

A PHENOMENON OF REBIRTH: COMING ALIVE IN ANALYTIC AND MEDICAL PATIENTS

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THE THESIS OF THIS PAPER is that phenomena of rebirth in medical and surgical patients going through life-threatening illnesses are dynamically related to similar phenomena of analytic insight and generally to peak emotional experiences. Under rebirth phenomena in physical illnesses are subsumed those psychological and behavioral happenings, whether disintegrative or not, through which the patient resumes interest in and living in the world about him. I have found, although it is often not appreciated at the time of the experience, that such phenomena are of frequent occurrence, and that, unless the manifestations are dramatic, they are likely to be ignored by patient and physician alike. Also, the dramatic manifestations, such as post-operative psychosis and depression and acute identity crises, including psychosis, in psychiatric patients are viewed frequently as retrogressive and interruptive, rather than as a struggle toward intrapsychic and interpersonal reorientation. The data also illustrate a relationship between the duration of physical illness and the significance of the illness in the patient's living to the intensity and emotional depth of the rebirth phenomenon. That is, short-term illness is generally less incorporated into the mode of living than is long-term illness, and the experiencing of coming alive tends to be less intense in short-term illness.

The concept of rebirth is ancient and carries with it religious significance and symbolism from many cultures, primitive, Eastern and Western. The nature of rebirth phenomena, of identity crises and concepts of positive disintegration have been described, and their psychic significance has been elucidated by Kelman in connection with cyclical disintegrating and integrating,¹ with finding oneself through losing oneself, and giving birth to oneself,² and he has clearly elucidated the process in "Kairos and The Therapeutic Process."³ Maslow⁴ indicates the peak emotional nature of postoperative and other experiences of a rebirth nature. The Polish psychiatrist, Dabrowski,⁵ elaborates a theory of positive disintegration and views the process of disintegration of existing internal psychic environment as essential for the birth and development of a "higher" psychic structure. Camus⁶ notes the painful nature of becoming aware in his comments about the myth of Sisyphus. The process of disintegrating and reintegrating in the resolving of conflict through analysis is integral to the process, whether one is dealing, in Horney's terms, with neurotic conflict or central inner conflict.^{7, 8} Horney⁸ attributes anxiety to conflict, and she clearly indicates several forms of conflict related to matters of identity with the idealized self and/or with the real self. The anxiety in the rebirth phenomenon is such that it is

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shaking to the mode of living in sickness and in health. This depth is indicated by the awareness of the patient, the symbolization and the extent of body involvement in the emotional experiencing. Indeed, patients with physical and emotional illness refer to sensations of coming alive and of being born, thus suggesting relationship of the phenomena of emotional insight, identity crisis and rebirth.

CLINICAL DATA

Several years ago I was asked to see in consultation a divorced woman in her forties, hospitalized because of suspected herniated nucleus pulposus. The consultation was requested because of the continuous requirement of narcotics, the fact that her pain was made worse by lying in bed and by traction, and because of other behavior unusual for her diagnosis. She was annoying to staff by pacing the floor, lying on the floor with feet elevated, by her requests and the help she offered other patients. Because of all this, minimal findings began to be viewed as equivocal by staff, and the patient had become desperate. I was initially perplexed by this woman, a previously successful business executive, who over two years had developed neurological deficit, had become consumed by pain, had lost her business and most of her friends. She moved continuously about the office or knelt on the chair supporting herself on her elbows on the back of the chair. She used drugs and activity to narcotize her distresses. During the next few weeks increasing findings led to diagnosis and removal of a Schwannoma of the cauda equina. During the first four postoperative days she continued to require large doses of narcotics, found it difficult to remain in bed, and was suspicious of caring personnel, who found her a management problem. During the fourth night after the operation she became disoriented and screamed with the illusion that red splashes in the

curtains were fire. She talked about and made motions of knitting in the air. She was calmed by tranquilizers and constant attention. The next morning she greeted me warmly and rationally, stating she felt better, was in no pain and was recovering. She recounted events of the preceding night with some embarrassment about having been out of her mind and about her fears of burning in the fire. She reviewed the history of her illness and then, for the first time, spoke meaningfully of her daughter, occupation, money and home. She required no further medication and after convalescence reentered the world of business. Through delirium she had resumed interest in her living.

