PRIMARY AFFECT HUNGER.*

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In a previous study of maternal overprotection, an investigation was made of a mother-child relationship featured by an excess of maternal love. This excess was demonstrated overtly in maternal behavior through physical and social contact with the child, infantilization, extra precautions and protective behavior. Definite criteria of a relationship were set up, and cases selected, out of a large number, in which the criteria were satisfied. Case studies were thereby utilized in the form of an experiment, as though to say: If we could make an experimental study of such a relationship, we would have to satisfy certain conditions. Let us see if in a large body of case material such conditions are already satisfied. Naturally, the more definite and numerous the criteria the fewer the number of cases that can be filtered out by this process. The advantage, however, is that the greater the selectivity, the "purer" the relationship to be studied.

During the study of maternal overprotection, it was necessary to select, for the purpose of contrast studies, cases of maternal rejection. In the latter group, however, selective criteria were never adequately worked out. Since the investigation of the overprotective groups was terminated by the closing of the Institute for Child Guidance, a staff was no longer available for study of the numerous details that were part of the undertaking. In the absence of such aids to a companion study of maternal rejection, it is necessary to have recourse to a simpler method. I must therefore, in this paper, utilize illustrative cases to indicate certain basic dynamic principles, without statistical aids. Furthermore, this study is limited in its orientation to the child who suffers the rejection. It is also limited to the experience of a certain type of rejection, to which I am applying the name "affect hunger."

The term, affect hunger, is used to mean an emotional hunger for maternal love and those other feelings of protection and care

* This and the following five papers, constituting a symposium on child psychiatry, were read at the ninety-third annual meeting of the American Psychiatric Association, Pittsburgh, Pa., May 10-14, 1937.

implied in the mother-child relationship. The term has been utilized to indicate a state of privation due primarily to a lack of maternal affection, with a resulting need, as of food in a state of starvation. Since the symptoms of affect hunger are clearly manifested in children who receive maternal care and direction to a high degree in a physical and intellectual sense, though without any evidence of affection, the analogy is more accurately related to a vitamin deficiency rather than to a gross starvation. The use of the term affect hunger, rather than affection or love hunger, opens the possibility, also, of a privation of other sources of the emotional life, even possibly of hostility, though this is yet to be investigated. A child who has been overprotected and later, through the birth of another child, thrown into a rejected state, may also suffer affect hunger. In the present paper, however, I am using the term to apply only to individuals who have suffered lack of maternal love in the early years of life. Assuming for the moment the value of maternal love as an essential component in the development of the emotional life, what happens when this element is left out of the primary social relationship? Is it possible that there results a deficiency disease of the emotional life, comparable to a deficiency of vital nutritional elements within the developing organism?

My first example is an eight-year-old girl who was adopted a year and a half before referral. After a illegitimate birth, the child was shifted about from one relative to another, finally brought to a child placing agency, and then placed in a foster home for two months before she came to the referring foster parents. The complaints were lying and stealing. The parents described the child's reaction to the adoption as very casual. When they brought her home and showed her the room she was to have all for herself, and took her on a tour of the house and grounds, she showed apparently no emotional response. Yet she appeared very vivacious and "affectionate on the surface." After a few weeks of experience with her, the mother complained to the husband that the child did not seem able to show any affection. The child, to use the mother's words, "would kiss you but it would mean nothing." The husband told his wife that she was expecting too much, that she should give the child a chance to get adapted to the situation. The mother was somewhat mollified by these remarks, but still insisted that something was wrong. The father said he saw nothing wrong with the child. In a few months, however, he made the same complaint. By this time, also, it was noted that the child was deceitful and evasive. All methods of correction were of no avail. A psychoanalyst was seen. He recommended that the parents stop all correction and give the child a great deal of affection. This method was tried, according to both parents, with no result. The school teacher complained of her general

inattention, and her lack of pride in the way her things looked. However, she did well in her school subjects, in keeping with her good intelligence. She also made friends with children, though none of these were close friendships. After a contact of a year and a half with the patient the father said, "You just can't get to her," and the mother remarked, "I have no more idea today what's going on in that child's mind than I knew the day she came. You can't get under her skin. She never tells what she's thinking or what she feels. She chatters but it's all surface."

