

# Anaclitic Etiology and Treatment of Neurosis: An information-attachment model

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Joachim F. Sousa-Poza, M.D., D.Sc., F.R.C.P. (C)\*; Robert Eagle, B.Sc.\*\*;  
Robert Rohrberg, M.Sc.\*\*; Suzanne Steinberg, M.D., F.R.C.P. (C)\*\*\*

## Abstract

*It is proposed that persistent disconfirmation of the child's self by the primary attachment figure provokes anaclitic micro-reactions, the summation of which constitute the core pathology of neurosis. To preserve the bond the anaclitic reaction is suppressed by defensive exclusion. Yet, it remains somatically stored, generating symptoms. Disconfirmatory aspects of the parental imago are replaced by positive fabrications, in function of which a false self develops. The primary objective of anaclitic psychotherapy is the correction of the false self. This is accomplished by lifting defensive exclusion, leading to a series of abreactive regressions which approximately recapitulate the stages of an anaclitic reaction.*

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\* Department of Psychiatry (Anaclitic Clinic), University of Sherbrooke, Quebec, Canada.

\*\* Mount Orford Humanistic Institute, Magog, Quebec, Canada.

\*\*\* Department of Psychiatry, McGill University, Montreal, Quebec, Canada.

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## Historical perspective and current theoretical formulation\*\*\*\*

*«...by the induction and maintenance of regression, concomitant with an adequate gratification of basic needs, an alteration of memory traces of a frustrating mother, i.e., bad introjects (as constitutive of fixation) can be initiated. The hypothetical sequence of experiential events would be: regression-gratification-changes in the introjects and progression». (8, p. 59)*

The term anaclitic derives from the Greek «anaklitos» meaning «to lean upon». Freud used it to signify «...the close associations of libidinal drives with vital functions necessary for self-preservation» (8, p. 59).

Spitz (64) coined the term «anaclitic depression» to describe a catastrophic disorder observed in infants separated from their mothers for an extended period of time; the syndrome evolves according to a spectrum of symptoms beginning by sadness and weeping to end eventually in a «stuporous» condition (64). A complete description of the three stages of the syndrome, protest, despair and detachment, is given by Bowlby (13, 14, 16). The anaclitic depression could be reversed if the mother was restored to the child within a limited period of time, and could be partially averted or ameliorated by the presence of a substitute mother.

Margolin (51) coined the term anaclitic therapy to describe a treatment for psychosomatic

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\*\*\*\* Given that this paper is mainly concerned with etiologic psychodynamics the term neurosis has been retained instead of the more descriptive classification of the DSM-III.

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disorders. The main pioneer in this field has been Dr. H. Azima (2, 3, 4) who, working at McGill University with several collaborators (5, 6, 7, 8, 9), created a modified psychoanalytic treatment process involving the induction of deep levels of regression to permit «...the establishment of a massive oral relationship (anaclitic transference) perceivable or symbolically near the early mother-child transaction» (8, p. 67). Once this state was achieved, basic oral needs were gratified in an effort to eradicate the negative introject resulting from maternal frustration. This work, conducted primarily with schizophrenics, was not, to our knowledge, further developed in large measure due to the untimely death of Dr. H. Azima (59).

Yet, in spite of the work of these authors on the therapeutic potential of anaclitic regression, as well as the extensive work of Bowlby on attachment (13, 14, 15, 16), no specific model has to our knowledge been developed establishing the etiological role of attachment disorders in the pathogenesis of neurosis.

It is the main thesis of this paper that there is a direct etiological link between early disturbances in the affectional bond and the development of later neurotic processes. If we consider the self as an information system, which Batista (12) views as the final metalevel of information processing, and thus as the seat of all experience, then the mother-child affectional bond can be conceptualized as an informational one, which can be damaged without actual physical separation. We propose that the primary pathogenic factor damaging this bond is a message that communication theorists have termed «disconfirmation». The response to such injury is as it would be to actual physical separation but in an attenuated fashion, that we shall term «anaclitic micro-reactions». These reactions are excluded from conscious processing in the overall interest of preserving the bond. Defensive exclusion, however, induces error in the consciously formulated (mental) self.

