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Characteristic Interpersonal Relations of the Prevailingly Hysteric

What are the characteristics of the interpersonal phenomena, the observance of which justifies a strong surmise of the presence of the hysterical entity? The observable interpersonal relations of the prevailingly hysterical person are characterized by an extravagance of emotional color. Euphoria is higher than an appraisal of objective reality would seem to justify, and it alternates rather vividly with equally extravagant negative emotions. Unlike the excitement or the depression of the person who is prevailingly cyclothymic, the emotional aspects of the hysteric are highly labile. Moods come and go as fleetingly as summer showers and there is no close relationship between the prevailing mood of an hour, let us say, and what might be described as the most important personal events of that hour. The hysteric can be very angry, immensely pleased, very devoted, and very hostile in rapid succession. But if these dramatically extravagant emotions effect their purpose, that's the end of it. And I suppose that no other group of people show such amazingly sudden shifts in emotional address to other people as the very hysteric people do. This is in many ways a function of their formulated role, which is both much cruder and decidedly more spectacular than the formulated role that the rest of us try to live. The maturity of the motivational system is shown to be quite incomplete in the hysteric. The proportion of hysterics whose personality development has not progressed through preadolescence is, I surmise, quite notable. The relationship of the hysteric with other people is therefore never a relationship that amounts to love as I define it, and sometimes not even to intimacy in the sense in which I define it. Quite often there is a conspicuous predominance of the competitive motivation that has such prominence in the juvenile era, and the competition is often with members of the same sex.

Hysterics ordinarily have a rather bad time of marriage. But whether they advertise the bad side or the good side of it is a function of the particular moment in which one encounters them and, beyond that, is an index of the ease with which their morbidity is solving their problem. A markedly hysterical woman who has told her neighbors on every occasion what an idyllic home life she has, may, when encountered by one of these neighbors after a row with her husband, give an astonishingly different account of what a beast he is privately. Such a deviation from the usual account of the idyllic home life would not bother the consciousness of the hysteric particularly. She would provide herself with fairly crude loopholes, and return later to the prevailing mythology. And again, even when having a dreadful time, hysterics may for a short while be so swept by their euphoria that they give a divergent account to some neighbor; but again they provide themselves with fairly crude loopholes before returning to the conventionally unhappy state. The competition is, as it were, a competition in exaggeration. Nothing seems to irritate the prevailingly hysteric person so thoroughly as someone telling what cynical bystanders might call a better whopper. In other words, anyone who is more extravagant than the hysteric is the bane of the hysteric's life. And sometimes this competition gets the hysteric into singularly awkward positions with the calmer part of the community and leads to new hysterical symptoms to cope with the difficulties in interpersonal relations into which his competitive extravagance has led him.

The relationship with the more or less innocent bystander is more striking in the case of the hysteric than in any of the other entity types because so much goes on in words. And since language is a very important part of the culture which is built into all of us, the nonhysteric—or the not prevailingly hysteric—part of the community takes the verbal communications of the hysteric with a certain amount of seriousness and has to build up ideational processes of evaluation and discounting with regard to them. Soon after the innocent bystander shows up for the first time, he is involved in a not particularly realistic fashion in some more or less dramatic fantasy of the hysteric. So hysterics seem to inexperienced or superficial people to be quite sociable, quite warm and outgoing. Hysterical women are particularly attractive to markedly schizoid young men as an improvement on obsessional mothers and as the kind of people one would like to live with for the rest of one's life. And since people who are schizoid are relatively meek and disinclined to protest about tales thrust upon them, a good many of them get themselves bound to hysterics in holy wedlock. Then the schizoid husband has something to do for quite a long time, and the hysterical wife is no worse off than previously.

