in my view, it is primarily security building. In a recent publication (Ellman, 2009) I have presented data from Prescott, Hrdy (1999) and others (Hunziker, U. A., & Barr, R. G., 1986). about genetic flexibility of primates but in this context I can only mention this point of view.

The mother–infant dyad and REM sleep

In what follows, I will simply state our theory with the understanding that it is a theory, not findings that have been demonstrated experimentally. I am, however, using some of our past experiments as a model for this theoretical exploration. To keep within the paradigm of our past experiments, I am using the term stimulation instead of activity or behavior; therefore, there will be stilted sentences in what follows. These sentences will state that the mother stimulates the infant when, in fact, the mother is playing with, feeding, holding, or changing the infant. In any of these exchanges, the mother, to a certain extent, stimulates the infant, and this will be our focus. To begin this discussion, we will picture an infant with a high level of endogenous stimulation. The hypothesis is that individuals differ in the amount of endogenous stimulation that they produce. (We are using the term "amount", but more intense stimulation is probably produced by the rate of stimulation per unit time.) This stimulation is produced every 70–90 minutes in human beings (REM periodicity). Since we are imagining an infant with a large amount of endogenous stimulation, for this type of infant a small amount of external or exogenous stimulation will be mildly pleasurable and larger amounts or more intense stimulation will be unpleasurable. The summation of internal and external stimulation in this illustration pushes the infant into the negative, or unpleasurable, range of experience[3]. Thus, what other children experience as a normal amount of

[3] We have demonstrated that the amount of stimulation from pleasure sites determines whether the stimulation is positive or negative.

pleasurable stimulation may be experienced as unpleasurable for the high endogenous infant. This infant will be like the animal (Bodnar, R., Ellman, S. J., Coons, E. E., Achermann, R. R., & Steiner, S. S.,1979). that receives too much stimulation; they will want to escape from the situation that is producing unpleasure or pain for them. Since the normal mother wants to bind with her infant, it will be painful for her when her infant responds negatively to a range of her behaviors that she intends as behaviors to entertain or even soothe the infant. It will be the task of this mother to attenuate her responses and try to feel and accept what the infant is experiencing. If she can contain her disappointment and feel the infant's experience, the infant has a greater probability of binding with its mother. It is a difficult task for a mother to be able to feel her infant's painful experiences even though the mother perceives herself to be behaving in a "normal" manner. Of course, there may be the ideal mother who does not take it as a narcissistic blow if the infant responds negatively to her seemingly moderate attempts at engagement. Most mothers will want the infant to respond positively to their ministrations and, when this does not occur, it requires a resilient mother to accept this and learn to titrate (effectively modulate) the level of her activities with the infant. What happens if she feels that she is a failure or feels that there is something wrong with her infant? This may spur her either to provide more stimulation for the infant (to desperately try to attract the infant) or, alternatively, to keep her distance from her child. It can easily be a narcissistic blow (not to mention a depressant) for a mother if a baby fails to respond to what Laplanche (1997) has called the mother's seductions. This might happen actually or metaphorically. The task of dealing with a high endogenous stimulation infant may be quite difficult for a mother who, for one reason or another, wants to be active in producing responses in her infant. For a high endogenous infant, the adaptive internal response may be to begin to develop false self responses. In other terms, the infant learns to respond to a mother who is disappointed and wants the infant to enjoy her active stimulation. False self, in this context, means that the infant is forced to comply with external demands at a time when it requires effort and requires the infant to inhibit its normal responses. In this description of early development (0–5 weeks), the infant should not be overly concerned with external objects. The beginning of a false self development signals the infant's attempts at limiting its spontaneous actions (gestures). Other infants who are unable to falsely comply may turn away and fail to engage with their environment. A mother who is able to feel the infant's displeasure to active or intense stimulation and is able to modulate her responses may

gradually be delightfully surprised by the infant's/developing toddler's spontaneous activity. The word "toddler" is put in here because it may take a period of time for the mother to be able to actively enjoy her child. This type of infant/toddler might then be able to seduce and intrigue its mother. If the mothering is facilitating, this may allow the infant to be in touch with their active internal life and eventually enjoy their sense of self. An infant with a mother who is negatively affected by the infant's sensitivity might lead the infant to try to silence or actively inhibit their internal stimulation, or actively evacuate their mind in some manner. Certainly, Klein's concept of projective identification is relevant to the way these infants may evacuate their minds.