### The Development of the Self as an Information System

As the development of the self unfolds, it becomes more differentiated as more efficient coding modalities emerge. Each classical psychological stage of development of the self can be seen as a direct reflection of the underlying modality of information coding particular to that stage. Thus the first stage, the body or physiolo-

gical self, a term derived from Freud's (28) early observation that at first the ego is a body ego, represents a stage of *iconic* information coding. In iconic coding the information carrier is itself the message to be conveyed; soma and psyche overlap.

The second stage, the «imaginal» self, is a transitional step, the raw data of which consists, in Winnicott's terms, of the «imaginative elaboration of pure body functioning» (74, p. 60). This stage is one of *analogic* coding, characterized by an unbroken continuum of similarity of representation. A painting, for example, is an analogous (i. e. more or less accurate) representation of the reality it depicts. The primary examples of analogic coding of «conscious» data are imagery and affective states.

As cognitive functions develop, the mental self, involving at this rudimentary stage simple representational thinking, begins to emerge (71). The self then starts to differentiate from the representation of thought processes themselves into a state that Piaget calls «formal operational» (38). The attainment of the highly efficient final stages of the mental self is primarily made possible by the exclusive access that man has to the *digital* code (10) as exemplified by linear, logical thinking, abstract representation, and language. At the mental self level, information processing is largely conscious; from the data of the mental self emerges our conscious sense of identity or self-definition. However, as Bateson (10) pointed out, given that such digitally coded information is largely subject to voluntary control, it is also subject to manipulation, a key factor in the development of a neurotic false-self.

In spite of the evolution from one coding modality to another, the earlier modalities are not discarded: the adult self is still composed of three sub-systems and although the digitally coded mental self takes functional prevalence, translations of data between sub-systems do normally occur (70). As we shall see later, *in neurosis there is a barrier to the flow of data between self sub-systems*.

### The Data of the Informational Bond: Self-Knowledge or Autoplastic Information

The mother-child bond is created and maintained by the transaction of a specific type of information, whose data constitutes the self. This information, recently termed «self knowledge» (39) and perhaps more appropriately autoplastic information (63) excludes most of our cognitive,

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reifiable map of the external world, and consists primarily of non-objectifiable experiential data. This information has the characteristic of being triple coded (somatic component, imagery, meaning), what Ahsen (1) terms the experiential triad, whose integrity is necessary for an unified sense of self. In contrast, most of our information about the world of external events [alloplastic information (63)] follows Pavio's (56) double code (image, meaning).

### Confirmation and Reduction of Uncertainty of the Self

One type of message is of paramount importance to the affectional bond [via which the self develops (39)]: *confirmation*, whereby a person acknowledges and ratifies the genuine self-definition of another's. Alternatively in *disconfirmation* the receiver of the message denies the existence of the self of the sender (70). Buber (17) has spoken of confirmation as the essential psychological need of human beings. Similar views have been expressed by Cummings (24) and Sullivan (66). Yet, it is perhaps Watzlawick et al (70) who have most strongly emphasized the crucial role of confirmation as «...probably the greatest single factor ensuring mental development and stability that has so far emerged from our study of communication» (70, p. 84). Psychoanalytic literature refers to confirmation by the apt analogy of «mirroring» (47). Information theory uses a more accurate concept: redundancy. Although historically this term referred to repetitious hence useless data, it is now known that some degree of redundancy facilitates the proper functioning of a system. It acts synergistically to counteract uncertainty and reduces the likelihood of erroneous outcomes (55, 27). The early self, relatively undifferentiated, is in a high state of uncertainty (disorganization) and requires the mother's self to act synergistically with it in the form of consistent, redundant acknowledgement, especially prior to the attainment of evocative memory or object constancy. As Popper (cited in 39) stated, «Just as we learn to see ourselves in a mirror, so the child becomes conscious of himself by seeing his reflection in the mirror of other people's consciousness of himself». (p. 16).

This informational bond is a privileged one for the child in the sense that, in healthy conditions, the direction of the flow of redundancy is preferentially biased towards the child. A different and more severe type of damage to the self

occurs when this flow is altered and the mother, due to her own narcissistic pathology, sees the child as a source of redundancy for herself. An inverted symbiosis is thus created and the child-mother self-boundary of the child is eroded preventing the development of an autonomous self, that is a narcissistic condition.