The sexual relations of the hysteric are often badly marred by immaturity, and disorders arising from genital impulses are so common that I think that accounts for the libido of orthodox psychoanalysis being indistinguishable from a generalized lust. In looking for what is the trouble with the sex life, one encounters the crudest expression of Oedipus survivals. It is in this field that one would expect to find the woman who quite cordially hates her mother and is all but obviously still very devoted, very firmly attached, in fantasies to the father; and one finds wives who frequently run off comparisons between the husband and the father which are quite simply derogatory of the husband. One also occasionally hears the hysterically predisposed man make open, uncomplicated comparison between the woman he unfortunately married and his mother. The notion of the Oedipus complex is therefore not at all difficult to maintain if one works with this type of material. As another manifestation of that, one finds more open revolt against the certainly prescribed role in life—that is, the sexual role—in the hysteric than in any other group. In other words, the hysteric woman can be a man in a homosexual relation with an abandon which is scarcely conceivable in any other

type of human organization, and the hysterically predisposed man can act the woman with incomparable thoroughness and lack of cynicism.

Conversion Hysteria

The distinction between conversions and other hysteria is perhaps less important than one might think. The conversions are solutions of conflict by the utilization of some part of the somatic equipment—some part of the body—on very simple ideational grounds. For example, conversions are much simpler than the rather astounding way in which hypnosis may affect particularly suitable people, or the dynamics of such 'psychosomatic' disturbances as neuro-circulatory asthenia or the peptic ulcer syndrome. The conversions are at the level of ideation which corresponds to the time when the hysterical type of disablement—the hysterical dynamism—was formed. In other words, the concepts of body structure are those of the juvenile —rather amateurish, rather young. So in this type of utilization of part of the body which occurs in the major hysterical entity, the disturbance follows this rather simple notion of body structure, and also a relatively simple notion of function. It only very rarely includes vasomotor disturbance and never, so far as I know, applies to any system as the system is actually organized physiologically.

Now, when there is this conversion, it performs a useful function; and that function occurs principally within the self-system—in other words, that is where one would look for the real meaning of it, rather than the patient's view of the meaning. There one discovers sometimes the almost juvenilely simple type of operation set up to profit from the disabling system. The patient will often tell you in the most transparent fashion: "If it were not for this malady then I could do ——" and what follows is really quite a grandiose appraisal of one's possibilities. The disability functions as a convenient tool for security operations. We know that under cover of the hysterical disorder the patient works out dramas that are rather blatantly expressive of what is in his mind, and we marvel sometimes at the prodigies of inattention by which no clue as to what is the source of the difficulty reaches his awareness. Here again, as in every aspect of hysteria, we see a peculiarly simple sort of caricature of what we encounter in the major dissociations. This aspect of hysteria—the inattention, the failure to develop referential processes, to think about details in the hysterical performance—is interesting chiefly in contrast to the refinements found in the major dissociative conditions.

Amnesia in the Hysteric

The distinction between real dissociation and an imitation of it is clearly seen in the thoroughness with which a whole course of life can be wiped out and highly desirable results be brought right into the hysteric's hands by means of amnesia. Dissociation just does not work that way. Amnesia as such is not evident in dissociation. The dissociated state is characterized by a profound disturbance of attention; but the hysteric, as was recognized very early in the history of modern psychiatry, suffers from amnesia. It is singular also that, in dissociation, any juggling of external events which would necessitate acceptance of the dissociated system by the self would probably lead to panic; in other words, this cannot be attempted. But an hysteric, under the same circumstances, abandons or shifts the symptom.

I shall illustrate this by a case on which I was called in as a consultant a few years ago. The patient, one of the many children of a steel worker, had some years before been taken under the wing of a well-to-do industrialist engineer and his wife. This couple were childless, and the patient had lived with them as practically—although not legally—an adopted son. He was then seventeen or eighteen years old.

The condition on which I was called in had come about following a minor accident in some sport event at school. As a

result of the accident, he was clearly unconscious for two or three minutes; but there was no blood from the nose and no post-concussion headache. His foster mother was summoned and she took him home and called an internist. Almost immediately the patient developed a tremendous amnesia. He could not by any device be persuaded that he was in truth the child of this large family, didn't recognize the members of it, had no idea what his name was, and just couldn't remember large chunks of recent events. After a few days of this, the internist called me in on the case.