What about an infant with low levels of endogenous stimulation? Here, one sees a child that will be less likely to respond to normal amounts of exogenous stimulation. The exogenous stimulation may not be pleasurable or intense enough to entice the child. This mother may be disappointed because of the lack of response of the infant. The disappointment may be less intense than that of the mismatched mother of the high endogenous infant, since the low endogenous infant is not turning away or fretting as actively, it is simply not responding with enough pleasure. Again, the ideal mother feels that the baby either needs more stimulation to engage it, or, at times, the mother deals with her disappointment that the infant is not as reinforcing as she would wish. If the mother cannot contain her disappointment, then she may either turn away herself or try to get the infant to act in a manner that is uncomfortable for the infant. She may, too continuously, try to produce a response in the infant. This type of mismatch also may produce a false self, as may be the case with a number of mismatched mother–infant dyads.

Let us focus for a moment on the mother's tendencies. In a study performed by Alfasi-Siffert (1985), she looked at gaze–gaze aversion in three-month-old infants. Part of the paradigm for this type of experiment was used by Stern (1985). In this study there were two different conditions: one where the mother and infant's gaze–gaze aversion patterns were recorded, while the other involved an experimental confederate who was trained to gaze at the infant only when the infant wanted to initiate gazing. With most mothers, the infant would gaze and meet the mother's gaze, and then the infant would dart away (move its gaze away) and then come back again to gaze. Most mothers would allow the infant to dart away, and then the infant would return to meet the mother's gaze. One mother, however, would follow the infant's gaze when it darted away and she would try to regain contact. When she did this, the infant would again dart away, and,

rather than having a period of gazing and a period of darting, this pair engaged in virtually continuous darting. In this study, we could compare the infant's responses to its mother with the infant's responses to the confederate. Since the confederate did not try to stop the infant from darting away, the infant with the confederate looked like other infants in terms of a gaze–gaze aversion, return gaze pattern. This mother could not tolerate the infant being separate from her, even in terms of gaze patterns. She stimulated the infant to such an extent that the infant continuously wanted to avoid her gaze. Here is a case where the infant seemed to have mid-range sensitivities but his mother was so overly stimulating that he found it difficult to tolerate. This example tells us that it is not just the infant's sensitivity, or lack thereof, that determines patterns of interaction. It is always the interaction between mother and infant that determines the effects of stimulation, but, clearly, in some interactions, one party or the other accounts for most of the interaction.

Some other theoretical issues

Melanie Klein emphasizes the infant's frustration tolerance (Ellman,2009) as important in understanding early development. She writes as if this is a characteristic inherent in the infant, as opposed to one that is the result of interactions between mother and infant. In our theory there is a higher probability of the high endogenous infant displaying lower frustration tolerance. These infants are more sensitive to a range of stimuli and often harder for mothers to read consistently. Moreover small increments in stimulation can go from positive to negative quickly making the mother and the environment a "bad" or aversive place. The infant may need to actively split its nascent representations to maintain some goodness. Thus a high endogenous infant is more likely to look like an infant that Klein has described.

However, a mother who can read this type of infant may help develop an infant/child who eventually has greater than normal frustration tolerance. This type of child may experience the mother's mind and caring in a manner that leads to more gratitude than is usually the case. In addition, this type of infant may develop into a person who has access to a greater range of internal states. If one can access and control these states, frustration tolerance may develop along wide and deep lines. Thus, frustration tolerance, while important, should also be seen as almost always a product of environmental–infant interaction.