### Confirmation/Disconfirmation of the Developing Self

#### a) *The physiological or body self*

As Steele (65) noted, in the early stages, maternal care is the total and only experience of confirmation of the child's self. At the pre-linguistic level, confirmation is conveyed primarily by iconic-analogic (non-verbal) communication, i.e. caretaking behaviour and complex paralinguistic (cooing, etc.) and kinesic (gestures, body movement) interactions which are highly synchronized (22). As Steele notes «If maternal responses to the infant's needs are not reliably and repeatedly appropriate... the infant must experience 'self' as irrelevant if not actually erroneous, and it is henceforth in some degree disregarded» (65, p. 24).

#### b) *The mental self*

The development of the mental self requires a more complex type of confirmation primarily in the form of cognitive validation through verbal communication. Verbal interchanges transact two types of hierarchically differentiated data, namely the content and the command (70). The content is the explicit data of the message. The command carries information about the self of the sender as well as his/her view of the self of the receiver; the command is a conveyor of self data. Watzlawick et al (70) consider that the command may convey several types of meta-information, two of which, confirmation and disconfirmation, have already been defined. A third, rejection, «...no matter how painful, presupposes at least limited recognition of what is being rejected and, therefore, does not necessarily negate the reality of P's view of himself» (p. 85). Rejection is thus less pathogenic than disconfirmation.

### Damage to the Bond; Defensive Exclusion and the Somatic Coding of Anaclitic Micro-Reactions

We have been assuming that disconfirmation injures the child's self, provoking what we term

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an anaclitic micro-reaction. Relying on Bowlby's work one can assume that the survival needs of the child preclude expression of this reaction (particularly anger); hence its suppression by defensive exclusion. As a psychological defense, it serves to exclude information which if consciously processed, would induce suffering or psychic pain (16). Its adaptive function is to preserve as much as possible of the bond so that the child may remain at least to some extent close to and on «fair terms» with his parents. Defensive exclusion, however, cannot neutralize the somatic reactions inherent in the anaclitic state. This information remains iconically coded in what could be termed the *somatoself* (the adult's counterpart of the infant's body self, equivalent to the somatic component of Ahsen's experiential triad). That is, the processing of the self data is halted: the aborted anaclitic micro-reaction is not integrated into the functional mental self but remains compartmentalized *at another level of consciousness* in the somatoself. Thus, in the normal mode of consciousness, (characterized by the mental self and its primarily digital coding) this information is not «known», does not form part of the patient's subjective, cognitive history. Its retrieval, not possible by purely verbal means, requires mobilization of the anaclitic feelings stored in the somatoself through induction of an altered state of consciousness (68): the abreactive regression.

#### **Psychodynamics and Clinical Consequences of Defensive Exclusion: the Somatoself/Mental Self Synchronic Conflict**

In our model defensive exclusion creates an intercode barrier to the flow of information, particularly between the somatoself and the mental self, and leads to the compartmentalization of the self sub-systems. Ahsen proposed that under traumatic conditions «...somatic patterns and psychological themes establish their own identity as physiological or emotional states unconnected with the other components of the original event» (26, p. 597). Guidano and Liotti (39) speak of an «apparent unawareness» of traumatic events preventing their transformation into objects of thought. Thus disconfirmatory information is prevented from taking part in the formulation of the mental self. Meanwhile the mental self manipulates disconfirmatory data in order to fabricate false but more acceptable imagos. With each disconfirmation the bond is based more and more on false premises, and

the mental self is progressively falsified in at least two ways: first, simple omission of relevant biographical data; second, as the child becomes attached to false introjects the development of the self is of necessity also falsified. This creation of a «false self» (73) is one of the hallmarks of neurosis.

At some point the somatoself and the mental self uphold simultaneously incompatible data, what is called in information theory a *synchronic conflict*, a second hallmark of neurosis. Bowlby (16) has anticipated this notion in terms of conflict between episodically and semantically stored information; as he noted, it is not unusual to obtain an appalling history accompanied by the patient's assertion that she or he has had a «happy» childhood.