The one reference I have found in which phenomena around recovery through operation are referred to as rebirth is that of Meyer *et al.*⁹ in their paper documenting preoperative deadness and lack of interest in daily living and postoperative aliveness in patients undergoing surgery on the mitral valve of the heart. The history I have presented is unusual, but not unique, in the dramatic form of the two-year illness, in the emotional components of the acute phase of illness and surgical intervention, and in the opportunity to observe and to participate in the process during the latter phases of the illness. I shall discuss later the symbolism and process represented by this and other experiences, but I want to remark now about the observations.

As a physician I had long been familiar with and too superficially accepting of behavioral and emotional components of acute illnesses such as myocardial infarction and surgical conditions. At the time I saw the patient I have just reported I was open to observing and to seeking meanings of the phenomena. My first reactions to the observing were a sense of familiarity, and awareness that in some way the phenomena heralded a change from the position of being ill to the position of convalescing. I felt that the

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phenomena had to do with the life-threatening and life-changing nature of the process, and that the observable behavioral and emotional components frequently occurred overnight. In the woman I have presented the form of the acute reaction was that of delirium. The process was disintegrating and was toward reintegrating with the world about her.

What was disintegrating? For two years her existence had been focused on seeking relief of pain through one or another way of narcotizing. Postoperatively this driven reaction to illness was no longer necessary and disintegrated through the delirium in the illusion of burning and the fantasy of knitting. She had felt that she was being destroyed, and viewed the knitting, in which she had pride, as constructive in face of her fear of the fire.

It is common clinical observation that the third postoperative day tends to be the worst, and that thereafter the patient is actively convalescing. There is not concomitant worsening of the physical state of the patient. Actually the timing of this phenomenon is variable within a few days, and the form is individually determined. Evidence of it is found in the succeeding reduction in the need for narcotics, change in the direction of complaints, e.g. from the complaint of pain to complaint about the food, in the willingness of the patient to care for him or herself, and in the more open, more friendly relating to personnel, including the physician. It is a looked for and gratifying experience that a patient, who has grudgingly acknowledged your presence with worry about his condition and survival, will one morning greet you with, "Good morning, Doctor, isn't it a lovely day? I feel better." The tide has then turned toward convalescence.

With these thoughts in mind I enquired about such occurrences of colleagues who had undergone surgery and re-examined my own experiences. My

expectation that psychologically oriented colleagues would be aware of nuances of the phenomenon has been borne out. In all instances as I spoke of the idea of rebirth after surgery, there was immediate recognition and a sense of familiarity with the experience. One analyst, a man, related two experiences awakening from anesthesia for relatively benign and acute conditions. In the first instance he propositioned the nurses while feeling sexually aroused, and in the second he was relieved that his coming alive took the form of feeling very hungry. A second colleague, a woman, recalled that one day while in the hospital after difficult abdominal surgery with prolonged recovery, she stood for some time at the window watching children playing in the street below. She warmly felt how good it was to be alive, and viewed this as an ecstatic experience and a changing point in her life. Both colleagues were definite about the meaning of the experience.

At an annual summer outing, while speaking to a man who operated a booth I noticed a sense of illness and a look of fright in his eyes. I learned that for some months following surgery for renal stone he had found it difficult to work because of various pains, sweating on any exertion and worry about his health. His doctors told him it was nerves. I indicated my interest in the subject of reactions after surgery, and asked him about any unusual experiences following his operation. With a smile of relief he stepped over to me and spent about an hour telling me of a terrifying night in which he had been disoriented and had had the delusion that people were after him and were going to kill him. Despite no further evidence, he had continued to worry about losing his mind, and felt the occurrence as weak and shameful. In his practically-oriented, Anglo-Saxon, rural subculture, such phenomena would be viewed as particularly weak and tragic, so that he failed to talk about and to integrate the experience, with the resulting

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agony and waste to him. On the next day I passed his place, and he called, "Hi, Doc. My feet hurt, but I'm struggling with it." I had the distinct impression that during the conversation with me, in which I had validated the humanness of the experience, he had been able to integrate the experience and to resume living.

