with cold narcosis so as to produce a state resembling animal hibernation.

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PSYCHIC DRIVING: DYNAMIC IMPLANT*

BY D. EWEN CAMERON, M.D.

In an earlier communication, the procedure of psychic driving has been described in some detail.** Briefly, it is the exposure of the patient to continued replaying, under controlled conditions, of a cue communication derived from one of the original areas from which his current difficulties arise. A major consequence of such exposure is to activate and bring progressively into his awareness more recollections and responses generally from this area. The ultimate result is the accelerating of therapeutic reorganization.

It was early noted that continued replaying of a cue communication sets up a persistent tendency in the patient to act in a way which can be predetermined with respect to its general characteristics. In other words, by driving a cue statement one can, without exception, set up in the patient a persisting tendency for the cue statement and other components of the relevant "community of action tendencies" to return to his awareness. This tendency has been termed the dynamic implant. By "community of action tendencies," a group of related activities and attitudes is meant—such as, for instance, those existing between the patient and his mother, or those related to his feelings of inadequacy.

Since, clearly, this continuing result of psychic driving might greatly enhance its effects, considerable study has been directed to the conditions controlling the setting up of the dynamic implant and to the effects of the implant. The findings are reported herewith.

Procedure

The dynamic implant may be set up either by autopsychic or heteropsychic driving. The first procedure consists in the repeated playing of a cue communication made by the patient. The second is the replaying of a communication devised by the therapist from his knowledge of the patient's dynamics.

*From the Allan Memorial Institute of Psychiatry, Montreal, Canada. This paper was read at the 111th annual meeting of the American Psychiatric Association in Atlantic City, May 11, 1955.

**Cameron, D. Ewen: Psychic driving. Am. J. Psychiat., 112:7, 502-509, January 1956.

Since autopsychic driving is more easily carried out, this report has been based upon that type, with implants set up by means of periods of 10 to 30 minutes' driving—repeated, if necessary, once a week.

Preferably, the communication should deal with one topic only and should not be longer than about 20 seconds. In practice, the material is derived from a psychotherapeutic hour which has been recorded on magnetic tape. It has been found useful to transfer these communications to 14-inch records and to reproduce them through a high fidelity phonograph adjusted for continuous playing.

The communication should be derived from a community of action tendencies which are of basic significance to the patient. Moreover, it is most effective if taken from the time of origin of this communication. It may, for instance, be selected as expressive of one of the great formative relationships of the earlier part of the patient's life, as in the following communication, in which the patient is reliving her early relationships with her mother:

"Everything about me was wrong—the way I acted, the way I spoke, the way I dressed . . . everything, everything I did. Many times she [the patient's mother] would just talk and talk and talk, and . . . well, I can't go thinking up these things."

Or it may be drawn from a long-continuing climate of rejection, insecurity, or hostility which prevailed during a critical early period in the patient's personality growth:

"Now that I think about it, seems to me that my parents had me just to even up the family . . . not because they wanted me . . . because of course their attitude towards me . . . Gee, I don't remember the boys getting as much hell as I did . . . or my sister."

The significance of the cue communication must be assessed, not only in terms of the therapist's conception, but also in terms of the patient's response. The two do not necessarily coincide. The second is the more realistic guide.

The following is an example of the patient's immediate response to the implanting of a cue communication. For the purposes of presentation, a response at the upper level of intensity has been selected. The case is that of a woman suffering from anxiety hysteria with many conversion symptoms. The cue communication ran as follows:

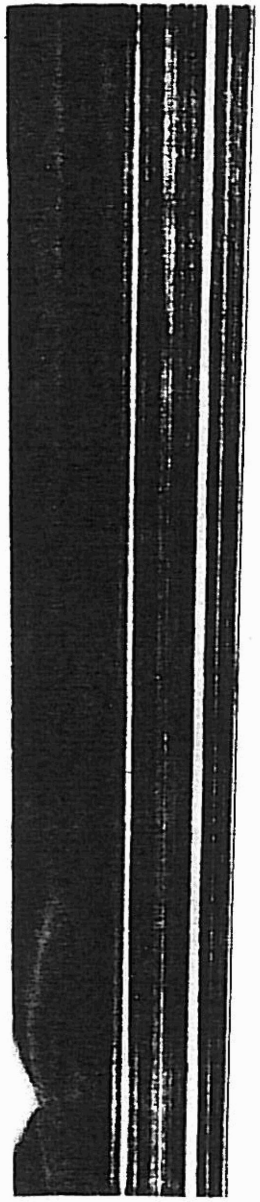
"I stayed home all the time when my mother lived. I stayed with her . . . didn't want to leave her. I was always left staying home with her and . . . I didn't have any life like all . . . the other girls."