I have selected this case as my first illustration of a type of difficulty that is familiar to everyone who works with children, because I feel reasonably sure that the parents were distinctly affectionate with children, and also because their own child, aged twelve, was affectionate and well adjusted.

Repeated experience in the treatment of the type of child referred, indicates a poor prognosis. Before considering this phase of the problem, I would like to cite further examples.

An unmarried woman, aged forty, adopted a child aged two years and eight months, through private arrangement. The child was the illegitimate son of a woman of high economic and social status. The family history was negative. The child was turned over to an agency very soon after birth, placed in an orphanage from age 12 to 27 months and then transferred to a boarding home, where he remained until the period of adoption. After a year, the mother gave up the possibility of getting any emotional relationship with the child. She had never been able to get any sign of affection from him. He never accepted her fondling. In the household there was a doting and indulgent grandmother, to whom the child also did not respond. The mother felt she had been taking punishment for a year and could stand it no longer. Besides the lack of emotional response, she complained chiefly of his negativistic behavior. According to tests the child had superior intelligence, and the physical examination was negative.

The third example is that of a boy adopted at the age of three. The previous history was unknown, except that he was illegitimate and had been shifted around from place to place. A Wassermann test and physical examination made at the time were negative. I examined him at the age of eight years. There was a good health history, and the physical examination was negative. According to tests, the intelligence was adequate. He was referred because he had been twice suspended from school for poor work, and the fact that he made a general nuisance of himself. The mother had given up hope of making any relationship with him. He showed no affectionate response. Altough she made several trips away from home, he never asked about her when she was away. Punishment or ordinary methods of correction had no effect. He would "forget" too easily. His behavior in the office was quite infantile, I thought like that of a three year old boy. He showed a

complete lack of appreciation of his difficulties at school and at home. There was no question of some distinct emotional deficiency in his response.

The fourth case is another example of an adopted child, a girl aged nine years and ten months at the time of referral to the Institute for Child Guidance. She was referred for general incorrigibility. She was adopted at the age of seven months into a home in which the foster mother could give little affection, but demanded highly conventional behavior. Before the referral, she had been seen by two psychiatrists, one in consultation and the other for a series of about twelve interviews. She had also received thyroid treatment for a period of time, though our findings showed no evidence of physical difficulty. Our examination revealed, besides the problems for which she was referred, fantastic lying, difficulty in making any friendly relationships with children, and school retardation. The parents noted especially her "failure to profit by experience" and "unresponsiveness to affection." The problem was complicated by the fact that the home was of superior type in a cultural sense—requirements that were too high for a child with an I. Q. of 80. The entire history led to the conclusion that the patient had some inadequacy in her emotional response and was an unfavorable subject for therapy. The parents were, throughout the long contact that ensued, conscientious in cooperating with every therapeutic effort. The patient was treated by the psychiatrist, utilizing chiefly a psychoanalytic method, for a period of two years. The behavior of the patient during the process of over 200 sessions was markedly negativistic. There were some interesting periods of improvement. Nevertheless, the result of the entire therapy was practically nil. At the end of the treatment, the parents were willing to consider another therapeutic adventure before referring the child to foster care. Through special circumstances, it was possible to send the child to Vienna, where she was treated by a psychiatrist of the Adlerian school, with whom she lived for a period of three years. The results were essentially negative; indeed, the child's problems became more alarming because of her greatly increased aggression. She was thereupon sent to her own mother and very quickly got into difficulty because of her incorrigibility and because, somehow or other, she had managed to collect five revolvers. From there she was sent to an orphanage, from which she ran away on two occasions, and then to a detention home, from which the psychiatrist wrote that he considered the patient an excellent prospect for intensive psychotherapy. At the last notation patient was eighteen. It is interesting that the typical attitude of the psychiatrist was that she would respond to psychotherapy. I have cited this case especially to show the failure of psychotherapy to meet these problems.