I have had three operations for patellar fracture. The first time, I was operated under spinal anesthesia within an hour or so of the fracture. While there were many difficulties, there was no sense of integrating the illness nor of resuming living. I was focused upon carrying on as much activity as possible in spite of the disability which I resented as an interference with my interests. Several months later the wiring of the patella gave way, and integration of illness came through immediate uncontrolled sobbing and during a week of waiting for the second surgery. Integration of illness was evidenced by my thoughts of metabolic difficulties in bone healing and in a sense of hopelessness about again facing the painful process of rehabilitation. One early morning following the second surgery, performed under general anesthesia, I watched with interest and amusement the activities of some pigeons struggling for living space under the eaves opposite my window. That day I was hungry, in good spirits and in less pain, and I did some work. Following the third operation, also under general anesthesia, I lost to memory one day, the fourth or fifth postoperative day. I think I slept most of the day, but I have been told of some rational conversations of which I have no memory. The next day I was free of pain, interested in things about me, and convalescing.

I mention these personal experiences because of four points. One is the helpfulness of these experiences to my understanding of the meaning of these emotional happenings in physical illness. A second is the importance of under-

standing help in going through the experience, help I had through analysis with Dr. Harold Kelman. The third point is the role of general anesthesia in the rebirth phenomenon after surgery. I am at present tentative about formulations of the role, but am certain that it is important to the mental processes around surgery and recovery. I doubt if any adult or near-adult approaches general anesthesia without thoughts about awakening and not awakening. These fears are expressed in remarks and questions to the physician. I can opine that the importance is related to fears and sensations of dying, to symbolism of dying and of being born, to loss of control during illness, that control going to another human being and, even if desired, being infantilizing. The fourth point is the importance of the integration of illness into the mode of living in order for rebirth phenomena to occur as illness is lessened. In the rebirth phenomenon something in the mode of living in order for rebirth phenomena to come alive; in physical illness, the mode of living with the illness is lost to living after the illness. To quote Dr. Kelman, "There can be no gaining without a losing," a process he writes about in connection with disintegrating in the interests of integrating,¹ and again in connection with finding oneself through losing oneself and giving birth to oneself.²

Integration of the neurotic and psychotic processes, if not their symptomatology, into modes of living is clearly indicated in Horney's concept of the neurotic pseudosolutions to the problems of living.⁸ It is inherent in the holistic approach to schizophrenia¹⁰ and, along with the struggle through which the degree of integration lessens, is a daily experience in the office. I prefer the term rebirth to that of birth, because I feel that at some time and in some degree a previous sense of aliveness is most helpful and nearly essential to more healthy integration. Put another way, illness must be in some way dystonic for there to be a

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struggle toward more healthy integrating and self-realizing. I shall present a few examples of rebirth from psychoanalytic practice to emphasize similarities to the foregoing instances.

I had been seeing a young man, aged 21, for almost three years before the following incidents occurred. He is the youngest of seven siblings, and had developed an acute catatonic excitement near the beginning of his second year in college and a few weeks following the marriage of the last sibling remaining at home. Following this marriage, his European born, orthodox Jewish parents, themselves quite emotionally ill, began to cling to my patient and to pressure him into their isolation. He had been hospitalized for three months. In the course of our work he had not missed one session. He had stopped hallucinating, had moved out of his parents' home and had been working for almost one year. Following a severe tonsillitis he missed one session. The next day his mother called stating he was locked in his apartment not answering the door. She had spied on him from an adjacent building.

During two additional days I was uncertain of his state of life. He had no telephone, and I elected not to go there. I could have been involved in some delusional system, and to have gone in company almost certainly would have precipitated suicide in response to his fear of further hospitalization. Dr. Kelman helped me plan what could be done. Two notes to call me were placed under his door. We knew the second was picked up. He did not call, but the same night he was able to accompany a sister and her husband to my office. He was unshaven, unkempt, excited, more communicative and more involved than I had ever seen him. He had started to take previously refused medication, was talking about returning to the job he hoped would be open to him, and was talking about matters of daily living. I learned that he had walked the streets during the first

day, and had then cowered in his apartment.