On the first implanting on January 4, 1955, the patient, who had come in that day and rather gaily said that she had nothing on her mind and nothing to talk about, was silent. At the end of *five minutes* she said, "It makes me nervous, you'd better stop it . . . it makes me feel bad." She was now restless and anxious and very different from the gay person she had been when she came at the beginning of the hour. At *eight minutes*: "Doctor, doctor, I've had enough, please stop it." Holds head. *Nine minutes*: "That's enough. It makes me nervous to hear that." *Ten minutes*: "Why don't you stop it, doctor. I've heard enough. It is always the same."

At the end of 10 minutes, the patient was asked: "What did you think about it?" *Answer*: "It made me nervous all over again. Everything hurt me all over as it did before. My voice sounds like I am going to die." She then went on to bring out a great deal of new material, saying: "My mother almost might not have had me, I was so quiet as a child." And again: "After my mother died, my father gave up his music and began to drink. I tried to take her place for him. I wanted so badly to please him and I cried every night and I tried to carry on. I kept everything very much to myself. My father was like a child. I had no friends by the time my mother died, I had stayed at home so much."

If the cue communication evokes too great a response from the patient, it will, in a measure, defeat its own purpose, since defenses will be erected which may take a considerable time to reduce.

The writer would like to state here clearly an answer to a question which he is sure will arise in everybody's mind. In two years of exploration into this new field, covering more than 100 cases, in only one has there been seen a possible persisting trauma resulting from the implant; and even here, current events —such as the breakdown of a love affair and threatened deporta-



—undoubtedly contributed to, if they did not cause, the panic state through which the patient passed.

As an example of a cue communication which is not well chosen, the following is presented. It was selected earlier in the writer's experience and, as can be seen, is drawn from a period when the patient's personality structure was already well developed; it is representative of current stress and is not expressive of those forces which brought about a formation of the early neurotic traits which have got the patient into continual difficulties through her insatiable seeking for affection and endless understanding:

"Well . . . because . . . Robert doesn't care . . . and I have always thought I would have it in time [a house] . . . and I have been very patient . . . and I don't know whether it has just suddenly . . . I realize now it is all so hopeless, thinking about it."

After considerable experimentation, two additional procedures which facilitate the establishment of the implant have been found. The first is that the sound should be conducted to the patient's ears through headphones. This causes the patient to experience the driving with much greater impact, the more particularly since he frequently describes it as being like a voice within his head. For instance, one patient said: "I've heard enough. It goes right through my head." Another reported: "It's too close; it's horrible; I hear all the stuttering."

A second procedure is to produce a filtered record: that is, having a recording made of the cue communication with the emphasis first upon treble notes and then upon bass; or, again, with the emphasis upon a low volume or a high volume; or with spacing or repetition of key phrases; or with the introduction of an echo-back into the communication. All these variations serve to keep the patient continuously oriented toward each repetition and, hence, serve to diminish the most common defense—not listening.

On November 9, 1954, the first attempt was made, using an ordinary record to implant the following communication:

"I was afraid of them all the time. I mean I didn't dare . . . talk anything over with them whenever I went out on a date or something like that . . . I mean a lot of kids . . . you know . . . they'd come home and tell everything they did and everything . . . I never . . . I always felt as if I would be scolded, I mean if I ever did mention what I had done and then I wouldn't do it."

At the end of 10 minutes, the patient, who had shown no response, said, "Is that a record, doctor?" Asked what she felt, she said: "I had no feeling at all as I listened; I was thinking of something else."

The same communication was then set up in filtered form. To this the patient's response was at once different. She commented that she felt extremely tired after listening to it, that the voice sounded as though it were inside her head; and she said: "It brought back a lot of memories of my childhood days." A few weeks later, when it was used again, the patient said: "When I listen to that voice now, I feel like screaming and putting on a tantrum. The voice seems to scream at me all the time. It is like the voice of a stranger, though I know it is my own. It seems to say, 'I was afraid of being scolded.' It says it over and over again. It makes me think that even with my husband and my father and my father-in-law I have to hide things from them. I feel trapped. I feel I can't talk to anyone."

Experience shows that the implant can most readily be set up if the driving is carried out during the last 10 minutes of the psychotherapeutic period, the reason for this apparently being that best results are obtained if nothing is done to interrupt the ongoing response of the patient to the fresh implant—as would be the case if one continued therapy afterward. It is sometimes useful, however, to spend some five minutes asking the patient what fresh recollections the implant has brought up. This immediately widens the area of the patient's response and probably tends to stabilize the implant.

A question which must be met at this juncture is: Why is it that statements which the patients have already made, had formulated in their own minds, and had listened to themselves uttering, should be so potentially disturbing when replayed to them—far more so than when they first made them, never more than a week before and sometimes only 10 minutes before. This question has been explored in some detail and reported earlier. Discussion will be limited to three brief statements: (1) The work involved in listening is far less than the work involved in speaking; hence the patient, when listening, is much freer to respond to what he hears. (2) The law of the summation of subliminal stimuli

seems to be operative: The longer one listens to a statement, the more response it evokes. (3) In all of us, a defense is set up against responding to all the implications of what we say. This defense appears to be with respect to a synthesis of air-conducted and tissue-conducted sound. The recorder, making use as it does of air-conducted sound only, evades this defense.