Winnicott's version of good enough mothering makes it seem as if good enough mothering is a normal state for mothers. While he acknowledges that the mother needs support, nevertheless he writes as if

mothering is a state that a woman can easily transition into once the infant is born. Reading Hrdy's book (1999) about mothers, infants, and natural selection, one gets a view of mothering from a number of different perspectives. Hrdy relates how important it is for the infant to seduce the mother into caring, since it is her thesis that motherhood is neither instinctive nor automatic. While puerperal insanity (a term Winnicott uses) may invade some mothers, Hrdy documents higher rates of infanticide and abandonment than would occur if all mothers developed this type of fever. Magurran (2000), in a review, states that Hrdy goes so far as to suggest that the extraordinary plumpness of newborn humans, much fatter than other infant primates, is an attempt to convince their parents that they are worth rearing. Even an infant's smile becomes, in Hrdy's eyes, part of its strategy to seduce its mother. Even with this seductiveness, many mothers have a hard time attaching to their infant, perhaps because some infants are not that seductive, more likely because some mothers are not ready or able to mother at some points in their lives. In terms of the interaction between mother and infant, Hrdy makes it clear that the seduction by the infant is an important part of most interactions. Winnicott, with all his sensitivity, is still writing largely from the baby's perspective. He accentuates the mother's tasks in providing an auxiliary ego for the infant, but he has a hard time in remembering how the mother needs to be at least somewhat induced (seduced) by the baby. This seduction is particularly important given all that the mother has to provide during what Winnicott describes as the period of absolute dependence. Thus a baby that can seduce and show pleasure as a result of the mother's ministrations is more likely to look like a Winnicottian baby. Most often these babies are neither high or low endogenous stimulation infants.

Primary and secondary processes, aggression, and Ms W: a note about treatment

In some ways I am proposing a return to a version of Freud's early instinct theory. There, the two instincts were survival of the self and survival of the species, and it is a reasonable hypothesis to imagine that both of those tendencies are hard wired into human beings. We have already looked at the differences between a theory of endogenous stimulation and Freud's instinct theory, but, to this point, we have not presented a theory of aggression. In the present theory, aggression is seen as one aspect of all, or most, survival activities.

For example, if food gathering is an activity that is being primed or lowered, thresholds for aggression are simultaneously lowered. In this

theory, aggression is a possible concomitant of all mid-brain regulated activities. Whatever the survival activity, the threshold for aggression is lowered. The organism, then, is always somewhat prepared for threatening circumstances in all survival activities. This may seem like a strange idea; if one is having sex or eating, thresholds for aggression are also lowered. To sharpen this perspective, the threshold is lowered in the active phase of the activity, after consummation, the assumption is that all thresholds are then raised. If consummation occurs, the assumption is that the organism feels safe enough to let this happen. Species with poor judgment about this are no longer with us.

Leaving aside the specifics of consummation, the main point in this hypothesis is that aggression is a behavior that is more likely to be primed than any other behavior. This is the preprogrammed part of endogenous stimulation; clearly, there are many things that may, in the development of an individual, specifically inhibit aggression or transform aggressive tendencies so that they are blended with many other behaviors. However, in a theory that places survival as a key concept, aggressive sites are the ones that are most easily triggered. As a final aspect of the concept of aggression, aggression is seen as a pleasurable activity. Sites that trigger aggression (Ellman, Achermann, Bodnar, Jackler, & Steiner, 1973; Olds, Allan, & Briese, 1971; Valenstein, Cox, & Kalkolewski, 1968) are also sites that lead to positive reinforcement. Conversely, all sites that trigger flexible aggressive responses are also ICSS sites.

This concept, then, is very different than the one that Freud offered in the era of the structural theory. Freud's concept of Thanatos posited a self-destructive drive that could be projected outward. The projection of Thanatos was the way Freud explained aggression towards external objects. Klein's view agreed with Freud, and assumed that a destructive drive was actively present at birth. Clearly, these concepts differ from the one that is being put forth in this chapter. However, let me again hypothesize a mismatched infant; for example, a high endogenous infant with a mother who is overly stimulating might look like a Kleinian baby. The infant might want to get rid of the maternal representation, since the mother is a frustrating, aversive presence. It might need to split the representation of the mother to hold on to something good about the maternal presence. Thus, in this theory, there may be infants that look like Kleinian infants and other infants that look more Winnicottian (Ellman, 1992, 2009). The theory actually would posit a range of infants that might provide support for different theories. That is, some infants might support Winnicott, some Klein, Fairbairn, Stern (1985), etc.