It was a long time before he told me he had been driven by two related delusions: one that he had killed his mother and the other that he was the Messiah. Of particular significance to him was my not hospitalizing him, which represented a new form of relating in contrast to his previous experience. Almost a year following these events, he came from work one day, sat staring at me as though seeing for the first time, buried his head on outstretched arms on my desk and said, "Dr. Hite, who's son am I? My mother and father aren't parents. Am I anybody's son? My boss called me son. I'm mostly your son. You care." He then essentially detailed his life history, and at the end of the hour commented on the beauty of some flowers in the room. I gave him one. Since this time he has improved his job, including taking improvement tests, has been increasingly self-caring and fantasizes less.

He recently has told me two sequential dreams. In the first he is swimming in a tropical lake surrounded by palm trees. There are other people his own age whom he cannot quite contact. These people included a blonde girl he thought exceptionally beautiful. The sensations were of great pleasure and of beauty. In the second dream he and another fellow are taking pictures of a guarded manufacturing plant, such as in wartime. He is apprehended by one guard whom he fights off, and he escapes with the pictures. Again he was very pleased with himself, and commented that he would soon return to college. In association to these dreams he commented upon the cleanliness and purifying aspects of water and of the Hebraic custom of *Tashlich*, which is going to the water on Rosh Hashanah and, through prayer, leaving one's sins in the water. His comments about the second dream were of doing things, and this time *with* people. These dreams may of course be interpreted by

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sexual theory along lines of return to the womb in the first instance, and as prohibition against the primal scene in the second. Such interpretation contains the idea of birth, and is not contrary to my thesis of rebirth. It is limited to birth in one frame of reference. Of greater importance, it leaves out meaning of the symbolism to the patient, in which sexuality played a minor role.

A successful, bright, divorced man in his thirties had begun therapy because of anxiety, agitation and depression. Some months later, while on vacation, he was on the beach at a time of exceptionally high waves and was pulled into the water by one wave. Later, he recalled hearing screams as the wave struck him, remembered his sense of helplessness and the struggle to keep breathing as long as possible. His attention focused on a birthstone ring he was wearing, and he concentrated on not losing that ring. He was rescued, and on the way back from the shore he and friends, including girls, stopped at a wayside tavern where their laughing, crying, clinging to each other prompted the owner to tell them love-making was not permitted. He felt the goodness of being alive after he had thought he would surely be carried out to sea. He felt that his problems of daily living were trivial and superficial. Thereafter in our sessions and in his living, this man has worked in a more involved and committed way. The occurrence at the shore heralded a change in his orientation from escaping any difficult situation toward working with it. In sessions I sometimes fantasize this drowning scene, and have come to associate the fantasy with particularly significant moments of struggle and aliveness in the analysis.

A 50-year-old woman, mother of a son and daughter, had been in analysis five years when she began to go swimming at a beach familiar to her from childhood, but not frequented by her in many years. She spoke at length of how initially she felt cramped in her movements through

the water and her concern about how she swam. Later she spoke of the freedom and the feel of moving in the water. About a month after she felt freedom in moving in the water she spoke of being born, and on the couch raised her knees and went through birth pains. Her birth has been a theme expressed through art; always a lover of art, she has begun to draw and to paint.

Through the thoughtfulness of Dr. Sara Sheiner, I have an example of coming alive as experienced and written by one of her patients. The patient first describes her long period of not feeling, her terror of disintegrating, her envy of friends because they did feel, and of hope lying with her doctor who understood. She used the third person in writing of her friends: "They could only equate *her* pain with the commonality of their own." I have two comments about this use of the third person. First, it is an evidence of the degree of alienation from her own pain. Second, this remark, taken together with the possible interpretations of my patient's dreams, calls attention to the dangers of generalizing and directing symbolization. Meaning and feeling are often quite different, qualitatively and quantitatively, to the severely alienated person than they are to associates. Dr. Sheiner's patient continued writing about her evasions, her feeling old and haggard physically and of her hiding. As she spoke of how like her mother she felt, she began to recall one woman she had trusted, loved and felt loved by. Then, as she spoke of her shame in admitting her need to be loved by and mothered by Dr. Sheiner, she began to cry. At the end of this hour Dr. Sheiner offered an extra appointment. On that day the patient awoke hopeful and, unusual for her, took no pills before coming to the office. The office looked very bright, and she noticed the plants and use of the color green. After an interpretation of how she assumed chameleon-like qualities in response to the threat to her being by