A. Findings Relative to Process of Setting up of Implant

Several factors governing the establishment of an implant have been identified:

1. *Intensity of Response.* The intensity of the response of the individual to the driving period tends to increase the dynamic character of the implant which is thus set up. This is true whether the response takes the form of tension, anxiety, hostility, unhappiness or any other facet of the intensification response. This statement must be qualified in that, as the area involved becomes progressively activated by the patient and worked through by him, the intensity of the response will, after having risen to its maximum intensity, gradually decline. Factors limiting the intensity of the response are: the patient's defense, his stress tolerance, and his capacity for desensitization. These will be discussed later.

2. *Amount and Repetition of Driving.* Repetition of the driving of the cue communication on subsequent days will reinforce the dynamic aspects of the implant. Less clear is what the optimum amount should be, either of the driving on any given day, or the frequency of the driving within a series of days. The practice has been to limit driving to 10 or 15 minutes on any given day, as it is found that thereafter the patient usually succeeds in establishing defenses or becomes so disturbed as to be unwilling to continue. The repetition of the driving thus far has been limited to a maximum of once a week and a minimum of about once a month.

3. *Defenses.* The defenses against the setting up of an implant are essentially the defenses against psychic driving itself.* The chief of these defenses are: (a) inhibitory reaction to implanting by thinking of other things; (b) suppression of emotional reaction to the material; (c) denial of responsibility for the statement, as where the patient states, "I listen to it as though it were a stranger talking"; and (d) misinterpretation; this is much less frequent, but on occasion patients succeed in completely reversing the sense of a statement, even when repeated 30 or 40 times, by changing it from an affirmative to a negation.

*Cameron, D. Ewen: Ibid.

Methods of penetrating the defense which have been most successful are: (1) continued repetition; (2) the use of the earphones; and (3) the use of the filtered record, as indicated earlier in this paper. This last procedure, by its continuous shift in pitch, in volume, in spacing, and by other devices, penetrates the patient's defenses by repeated evoking of what Pavlov has termed in the animal the "orientation reflex." Other methods, such as psychic driving carried out during mild sodium amytal narcosis or during continuous sleep or during the induction phase of nitrous oxide, have not been nearly so successful. In practice, the penetration of defenses has not been found to be a serious problem.

4. *Stress Tolerence.* Knowledge concerning this is rather limited; but it would appear, from preliminary observations, that patients vary considerably in their ability to bear stress. Those who can tolerate stress well will, in general, show less tendency to react to psychic driving by the setting up of a lasting implant. On the other hand, those who tolerate stress very poorly are likely to respond, either by withdrawal from the driving situation altogether or by the setting up of powerful defenses.

5. *Capacity for Desensitization.* Concerning this phenomenon, there is still less information. But, from experience in other fields, it would appear that here, again, patients vary considerably in their ability to desensitize themselves; and those who cannot desensitize themselves readily will show a persistence of the implant for longer periods.

B. Findings Relative to the Effects of the Dynamic Implant

1. *Mobilization of Action Tendencies and Progressive Problem Identification.* The dynamic implant, especially when reinforced by repeated driving, tends to mobilize more and more of the components of the community of action tendencies from which it was taken. These components tend to appear in the patient's awareness. This fact, in turn, facilitates problem identification by the

patient and the therapist. This progress may be *assessed* in the following ways: (a) by the extent to which the patient thinks about the cue communication in the period between his treatments, and the extent to which his ruminating over the cue communication evokes new material; (b) by the new material which is evoked at the time of reinforcement of the implant—namely, by playing the material back again on a subsequent occasion; (c) possibly by general shifts in the behavior of the individual subsequent to implantation; for instance, it may be possible to demonstrate that the fact that the patient is now sleeping better is related to reorganization brought about by the implant; (d) dreams and psychological testing may also reveal the reorganizing force being exerted by the implant.

The first two methods of assessment are obviously the most direct and scientifically satisfying.

Illustrative of the progressive problem identification brought about by the dynamic implant, is the case of a girl who had come to therapy suffering from long-term feelings of inadequacy, marked dependency and a highly ambivalent attitude toward the male figure. The cue statement was:

". . . and there's . . . uh . . . there's still that tendency to idolize or despise . . . that tendency still exists . . . uh . . . I perhaps don't do either quite as strongly now . . . or feel either, I should say . . . But . . . uh . . . there still is that feeling, that one is a king and the other is a piece of dirt. Well . . . I mean . . . uh . . . as you very well know . . . you know exactly the type of fellow that I go for, and . . . uh . . . all others I just seem to have no use for."