Synchronic conflict causes the two main categories of neurotic symptomatology: a) the neurovegetative and somatic symptoms are caused by the disconfirmatory information compartmentalized at the somatoself level; b) the florid cognitive symptomatology typical of the clinical variants of neurosis reflects the falsified mental self and its efforts to obscure and compensate for its erroneous foundation. Secondary, tertiary, etc., symbolic elaborations and meta-elaborations do not constitute the neurosis itself but merely an attempt by the neurotic mental self to reach a cognitive solution to a problem which can only be resolved by integration of suppressed somatoself data.

#### **The Metaphysical Hard-Core of the Self: the Lovability Principle**

Any information system exists as an aggregate of data organized around certain basic (and, to a large extent, «given» or unarguable) premises and laws characteristic of that system. Guidano and Liotti (39) view this hard-core as elaborated from experience. We believe, however, that there is evidence to postulate that such a principle is an *a priori* one, what Popper (cited in 39) terms expectancies or «inborn knowledge».

Utilizing abreactive regression as a therapeutic tool clinicians such as Casriel (18) and Janov (44) have presented evidence, which although addressed mainly to the popular literature is nevertheless congruent with ours, that all developmental psychological trauma appears to be ultimately reducible to the experience of not having been loved, secondary to persistent parental disconfirmation.

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This clinical evidence leads us to postulate that the central, innate premise of the self is what could be termed the «*lovability principle*», operationally definable as follows: the child anticipates in an innate way confirmation *at a one hundred percent level of certainty*. Seen in this light, the extreme pathogenic power of disconfirmation is rendered readily understandable — disconfirmation «goes against the grain» of the very foundations upon which the structure of the self rests, thereby inducing error and precluding its normal development.

### Therapeutic implications

With this proposed theoretical framework, the therapeutic goals are clear: enable the patient to regain a sense of self that is non-falsified, integrated, without barriers to the inter-systems data circulation and without synchronic conflict. This requires the lifting of defensive exclusion, involving a recoding of selfdata from the iconic to the digital. This lifting permits the processing of previously suppressed disconfirmatory data up to the mental self, generating insight that culminates in the realization of the falseness of the parental introject and the subsequent detachment from them. Gratification then provides material to make new introjects with which a new, integrated self can be formulated.

We shall now present the tool used to lift defensive exclusion, namely regressive abreaction, and clinical data derived from the authors' personal experience with the anaclitic process and from the treatment of a population of about two hundred patients over the course of the last five years.

Note should be taken that, as warned by Azima and Warnes (8), the undertaking of the anaclitic process without appropriate experience on the part of the therapist is a rather risky proposition which could lead to serious unwanted outcomes for both patient and therapist. Experiential formation in the process itself is a fundamental prerequisite.

### Regressive Abreaction and Psychic Pain

Lifting of defensive exclusion is accomplished primarily by means of abreactive regression, the main tool of anaclitic psychotherapy, by nature an experiential rather than an interpretative process (8). The disconfirmatory event — involving a loss of self — is always emotionally painful. Thus, defensive exclusion, aside from suppress-

ing the meaning of the event, conceals also an associated emotional pain. In anaclitic therapy, this distress manifests itself in the abreaction of what has been termed «psychic» or «primal» pain (18, 44) which has also been observed by most schools of psychotherapy that employ abreaction such as eidetic psychotherapy (1) focusing (30), autogenic therapy (48, 25) and LSD psychotherapy (61).

Our clinical experience leads us to distinguish two types of abreaction. Discharge abreaction does not necessarily involve integration of new data (insight) into the mental self, and can in principle be achieved without its participation. *Integrative* abreaction however involves the participation of all self subs-systems and generates new meaning (insight). It involves a deep regressive state with total suppression of ego function (absence of «observing ego»), and the experiencing of the «then and there» with total disconnection from the «here and now» and its surroundings. As anticipated by Azima and Warnes (8), «...the evoked events are more than 'as if' or 'instead' experiences, and ARE identical in their intensity and lived quality with their genetic origins» (p. 62). Abreactive regression is thus *an altered state of consciousness* permitting direct access to the original neurotogenic trauma. Safe, non-invasive ways to induce regression must be credited to the revival of scientific interest in imagery (56) and to its utilization in psychotherapy (60, 61) in particular, as the key element to induce abreactive regression. Bateson (11) considers imagery to be the ideal interface code between the purely iconic (somato-events) and the digital (cognitive process, language). Imagery facilitates translation between those two coding modes, and plays a fundamental role in overcoming defensive exclusion. This is consistent with the finding that psychosomatic patients have little capacity to generate imagery and are relatively unable to describe feelings in words (54, 62).