In previous publications (Ellman,1999, 2007, 2009) I have accented the development of analytic trust in the therapeutic situation. Trust in my view is the necessary condition that allows therapeutic interventions to be utilized in the analytic situation. In my theoretical matrix, a key element in the development of trust is the interpenetration of affect states; that is, experiencing and communicating the reception of the patient's affective states. In my view, this interpenetration involves gradually understanding the patient's endogenous tendencies. It allows the analyst to feel the patient's intensity or affective volume. This became clearer to me in the treatment of Ms W.

Ms W was twenty-five years old when I began to see her in first three, and then four, times a week analysis. She was a woman filled with remorse that frequently led to extreme self-loathing and self-criticism. At the beginning of treatment, she was severely depressed and had just signed herself out of a hospital ward where she was being treated for depression. She had a severe eating disorder and, when she entered treatment, she was about seventy-five pounds (5 ft 8in tall) and was so thin that she could barely sit without substantial pain. Her conscious life was devoted to feelings of regret that at times was disrupted by bouts of rage at those around her. She felt that her ex-boyfriend and her mother had put her in the vulnerable situation that led to her being raped and assaulted. Feelings of rage did not last long, since they not only disrupted any sense of stability she was able to establish, but also threatened to destroy the only object relations that she felt she had retained. Her fleeting anger (at times rage) could mostly safely be directed at Harid, who had decided that he could not marry her because of their religious differences (she is Jewish, he is Turkish and Moslem). This happened about six months before she moved into her own apartment and, while sunbathing on the roof of her apartment house, she was assaulted at knife point, raped, and beaten. This incident was extremely debilitating and traumatic, and amplified her eating difficulties, which began when she and Harid broke up.

When the treatment started, she was awash in regret that she had not converted to the Muslim religion. At times she berated herself for not converting and, when calm, would fantasize about converting and having Harid return. These fantasies were disrupted by thoughts where she depicted herself as a wanton woman, one who would never be accepted by Harid's Turkish parents. Her guilt about her past sexuality was a powerful factor, and she came to understand part of her anorexia as attempting to eliminate the observable feminine parts of her body (her large breasts and her other curves). Her sense of remorse was strongly associated with powerful guilt

about her wanting to possess Harid, and we came ultimately to understand her wish to steal Harid (a first son of wealth and fantasized power) away from his parents and his culture. It took a reasonable amount of time for her to begin to talk about her being raped. This surprised me, since I had thought that this would be constantly on her mind. However, I underestimated the amount of shame that she experienced and, fortunately, I allowed her to determine when we would discuss this traumatic event.

I will not go on about Ms W except to say that, during this period, I had seen several women who were anorexic: all of them (four) had severe conflicts with their mothers. They all had strong hatred towards, and yet at the same time could not easily differentiate from, their mothers. I felt that this was the case with Ms W, and, although after four years of treatment her symptoms had abated and she had begun a promising career, very little psychoactive was occurring in her treatment; her analysis, in my view, was at a standstill. She maintained her benevolent view of me and remained quite angry with her mother, with whom she had broken off all relations. Her verbalizations in her analysis were more like discussions with a caring (combined) parent, and my attempts to interpret her use of me were greeted with compliance and a certain bemused acceptance. There was little new that was happening in her treatment and yet she displayed no interest in ending it, and, in fact, seemed quite content as we entered the fifth year of her analysis.

Up to this point in the treatment, although the patient had certainly shown improvement, she still was not able to utilize her transference reactions in a therapeutically meaningful way. If I was idealized, it was "only real"; during the earlier phases of treatment, when she displayed paranoid reactions about my attacking her in one form or another, that, too, was only real for her. I have described this treatment in more detail in another paper (Ellman, 1999) but, for the purposes of the present discussion, one can say that it was not until she could gradually trust with me certain types of erotic transference reactions that she could utilize the treatment in a manner that led to new pathways and a different form of self-reflection.
In the fifth year of treatment, she had repeated dreams of her father, but he looked somewhat different and frequently he was bald (as I am). It was when she allowed herself to comment on the woman who was in the other office that the treatment substantially shifted. She had known for a while that the woman in the other office was my wife, but now everything that this woman did seemed to bother her. She wondered how I could possibly be married to someone like her, and strong rivalrous feelings began to emerge. As we explored those feelings, she began to remember that she was quite