These case illustrations are given as examples of emotional pathology caused by primary affect hunger of a severe degree. The symptom-complaints are of various types. They include, frequently, aggressive sexual behavior in early life, stealing, lying, often of the fantastic type, and, essentially, complaints, variously expressed, that

indicate some lack of emotional response in the child. It is this lack of emotional response, this shallowness of affect, that explains the difficulty in modifying behavior. The inhibitions to the instinctive impulses, normally strengthened by the response to maternal affection, are no longer in operation. As an instrument in modifying behavior, the power of maternal love may be seen most clearly in life histories where it is absent—a kind of ablation experiment in social life. That the difficulty in these cases is due to a primary affect hunger seems a reasonable assumption, even though not proven by any direct experiment or by statistical checks. Does it follow, necessarily, that any child who suffers complete loss of maternal love, during the infantile period, will develop into a psychopathic personality of the type described? Further, in a number of cases in which a child was given presumably normal maternal love, in the first two years of life, the same difficulties may occur when an attempt at adoption is made at this age. Such cases were sufficiently numerous in my experience to warrant the advice that adoptions be made either in the first year of life, or after the infantile period. It was assumed that when the early emotional attachments were made by the child, as the personality began to grow, a break at this stage caused a situation similar to one in which the child could make no emotional attachment to start with.

There is an interesting bit of evidence on the prognosis in cases of primary affect hunger in a recent issue of the American Journal of Orthopsychiatry.[1] Eighty-one delinquent girls were treated by a combination of social and psychotherapy. Successes and failures were tabulated by follow-up studies varying from one to five years, after discharge from the home. One of the investigators independently analyzed the parent-child relationships and classified them into four groups. The successes and failures were then checked against these classifications. They illustrate a finding already determined in previous studies, to wit that the cooperation of the parent is the most important item in prognosis. One finding, however, is especially striking, namely, that the 17 cases in which there was evidence of complete rejection, showed 100 per cent fail-

[1] F. Powdermaker, H. Turner Levis, and G. Touraine: Psychopathology and Treatment of Delinquent Girls. Am. Jr. Orthopsychiatry, 7: 58 (Jan.) 1937.

ure in response to therapy. This is in contrast with the general result of 50 per cent success for the group. The case examples of complete rejection cited are extreme and convincing.

In contrast with the extreme cases of affect hunger we have, at the other end of the scale, a series of children whose difficulties are solved by the restoration of maternal love. In such cases psychotherapy may be either unnecessary or merely a complementary therapy. There are a number of children who do well with affectionate foster parents, or with a psychiatrist who renders the therapeutic relationship primarily supportive. This type of treatment, to which the name supportive therapy has been given, is a recognition of the fact that in certain cases the child's hunger for love must be gratified. It is recognized that in every therapeutic relationship the patient receives some support of this type (transference) but there are cases in which the treatment must be primarily, even exclusively, supportive; a treatment in which the worker acts *in loco parentis*. Favorable results with such children are often utilized to prove the particular merits of this or the other type of psychotherapy, whereas it matters little what technique is used as long as the child feels loved.

A patient was referred to the Institute for Child Guidance at the age of nine years, with a complaint of enuresis and temper tantrums. A visitor to the foster home wrote a letter to the Institute from which the following excerpt is taken: "He is starved for affection. His mother rarely visits him, although she is urged to do so frequently. When she is there, he acts very infantile, climbing up on her lap, always wishing to be with her, and showing off. Then as time elapses after her visit, he becomes more unmanageable and disagreeable." The history of the case is featured by the child's affectionate response to grown-ups, his making up to any stranger, the explosive and dangerous temper tantrums, and marked jealousy of the other children in the foster home. The "hunger" element in the difficulty is seen in the response to grownups and to the mother, with whom he acts in complete disregard of what is usually a strong inhibiting influence—the presence of other boys. When his mother is about he is always sitting in her lap, he holds his face up to be kissed and puts his arms around her neck. According to the foster mother, he acts in these situations quite like an infant. Though affectionate to the foster mother, he makes no such display with her. The severity of the temper tantrums must be mentioned. On one occasion he tried to break up a game which the other boys were playing. The foster mother sent him to his room, whereupon he tore up the bedding and pulled all the pictures off the walls. On another occasion he attempted to hit a boy with an axe. On another, he chased the teacher and the children out of school.