### Treatment Process

In essence, the treatment process consists of a systematic biographical review of past disconfirmatory events via sequential abreactive regressions. Several periods or phases can be distinguished namely: 1) the preliminary stage; 2) the mourning stage (anaclitic protest); 3) modification of the parental imagos and gratification; 4) anaclitic anger and 5) progression. In practice these stages may overlap, and the sequence may

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vary from patient to patient, although the majority do follow it.

### The preliminary stage

Aside from cultivating the classical, trusting patient-therapist relationship, the main objective of this stage is to initiate the patient to what can be termed the «anaclitic monologue» — the key tool to induce abreactive regression. Sessions, which last from one and a half to two hours, are usually held twice a week in a quiet, dimly lit room with the patient in a recumbent position. The therapist first assesses the patient's current mood and feelings as well as his/her current mental associations. From there attention is drawn away from ongoing experience to a childhood event associated with the same general mood or feeling. The steps followed are: a) recollection of the analogue feeling event, b) its visualization and verbal description, c) the anaclitic monologue, in which the patient addresses him/herself to the parent (usually the mother) as if the event were actually taking place, utilizing the second person singular and present tense.

### The mourning phase (anaclitic protest)

The mourning period is one of working through loss. It is also when the anaclitic regression truly begins. The anaclitic monologue repeatedly addressed to the parental imagos leads to the overcoming of defensive exclusion with subsequent reunification of the self sub-systems. This occurrence is manifested by a very vivid experience, ushering in a regressive state in which the image of a past event with its corresponding suppressed feelings and meanings take over. The compelling reality of this image has been compared to some of the experiences evoked by Penfield via direct electro-stimulation of the brain (61). Working with LSD, Grof has noted that the deepest layers of these regressive experience are represented by «...vivid and colorful memories of experiences from infancy and early childhood» (37, p. 89). After a period of protest, pleading for love and nurturance instead of the experienced disconfirmatory abandonment, an abreaction of a depth and power exceedingly difficult to convey verbally ensues. It is followed by a flood of insights contradicting previous formulations and consciously held beliefs about the mother-image, thus affecting the basic premises upon which the mental self had so far been maintained. A period of quiet sobbing, relaxation

and a sense of grief follows as the patient gradually reestablishes connection with his/her surroundings. This process continues with progressive deepening of the regression. It is not necessary to regress and experience all disconfirmatory events since any given abreaction expresses a constellation of events represented by the same feeling. Grof (36) appropriately terms these constellations «COEX Systems» (systems of condensed experience).

The majority of patients progressively develop deep physical pain throughout this period, generally experienced around the solar plexus, peaking before and subsiding after each abreaction. At the same time the presenting symptomatology of whatever variety (be it phobia, anxiety, depression, etc.), gradually dissipates, and finally disappears towards the eighth month of treatment. The regressive experience is followed by a long-lasting sense of well-being, yet the progressive accumulation of evidence of disconfirmation leads the patient to reach the seemingly unavoidable conclusion that he/she has not been loved. From then on the patient no longer mourns particular disconfirmatory events, but rather the conclusion of not having been loved. This awareness evokes the most profound feelings of pain and despair, poignantly described by Alice Miller (53), lending support to our hypothesis that the hard-core of the self is indeed the lovability principle. This thematic change in the anaclitic abreaction, accompanied by diminution of well-being and relief following regression, generally signals the end of the mourning period (which can last from eight to fifteen months).