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her mother, and Dr. Sheiner's statement, "You are you," the patient began to sob and to shake. Dr. Scheiner had her take her hand, helped her to feel both hands and to taste the crying. It was real, and she began to feel a load inside her lift. In silence she heard a fog horn from the river, again followed by silence. She felt validated into being, and felt that she never again could be in the center of the abyss of despair. She wrote, "... whatever elevation I stood on all my life I walked off of and onto another place." This sensitive experience will become more meaningful in discussion of lessening alienation.

DISCUSSION

The data have focused on one aspect of stressful and life-threatening experiences, namely, the sense of coming alive, of rebirth, as a part of the process of resolving threat to organismal functioning. By threat I mean any menace to the organism's mode of existing in health and disease. In general we are tuned to feeling emotional or physical illness as stressful and undesirable, and resolution as desirable and, by inference, less stressful. Karen Horney⁸ emphasizes the degree to which neurosis is integrated as a mode of functioning of the person and the threat posed by any process disintegrating to this mode of functioning. In several of my examples of physical illness (the woman with the tumor of the cauda equina, the man with the kidney stone and two relating to myself, and in the cardiac surgical patients reported by Meyer *et al.*⁹) physical illness was of sufficiently long duration to have become a part, sometimes a large part, of the mode of living.

For comparison, I have quoted examples from patients in psychoanalytic therapy. Taken together these instances substantiate the view that the form of disintegration of the process in physical illness toward healthy reintegration is similar to that observed in lessening of

neurotic illness. In more acute happenings the condition tends to remain dystonic, there is less altering of the usual mode of neurotic and healthy functioning, and the form of disintegrating and reintegrating toward more healthy functioning is less dramatic. It is my view that the dynamics as well as the form are similar.

Each instance I have presented demonstrates one or more aspects of peak emotional experiencing. The feeling of strong emotions during analysis as reported by Sheiner¹¹ is evidenced by the totality and aliveness of the experience, involvement of body, mind and feelings, awareness and lack of reservation. Such experiencing has a quality of reality to it, an owning quality, which is productive of change. Martin¹² in *The Dynamics of Insight* also clearly indicates the totality of involvement, the awareness and the reintegrating aspects of deep emotional insights. For there to be a reintegration there must also have been a disintegration. Integration represents a way of coping with and adjusting to internal and external healthy and sick reality, and is not limited to healthy phenomena. It is this process of integrating in sickness that results in the neurotic developments as described by Horney⁸ in *Neurosis and Human Growth*. Threat of change in the position of the patient in regard to the material and degree of integration is anxiety producing, and the phenomena of rebirth illustrate how at times the threat is shaking to the foundation of the integrated structure.

In my data I have been explicit about the disintegrating of forms of illness and the reintegrating in more healthy forms. By extrapolation I infer the cyclical nature of integrating, disintegrating and reintegrating. In several places Kelman^{1, 2, 3, 13, 14} develops in an holistic manner the philosophy, theory, experiencing in and out of analysis, the significance of total emotional experiencing and the cyclical

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nature of the process of integrating and disintegrating. I have leaned heavily upon these concepts in the interpretation of my data.