The patient lived with his father and mother in the first year of life. After the death of the father he was placed in an institution for a year, then for two years in a boarding home, from which he was removed by his mother. He was placed again with the previous boarding mother. He was moved again to a foster home in which he had been living for a year and four months at the time of referral. There are certain elements in the history that indicate a certain modicum of affection from the mother and in the homes in which he was placed. In one boarding home there was an affectionate mother. The foster mother also was affectionate with him. Furthermore, his own mother, though very spasmodic and infrequent in her visits, was affectionate while with him.

In this case, treatment consisted in getting placement with a foster mother who could give him a great deal of affection. There were only four interviews with the psychiatrist. They consisted largely of chats about the foster home. Marked improvement in behavior occurred and continued for two years. A follow-up study made when the patient was twelve years six months old, showed complete cessation of the temper tantrums, good school adjustment, growth in responsibility, though no improvement in the enuresis.

The case described illustrates a very frequent problem for social agencies. A number of cases in the Institute for Child Guidance series show a growing adjustment under the care of an affectionate foster mother. Such therapeutic benefit may occur even in the adolescent group. However, the stumbling block is often the mother of the child, who continues sporadic contact. She visits the child once a week, more commonly once in several weeks, and thereby prevents the building up of a stable relationship with the foster parent. Furthermore, the fact that the child is under foster care while his own mother is still in contact with him, stimulates various fantasies of abandonment, confusion about his own place in the world, sometimes even a confusion of self-identity, often an illusion that the mother who has really abandoned him is a loving and protecting mother. Agencies seem to foster this illusion on the part of the child, because otherwise they would feel guilty of encouraging hostile feelings toward the mother. The mother who has given the child to foster care, yet refuses to give up the child for adoption, is motivated by her feelings of guilt over the rejection and thereby acts as a great handicap to the child's stability. Frequently, also, we have instances in which the mother removes the child from one boarding home, has the child live with her for a week, and then through the agency gets another placement. Because of her own guilt, also, she may find all kinds of fault with different foster

mothers. It is not unexpected, therefore, that a recent follow-up in the case of this patient, now age 18, shows this type of history: discharged from a foster mother to his own mother, back to another foster mother, truancies to his own mother, then placement in a farm school.

In a similar case, presented by Dr. Blanchard at the last meeting of the American Orthopsychiatric Association, the main psychodynamics are clearly discernible. (1) A group of activities representing responses to the primary need. They are manifested in various manoeuvers to hold closely to a person, to win demonstrations of affection, to plead for love, to utilize pathetic appeals and states of helplessness, in order to stimulate a love response from a mother-person. The kissing-bug reaction represents an avidity for physical affection, as illustrated in the previous case, and belongs in this category of responses. So also a number of the whiners and pleaders and naggers for attention, for closeness and for guarantees that the maternal sustenance will never be withdrawn. Out of this group, also, are derived the mechanisms of constant begging for gifts, also of making overwhelming demands from a friendship later in life, to insure against any possible break in the relationship. (2) A group of activities that represent various hostile acts designed to punish the one who denies love and to prevent the possibility of its withdrawal. The mother who has denied or withheld stimulates a hostile rejoinder in the form of wishes for her death, various sadistic fantasies, even threats to her life, also threats of suicide if she will not respond. The conscious level of these performances varies, but they may be overtly expressed. The temper tantrums, possibly also the enuresis may be manifestations in this group, as may all types of " bad " behavior. (3) A group of symptoms that are based on the child's fear of the hostile impulses. These represent the source of the emotional conflicts and neurotic derivatives of the original state of privation. Fear of death is a manifestation. In fact, for every hostile move there is a retaliatory fear. There are a number of interesting derivatives from this state that have to do with the feeling of being deprived, and its consequences. These have to do with various forms of self-pity, the creation in the individual of helpless states, and even depression, but time does not allow these elaborations.