### Modification of the introject and gratification. Anaclitic despair; the Late Anaclitic Syndrome (LAS)

Modification of the introject and gratification are on-going processes throughout the period of abreactive regressions. Psychodynamically, each abreactive episode — be it of pain or anger or a combination of both («angry pain») — progressively uncovers the lack of authenticity of the parental introjects, leading eventually to a corrective detachment from them. This detachment, involving a recognition of a most painful reality, although necessary in order for progression towards an authentic self to occur, is not without risks. Detachment entails the depletion of the bond which albeit based upon unreal, fabricated, parental imagos, had nevertheless provided

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a sense of bonding and some sort of pseudoredundancy to the self. The patient becomes aware of the unreality of the imagos, and by detaching from them must relinquish the long-maintained neurotic hope of retribution (53).

When these false structures, whose existence in the mind of the child served the purpose of preventing the onset of an anaclitic depression, finally collapse, the patient enters a vulnerable period which can result in the onset of what we shall term the Late Anaclitic Syndrome (LAS). This severe condition is usually heralded by a diminution of well-being after each abreaction and an insidious and progressive deterioration of sleep. The central symptom of the syndrome is a pervasive, intense sense of alarm to an imminent but indefinable danger which keeps the patient in a chronic, exhausting state of arousal and hypervigilance. This groundless fear is also felt at night where sleep becomes fragmented, with «alarm» awakenings, intense and disruptive dreaming, frightening dreams, early awakening, non-restorative sleep and in some cases nightmares and sleep paralysis. Eventually during the daytime the patient will also experience a peculiar anhedonic state characterized by an exquisite sense of loneliness with a total absence of illusions, planning and other hopeful projections into the future. It is pathognomonic of the LAS that the patients totally lack the florid mentation and cognitive elaboration of the mental self which characterizes most major depressions, such as self-depreciating rumination or suicidal ideation. One is dealing with pure alarm and anhedonia without any ideation to cause, justify or support this condition. Even though their attitude is rather stoic, the patients' anguish matches closely what has been referred to as «the despair of one's inner void» experienced in «existential» depression. Clearly this dangerous condition must absolutely be avoided or aborted. Two approaches have been found useful:

### 1) Gratification and replacement of the introject.

The therapeutic intervention now emphasized is akin to what Azima and Warnes (1) termed «gratification»; these authors, however, referred specifically to oral gratification; in our experience, what is needed is comforting, mirroring, confirmatory gratification. Clinical experience has taught us the obvious: the most effective sort of gratification is provided by working from the very beginning in conjunction with a female therapist with a history of having been a successful mo-

ther. The role of this female therapist goes well beyond the concept of transitional object advocated by proponents of object relation theory (23, 42, 72); she acts as a *surrogate mother* during the most excruciating regressive experiences (rocking, holding, cuddling and comforting in general). *Indeed, the ultimate goal of the regression is to provide the patient with the experience of another mind taking over the care of the self, i.e. the mother-child positive symbiotic state; the critical period when the patient consumates the separation from the false parental imagos provides an opportunity for replacement of the introject.* Further, given the intense suffering caused by the LAS and the remarkable success of a mother surrogate in avoiding the syndrome, no anaclitic therapy should ever be undertaken without the help of a female therapist. Personal growth oriented group sessions on a weekly basis are very useful in promoting integration.

### 2) Pharmacology

We observed that tricyclic antidepressants, particularly those with a strong anticholinergic effect, are very effective in suppressing the LAS; so is to a lesser extent clonidine. Adjuvant use of benzodiazepines was found to be helpful.

### Anaclitic anger

As the abreaction of pain stemming from violations of the child's lovability principle extinguishes and the patient for the first time experiences the well-being of a healthy bond, he/she becomes progressively aware of the damage inflicted to the self. Those whom he/she intensely loved and trusted did not reciprocate and the overriding feeling is one of betrayal. The rebonding process allows the patient the security necessary to express the anger inherent in this realization and it is rather difficult to convey the searing intensity of the narcissistic rage now fully abreacted, often accompanied by the statement «why me?» or «you did not have the right to do this to me». Somatically, the physical experience of discomfort and pain shifts now to the thorax — usually with a left side lateralization. Whereas in the mourning period the mental event precedes the somatic reaction, the situation is now reversed. The abreactive regression now begins with an intensification of the physical discomfort, followed by the recall of anger-provoking events. Another side-effect often observed while the patient begins abreacting pure narcissistic rage is the development of a transient tinnitus which tends to disappear as treatment progresses.