depressed when she was 4–5 years old. She remembered coloring everything black and being angry at her parents, and she was told that she had never been like that before. She suddenly realized something that must have been apparent to her at some point in her life, that her sister's birth was extremely upsetting to her. Her transference became not only erotic in nature, but classically oedipal. She wanted my attention and continued her rivalrous feelings with my wife and with other female patients. She began to envision the two of us having a child together, and, although now she was more self-reflective, the idea that we were apart was painful to her. There always seems to be someone in the way she commented to me, and then she said she wished that I would change offices—she laughed, and said "Perhaps you could move to my building." The dynamics that continued to unfold then were intermingled with her guilt about her wishes to eliminate my wife, who, at times, she reflectively felt "couldn't be as bad as I think she is." I could continue to follow the path of Ms W's Oedipal dynamics, but, rather than do that, I will try to explain how these dynamics influenced her symptoms and why she became depressed during her childhood rather than being a child who suffered disappointment and then gradually adjusted to her new circumstances (which her parents had seemingly tried to prepare her for).

Ms W was your quintessential high energy person. After her depression lifted she talked incredibly quickly, eventually was extremely energetic. and did everything at a breakneck pace. She spoke a little too loudly and laughed enthusiastically, and was in general some- what boisterous. When she came back to see me (she had finished her analysis several years before the visit), she said to me, "Some people don't like my enthusiasm, the fact that I talk loud and move quickly, and I have come to accept that I can't please everyone. I have also come to accept that this is the way that I am and some like it and some don't." I thought that this was an accurate piece of self-awareness that she had somehow achieved on her own. I agreed with her that once her depression lifted, she was a dynamo and it was not a manic state (at least in one sense of manic, that is, as a defense against depression), it was her true self. What we discussed was a correlate of her high endogenous states, that is, her extreme sensitivity and how powerfully she experienced the world if it entered her internal space. Sometimes, she was so active that she was oblivious to the world around her, but when her environment was perceived by her, it was experienced intensely. When she experienced a sustained conflict situation, the birth of her sister, the dynamics that she experienced was so intense that she became disorganized. What for others might have been a resulting neurotic organization, given the stage of her

development, was for her so intense that she developed the capacity for debilitating symptoms. I doubt that she would have been hospitalized for depression if she had not been raped, but before this event, when she and Harid parted, her depression seemingly was quite severe. In her reconstruction of her childhood depression, it took her quite a while to get over the birth of her sister. It has now been fifteen years since the end of her analysis and Ms W has flourished. She has a successful career and a successful marriage. During that time, I have seen her for a two-session consultation when she wanted to discuss her relationship with her husband's daughter. She has called me a few times to tell me about her promotions and a show that her husband has produced. She has not suffered another depression. I think that she has learnt about her intensities and learned to accept and regulate her internal states. In my view, she is an example of a person with a high endogenous motor who had a tendency to experience things quite intensely. At times her internal states and external stimulation summated into intense experiences. Over time, she came to realize this, gain acceptance and then control of her internal life, and then be able to utilize her high level of activity and her rich, active, internal world.

Clearly, one may have many different views of this clinical illustration. The main point, however, is to try to show that intensity matters and can often change the way an event is perceived or experienced. I have tried to give one view of how different intensities come into being, but, obviously, one may substitute the concept of threshold for frustration or other thresholds without including the concept of endogenous stimulation. I believe this concept might have more explanatory power, but the crucial point is that, in the clinical situations, one of the most important aspects of analytic trust is being able to feel the other's intensity level. This will help the analytic pair to build a facilitating intersubjective environment.

It is unlikely that anyone will doubt that intensity factors are important in development or the clinical situation. In this chapter, I have tried to present a model that looked at one of the underlying factors in determining intensity. I have also tried to look at the plasticity of the human mind and tried to show (or imply) that past dichotomies such as object and pleasure can be meaningfully joined in understanding human experience. Moreover differences in intensity thresholds may be a crucial factor in determining whether an experience is pleasurable, aversive or potentially traumatic.

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