Confirmatory evidence of the totality of experiencing, commonality of psychic and physiological stresses and the stressful nature of disintegrating and reintegrating comes from recent psychoendocrinological studies. Particularly pertinent to this paper are reports by Mason and Sachar *et al.* Mason¹⁵ reports elevated 17-hydroxycorticosteroids in a variety of circumstances, including admission to hospital, increased anxiety due to emotional states, during the third to seventh postoperative day, during chronic illness. Furthermore, he notes correlation of corticosteroid elevations with emotionality and involvement of the patient in the current situation as determined by interview and Rorschach testing. It is noteworthy that the surgical patients were awaiting elective thoracotomy, indicating a relatively long duration of illness, with the opportunity for integration of illness into the mode of living of the patient. The surgery may have posed the dual threat of the procedure *per se* and to the mode of living in illness. Although there are many references to endocrine responses in psychiatric illness, Sachar and his colleagues^{16, 17, 18} particularly emphasize correlation of corticosteroid elevations to periods of intrapsychic turmoil, such as going into and coming out of depressive and schizophrenic reactions, and report normalcy of corticosteroid levels during periods of relative intrapsychic stabilization in illness and in recovery.

Although psychic disturbance may result from medication with steroids, the evidence supports the view that elevations of corticosteroids are a part of the total mobilization of the organism to cope with any threat. I do not have endocrinological data. However, the literature is broad enough to support the concept of endocrinological participation in the total

body involvement in peak and critical emotional experiencing such as is being discussed.

My data include many symbols of living, dying, danger and purification; to mention some of them, burning in a fire, drowning, being attacked, swimming, knitting, holding onto a birthstone ring, the color green, plants, sex, hunger, children playing, birds struggling, *tashlich*. Symbolizing brings into awareness a way of being, of relating, of trying to be and to relate individually through a process of condensing and abstracting sensations, thoughts and situations onto meaningful simplistic forms. Such symbolizing is at times referred to as primary process thinking, a term which does not coincide with my meaning. Kelman¹³ emphasizes how at any moment we, with our whole beings, remember the past in the moment, and that we use symbols appropriate to expressing this moment. He also states that symbolizing is an aspect of integrating and is curative. Observing and experiencing the significance of the moment come later. In my examples, the sensations of being alive were usually only partially and peripherally experienced at the time, and were confirmed through the changing mode of being after the event.

The symbols of fire and water are particularly frequent in phenomena of coming alive. We are born out of water, we are composed of a large proportion of water and we require water for living. Thus, the individual and mythological birth and death symbolism of water is understandable. In Greek mythology Achilles was protected against injury by being dipped in the river Stix, and dying was referred to as crossing the river Stix. It is likely that in the troubled times under Herod the Jewish people were seeking purification and rebirth through *tashlich* when they followed John, the son of Zacharias, in baptism in the river Jordan. The rebirth symbolism is extended in the Christian story of the

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baptism of Jesus by John, in which the carpenter was reborn as the Son. In addition to performing baptism in water John is also reported as speaking of baptism through fire.¹⁹ In his chapter, *The Symbolic Significance of Water, Death and the Religious Experience*, Trigant Burrow²⁰ relates many aspects of the Judeo-Christian religious symbolism of water, the concept of space, his concepts of the preconscious mode, the nest instinct and death. He points out some philological parallels from the Sanskrit in words combining meanings of mother, space and breath, and he analytically relates these concepts and the Buddhist concept of nirvana, which is described as meaning, among other things, "... crossing the sea of Sansara or the cycle of births and rebirths." I mention these correlations to indicate the universality of experience, the depth nature of the symbolism of living and dying and the rending nature of rebirth stress, in illustration of which I have given two postoperative psychotic reactions, one acute catatonic disorganization, two microdisorganizations in therapy and some less dramatic instances.

I have discussed the rebirth phenomenon in relation to disintegration and reintegration, endocrinological components of the total body involvement, something of the nature of the emotional experiencing, and symbolization of death and birth through which the process is expressed. Lastly, I have some comments on the alienating nature of the integration of physical and emotional illness as and into a mode of living, and the dealienating nature of the disintegration of the mode of living in illness toward more healthy functioning. The dealienating process is in one sense itself alienating in that it represents separating from an established form of living, an aspect to which may be attributed a great deal of the emotional stress. Such a view is presented to emphasize the similar emotional nature of integrating at a more

alienated level and of disintegrating from a level of alienation toward the growing personal center of ourselves.