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### Progression towards an authentic self

Throughout the anaclitic process the patient gradually comes to grips, without denial or unrealistic hopes, with the dramatic consequences for his/her life of a loveless childhood. By detachment from the imagos, the patient is in effect forced to reconstruct his sense of self. Even a seasoned therapist does not fail to feel moved by the extent of the sober suffering that takes place during this integrative period [cf Alice Miller, (53)]. Through the pain, however, there is progression as the patient leaves behind the neurotic constructs with which he previously survived. He begins to accept his childhood as it was and recathectes the present as the only worthwhile stage of his life, equipped now with an authentic, and more autonomous sense of self.

### Ethological and neurophysiological considerations

We shall now discuss some of our observations in the light of recent work on anxiety in connection with an inborn «alarm» mechanism.

Noting that agarophobic patients often have a history of separation anxiety (31, 45), Klein proposed (45) to tie the separation anxiety which occurs also in non-human primates (21) with panic attacks by postulating an innate biological control mechanism provoking intense psychic distress when there is separation, to cause «...the vulnerable infant to emit signals that will elicit retrieval by the mothering parent or by others» (45, p. 247). Experimental evidence (21, 45) supports Bowlby's point of view of attachment as the primary drive at the root of separation anxiety. The separated infant and the adult entering the LAS have in common the absence of the mother and the lack of introject; this concurrence would constitute the trigger of Klein's alarm mechanism, which would account for the fear and alarm seen in LAS. In this setting the role of the female therapist is seen indeed as equivalent to a surrogate mother stopping the anaclitic depression in an infant. Klein speculates further that despair would follow protest for, if retrieval is not effected rapidly, a prolongation of protest would go against survival (45); as he noted, inhibition of the brain's pleasure center would efficiently reduce the organism's interaction with the environment while maintaining consciousness. This could well account for the deep anhedonic state inherent in the LAS.

From the neurophysiological point of view, the locus coeruleus (LC) (34) is seen as a structure possibly responsible for an «alarm system». There is compelling experimental evidence that stimulation of the LC generate anxiety, both in monkeys and humans (19, 20, 43, 57, 69); for example, «Electrical stimulation in the region of the LC in humans produces feelings of fear and imminent death» (57, p. 2154). This feeling of impending catastrophe is reminiscent of what we have observed in the LAS. Further, the LC is involved in the regulation of the sleep cycle (49, 50, 52): a gradual increase in the LC activity culminates with the termination of REM sleep; this increase «...may permit a lessening of active filtering during REM sleep to permit the dream content to reach consciousness» (50, p. 75). Hence, the LC could allow the frightening dreams occurring in the LAS to reach consciousness. Thus the LC seems uniquely qualified to be the physiological substrate of Klein's alarm system, with its capacities to cause pervasive anxiety and sleep disturbances. The observations we made on pharmacological responses are congruent with a role of the LC in the LAS: tricyclic antidepressants are known to decrease the firing rate of the LC neurons and norepinephrine (NE) turnover, apparently through their inhibition of NE uptake, resulting in an enhanced negative feedback (19, 20, 67). Further, it is known that acetylcholine stimulates the LC (52, 67) through what seems to be muscarinic receptors (35). Conceivably anticholinergic tricyclics would have an enhanced action on the LC. Tricyclics have been found effective in the management of panic disorders (29, 45, 46). Clonidine is an alpha 2 agonist known to decrease the firing rate of LC neurons (57, 67, 69) and to be anxiolytic (20, 41, 57, 69). Benzodiazepines (BDZ) lower the firing rate of the LC neurons and NE turnover (32, 33, 43, 58) but nevertheless constitute a more complex issue; it is now known that BDZ act through high affinity receptors [functionally coupled with GABA and other ligands in a supra-molecular complex (40)], widely distributed in the CNS (43), though only a moderate amount of BDZ binding has been found in the LC (58). There are some compounds that bind to BDZ receptors but induce anxiety (the LC is apparently not involved) (43); it has been proposed that, through endogenous ligands, BDZ receptors (particularly in the limbic system) constitute a system of anxiety generation (40, 43); that is, anxiety would be multiply encoded in the CNS through different neuroanatomical structures