So far I have cited two types of response to affect hunger, one, the extreme instance in which the emotional development of the child has been adversely affected from the start, with a resulting pathology of affect; the other, an instance in which the renewal of maternal love has a successful restorative function. There now remains a large mid-group of cases in which the problems derivative of the early affect hunger are marked by special and usually persistent relationship difficulties. They follow along the lines in which the denials of maternal love and affection are especially marked.

In the last case cited, a boy who made up to every adult, we have an example of what may become a characteristic of every relationship. Such examples are better seen in those adults, whose social life represents a series of relationships with older people, every one of whom is a substitute mother. They may be single or in combination, the point being simply that the patient must, throughout life, be in contact with a person from whom the same demands are made that were thwarted in the original experience with the mother. The life pattern then becomes dependent on maintaining such relationships. When one of them is broken there is a period of depression, or a feeling that "something is terrifically lacking," until another relationship is made. Another type of reaction is seen in the form chiefly of excessive demands made on the person who is selected to satisfy the privations of early life. Such examples also represent a distinctive cluster of cases seen in social agencies, especially in children who have difficulty in adapting to the foster home. The story in typically that the child makes a good impression, the foster parents are delighted, and then, within a week or two, the demands of the child become so excessive that the foster parents are worn out and insist on release from their charge. The problem is always the same—excessive demands for food, for money, for privileges. Attempts to satisfy them end always in disaster. They represent, it seems to me, the child's need of proof that the adult is a loving parent because he satisfies every requirement that is made, also a hostile motive to destroy by getting things out of them. It is as though the child has to repeat the original frustration. A recent example comes to me of a delinquent boy who, in relation with the social worker, tried to get money from her. It was put on the basis that "if you love me you will do this

for me." If the demand was not satisfied, the refrain would be " then this shows that you don't care for me." Every attempt made at giving insight into the relationship failed. The patient showed initiative in getting a job but quit in a short time because he thought he deserved more money, they should give him more time for lunch, etc., etc. Other jobs were terminated for the same reasons. The patient was able to respond only to stern necessity. He was never modified by therapeutic methods.

No doubt there are a number of children who feel a distinct lack that is related to an original privation, who, nevertheless, are in a state of externally good adjustment. Such children naturally are not referred for treatment, since it is rare that a child is not brought to treatment through an adult. There are, certainly, numerous examples of adults, well adjusted according to the criteria of overt behavior, with complaints of various dissatisfactions, chiefly in the form of futility, or depression, that have their origin primarily in affect hunger. How much of the difficulty is related to a true deficiency in the infantile period, and how much is due to neurotic mechanisms is a question that the psychoanalyst is in the best position to solve, but I feel sure that there are numerous instances in which the deficiency is covered by neurosis, and the difficulty mistakenly attributed to the overlying structure. At least, a recognition of this fact will compel a reorientation to the life history.

The responses described seem to pick out special elements of privation in the mother-child relationship. In the social relationship the protective phase of maternal care may be sought; or the giving function in maternal care may be the special point of attack. In others, it may be the mere demonstration of affection, including also genital satisfaction. These elements represent special incompleteness in the early emotional development of the patient and must be demonstrable in numerous phases of the life history, of which this account can only be a rough sketch.

I have tried in this study to indicate certain basic responses to affect hunger, showing a group of cases in which there are pathologic residues due to an extreme deficiency; second, a group in which the restoration of maternal love has marked therapeutic effect; and third, a group which demonstrates specialized difficulties in social relationships that are derivatives of a primary affect hunger.