Horney⁸ describes alienation at the core as abandoning or divorcement from the growing center of ourselves. She further states that forms of alienation involve separations from the material and actual self as evidenced by numbing of the body, remoteness from feelings, energies, accomplishments, possessions and by disconnectedness of past and present living. Horney clearly indicates that the alienating process occurs in many forms in the neurotic process—in each instance furthering remoteness from constructive forces, and increasing a lack of feeling a determining force in one's own life. This point of view is cogently presented by Vollmerhausen²¹ in "*A Symposium on Alienation and the Search for Identity*."²² The alienating process is inherent in the formation of neurotic character structure and development of the pride system.

Rubins²³ indicates a pride-invested idealization of physical health together with distortion of the body image and conflict around emotional body expression as important in the development of psychosomatic symptoms. Such dynamics are expressive of the alienating process, so that somatic symptoms may be viewed as an increase in alienation occurring within the neurotic process. Since the results of the alienating process are defensive against more disruptive happenings in the body economy, there are certain constructive elements which foster integration of the alienated state into the mode of living.

In the degrees to which each individual was living in and with physical illness, the data confirm the point of view that integrating of physical illness as well as the integrating of neurotic character structure is a reflection of alienation. In my examples, there was more neurotic and healthy integration of physical illness than somatic expression of emotional

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conflict. Thus, the source of alienation may be relatively more psychically external, as in physical illness with its concomitant giving over of responsibility for one's living to another, or the source of alienation may be more immediately intrapsychic as in the neurotic and psychotic development. In either situation there is integration at a more alienated level. From this point of view the dealienating process assumes the same characteristics in physical illness and in psychological illness: that of various manifestations of coming alive and of identity experiences. These manifestations are clearly illustrated in the account by Dr. Sheiner's patient.

I am focusing on only some factors operative in psychosomatic, somatopsychic illness and in the phenomena of coming alive in psychiatric illness. Schur²⁴ views pathological somatization as a phenomenon of ego regression. The process would thus be disintegrating, a view which places a value judgement upon what is integrating and disintegrating, and ignores the process at the moment in favor of the genetic view. Reiser²⁵ presents a thoughtful review of neurophysiological, psychoendocrine studies and develops a correlation with psychoanalytic concepts from the Freudian point of view. His view represents a broad psychophysiological approach from another theoretical position, and substantiates that, whatever the theoretical construct, physiological disease is dystonic to the mode of living of the individual in health. He says, "Once the disease is triggered or activated, the individual is changed—physiologically and psychologically." I have stated the point of view that the process is one of cyclical integrating-disintegrating-reintegrating in forms representing greater and lesser alienation. Teleologically the purpose would appear to be coping to whatever degree and in whatever possible mode with the stress of a changing form of living.

In regard to therapy and the therapist I have only a few direct remarks. The first is that more understanding of the nature of the process in phenomena of rebirth opens ways of going through it with the patient. Second, more understanding favors freeing of the therapist from the sense of hopelessness and despair which accompanies the disintegrating phases of the process in the patient. Third, these are troubled and dangerous times in the therapeutic situation, recognition of which is essential to seeking and giving help. Important, even fundamental, questions to giving help are: What is disintegrating? What is the direction of the alienating process? What can we do about it? Sheiner²⁶ describes the therapy of severe alienation and outlines her directions in therapy as: using herself as underpinning; bringing in external realities; opposing self-destructiveness; identifying the genuine. These directions are also useful guides in the therapy of rebirth crises. Even so, it is prudent to remember that all do not negotiate successfully the disintegrating phases.

CONCLUSION

Instances of phenomena of rebirth in physical and psychological illness have been presented. The phenomenon of rebirth has been discussed from the point of view of total body involvement, including some physiological components of the process. Some aspects of the symbolizing process in rebirth crises have been indicated. The main focus of the paper has been toward understanding the phenomenon of rebirth as a peak emotional experience and as an identity crisis through application of the concepts of the cyclical nature of integrating and disintegrating and of the alienating and dealienating processes. It is hoped that this presentation will stimulate greater awareness of the phenomenon in psychiatric liaison work and in the analytic situation, and will further application of our theory.

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