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[there is also evidence for involvement of a dopaminergic system (58)]; incidentally, there is some experimental data suggesting the existence of endogenous ligands to the supramolecular complex of which BDZ receptors are part (40). However, different systems could correspond to different clinical states: thus the BDZ receptors system with its «dense telencephalic representation» (43) is likely to be active in anxiety states with ideation (43), while the LC would be responsible for a more primitive «alarm» response (43), with little or absent ideation; this is congruent with experiments showing that activation of the LC influences the processing of stimuli according to the meaning of the stimuli (69), underlining its role as «alarm»; in separated infants or in anaclitic patients dissolving the parental introjects the alarm would be «appropriately» triggered by the lack of self redundancy.

Given the multiple connections in the brain, it is likely that in clinical situations both systems would be activated (43), as seems to be the case in panic disorders (45). This double activation would explain the benefits of adjuvant BDZ in the management of the LAS. This proposition is of course congruent with the «pharmacological dissection» of anxiety noted by several authors (43, 45, 46, 52).

## Resumen

*Nuestro trabajo se basa en la hipótesis de que las neurosis son consecuencia de depresiones anaclíticas subclínicas, múltiples y acumulativas, que tienen lugar durante los años infantiles. Basándonos en un modelo informático del self proponemos que la separación física de la madre no es necesaria para la producción de una reacción anaclítica subclínica y que una mera discontinuidad del vínculo informático es suficiente. La premisa básica del self como sistema informático es el «principio de queribilidad», según el cual es necesario un grado importante de redundancia para que se produzca un desarrollo normal. Esta redundancia es aportada por el aspecto vincular del mensaje humano en la relación madre-hijo, cuya repetición confirma el «principio de queribilidad». La disconfirmación de este principio, por el contrario, es altamente patógena, puesto que niega la existencia misma del self infantil, induciendo serios errores en su desarrollo. Basándonos en los trabajos de Bowlby, consideramos la formación de vínculos como el impulso psicológico primario, cuya función primera y principal es el mantenimiento del vín-*

*culo informático entre la madre y el hijo. Este instinto lleva al niño a modificar (o negar) información desconfirmatoria o de desamor, mediante el mecanismo defensivo de exclusión. Esta negación cumple su función protectora a nivel del self mental, donde la codificación es de tipo digital, aunque tiene como consecuencia patógena el desarrollo de un «falso self» en el sentido de Winnicott.*

*La información emocional procedente de la reacción anaclítica es codificada de manera analógica o icónica, y queda almacenada en lo que constituye el «somato self», parte no verbal del self. Gran parte de la sintomatología somática de las neurosis proviene de la interferencia del somato self alterado en las funciones fisiológicas normales.*

*La sintomatología cognitiva de las neurosis procede, en cambio, de la distorsión del self mental y de la formación de un falso self.*

*La psicoterapia anaclítica requiere la regresión a los traumas originales, esto es, a los momentos en que se violó el principio de queribilidad. Esta regresión profunda se acompaña de un estado alterado de conciencia que permite el retorno y la revivencia del trauma negado, provocando abreacción de sufrimiento psíquico y de agresividad. La abreacción anaclítica se consigue enseñando al paciente las técnicas de utilización de imágenes y del «monólogo anaclítico» o asociaciones libres dirigidas a las imágenes de los padres.*

*Según se desarrolla el proceso abreactivo se observan tres fases, que son paralelas a las de la depresión anaclítica:*

*a) Superación del aislamiento del self mental de la información disconfirmatoria procedente de los padres.*

*b) Duelo, con llanto, similar a la fase de desesperación de la depresión anaclítica.*

*c) Agresividad y rabia, como respuesta final a las violaciones del principio de queribilidad.*

*El papel principal del terapeuta es facilitar el proceso regresivo y promover la integración mediante técnicas de apoyo y, sobre todo, mediante confirmación correctiva del principio de queribilidad. La prevención de desesperación anaclítica extrema (síndrome anaclítico tardío) puede requerir la intervención de un terapeuta que juegue un papel maternal durante los períodos regresivos más difíciles. Participación en sesiones grupales de crecimiento y desarrollo personal facilita el proceso de integración y progresión iniciado a partir de las abreacciones terapéuticas.*

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