Immediately after the first implanting, the patient stated: "I sound bitter and dissatisfied; I sound as though I am reaching for something I can't have." A change in behavior took place following this first implanting. After reinforcement, a further change took place, the patient saying that her boss whom she had hitherto found extremely attractive to her because of his ability and business drive was now no longer so; she did not think of him any more as being a tycoon, and a love affair with him terminated. A third period of driving brought about no change at the time; but a week afterward the implant had most considerable consequences: She gave up, she said, the whole idea of a "king": she had now fallen in love with a man of her own age. Asked how this came about, she [illegible] I can't get a 'king.' I would give myself a chance to like John. I don't put people on a pedestal like I used to; I don't feel the same way I used to about the boss. I used to have a bitter grudge against my father for my troubles; now I see him as a weak person I don't admire."

2. *Durability of Implant.* The writer's experience has shown that the implant, if not reinforced, declines in its activity fairly rapidly after two weeks; although, on occasion, it can be found operative as long as two or three months after the first implanting. As indicated earlier in this paper, the intensity of the implant can actually be progressively increased by a suitable reinforcement at rates of once a week to once a month.

3. *Shifting Attitudes Toward Cue Communication.* The writer has frequently encountered the interesting phenomenon of the according of negative values to the pattern of behavior represented in the cue communication: "I hate my whining voice"; or: "I don't have to please people all the time; I'm not like that any more." This imparting of negative values is particularly likely to occur either after repeated implanting or with the progress of psychotherapy in general. A working premise concerning it is that, since the patient comes more clearly to identify the neurotic components in the cue communication and to organize more efficient behavioral patterns, he tends to reject the neurotic patterns and to express negative feelings toward them.

4. *Mobilization of Action Tendencies.* An interesting question which arises is whether an implant can mobilize action tendencies laid down before the event embodied in the implant. Experience indicates that, while this does occur, it is much less usual than the mobilization of action tendencies laid down subsequent to the implant and derived from the basic situation outlined in the cue communication used in implanting.

Summary

1. By continued replaying of a cue communication, a persistent tendency to act in a way which can be predetermined in its general characteristics can be established. In other words, by driving a cue communication, one can, without exception, set up in the patient a persisting tendency for that cue statement, and other

components of the "community of action tendencies" from which it was drawn, to return to his awareness.

2. The dynamic implant thus established, and especially if reinforced by repeated driving, tends to activate more and more of the components of the relevant community of action tendencies. These components tend to appear in the patient's awareness.

3. This materially contributes to problem identification by the patient and the therapist, and, hence, facilitates the processes of therapeutic reorganization.

4. The dynamic qualities of the implant are functions of: (a) the amount and repetition of driving; (b) the intensity of the response; (c) defenses; (d) stress tolerance; (e) capacity for desensitization.

(5) The major continuing effects of the dynamic implant are: (a) progressive problem identification; (b) resulting reorganization of behavioral patterns; (c) negative evaluation of the neurotic patterns present in the cue communication used in driving.

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FETISHISM: A REVIEW AND A CASE STUDY

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Introductory

The meagerness of the literature basic to the prevailing psychoanalytic concepts of fetishism is noteworthy. The bulk of scientific writing on the subject, starting with Binet's pioneer study in 1887, consists of the work of the early and eminent sexologists, Krafft-Ebing, Ellis, Moll, Bloch, Hirschfeld, and others. This material is primarily descriptive in character. Freud based his first contribution to a theory of sex on the facts gathered by these workers; and other analysts, even the prolific Stekel, borrowed case material from these writers.

Analytic case studies of fetishism are not plentiful. Clinical documentation of the basic analytic theses on the subject is surprisingly scarce and fragmentary. Several analysts have specifically commented on the scarcity of this material, noting that fetishism "does not often come under the scrutiny of analysis."[1] In addition, as Freud stated and others have confirmed, fetishistic practices rarely are the presenting symptoms, the fetish making "its appearance in analysis as a subsidiary finding."[2]

Therefore, the opportunity for the analytic study of a case of fetishism with numerous classical features, in which in addition, the fetishistic problem was one of the presenting complaints, seems to warrant its presentation. The plan is: first, to review critically the analytic literature on the subject; second, to add this case study of a homosexual foot-fetishist; and finally, to suggest tentatively some other formulations on the problem. These, briefly, are the aims of this paper.

Review of the Literature

The term "fetish" was brought into general use in 1760 by a French anthropologist, Charles de Brosses, in his study of the cults of fetish gods. Fetishism may be defined in a general way as the "worshipping, adoring or loving something that serves as a substitute for the original object."[3] In normal sexual life there usually exists a more or less pronounced preference for a particular portion of the body of the opposite sex. For the fetishist,