In seeing the patient, it was impossible to avoid the foster mother, and from her I learned a wealth of detail about a long, long relationship in which she had been decidedly the Lady Bountiful to this family and had gradually taken over their most attractive child. She pictured the foster father as being rather unsympathetic to this boy and particularly unsympathetic to his new mental disorder. There was enough obscurity and uncertainty in his wife's communication about the husband that I was glad to have a chance to interview him. He had made a good deal of money, and he had a fairly strong interest in the more frivolous aspects of life. His wife, in contrast, was something of a benefactress, and was busy with meetings and serious public affairs. The husband thought that she was in love with the boy, and he told me quite openly and not amiably—"I think she's gone on him." But he did not think that his wife had shown her interest in the boy clearly enough so that the boy knew about it—a surmise which seemed somewhat questionable to me.

I saw the boy himself quite a number of times, and he was very genial, very ingratiating in his manner. I traced out the limits of his amnesia, and they were wonderful. There wasn't anything that provided a convenient lead to the course of events that had led to his being practically adopted. I applied almost all the pressure I could to make anything in this tight system yield, with absolutely no results—only lots of transference in beautiful imitation of the psychoanalytic real thing. And, as usual, my problem was, Is there an element of schizophrenia in this thing? I had to dismiss this possibility, however, because of the patient's uniform suavity in defeating me and in leaving a large element of suffering, and so on, sort of free-floating. In other words, he handled the situation beautifully. Schizophrenics just aren't that way. They may be terribly able at analyzing, but they are rather wooden and clumsy or unduly tense in performance. This boy wasn't.

So finally I decided to arrange a piece of awkwardness for this patient that would make his disorder very expensive to maintain. The husband was willing to cooperate. And he was able to press his wife—because of his justifiable grievance about her devotion, I think—into fitting into the following plan: Since the boy had lost all recollection of the skills which he had acquired while living with her, he was left with the prospect of returning to a machine shop as an apprentice. So that was arranged—we turned on the economic and social heat. And lo! the boy had a miraculous recovery, late enough at night to wake up the whole household. He went shouting through the house his joy at having recovered his memory. Shortly after that he went away to school, and my latest report indicates that there has been no recurrence of the amnesia.

Treatment of Hysteria by Making the Symptoms Unpleasant

Many of the older forms of therapy with hysteria, in which the patient was permitted a role, were delightful, especially if the role was easy to get onto; but they failed to cure. Whenever the doctor began to get downhearted, the particular symptom which was oppressive at the moment would be cured, but unhappily with some residuals or some new symptoms. So the thing went on indefinitely at a fairly high level of entertainment for both the patient and the doctor. But during World War I the hysterical dynamism got a very severe jolt, when

some not too profoundly philanthropic or, I think, profoundly clever psychiatrists discovered that hysterical disabilities can be dispelled by making them very unpleasant. That works. They started turning high voltage sporadic current on these poor unfortunates. Well, I am afraid that sporadic electricity permits only one role, namely, to know that it is extremely disagreeable. And some of our psychiatric colleagues vied with each other, with wonderful results, in figuring out what new forms of nuisance could be perpetrated on hysterics. On the basis of this general war experience, hysteria has for some time fallen off as a subject of much interest. But there are now, in a new and even more desolatingly disturbing and threatening world war, the terrifying necessities which drive people to whatever dynamisms they have at their disposal. And hysteria may thus again be a subject worth giving some thought to.

A View of Hysteria in Terms of the Pragmatic Utility of Clinical Entities

Surely, if one puts a patient into some abstract category, such as hysteria, it is much better to do this with a view to what it determines in one's actions as a therapist than merely for peace of mind or for some obscure reference to outcome. Here we need some fairly reasonable schematization of the psychiatrist's work to guide us. And the work of the psychiatrist can, for my purposes, be schematized by the following questions which I shall attempt to answer in terms of the clinical entity of hysteria.

(1) *What can you learn from the patient, and what difficulties, facilitations, and safeguards are relevant in that connection? What must you seek through collateral channels or by dint of interpretation of obscure comments from the patient?*

The psychiatrist can feel perfectly certain that he will hear very little from the hysteric which is not merely an exaggeration of the conventional cliches of interpersonal currency.

Thus, in contradistinction to the schizophrenic, whose speech is notoriously apt to include utterly uncommunicative autistic terms—private words—there is no special problem about the language of the hysteric. It can be taken for granted that what hysterics say means simply what almost anybody would mean if he said it. It is perhaps for this very reason that hysteria has such a curiously parental role to modern dynamic psychiatry. What hysterics said *could be* translated without any very careful assay of just what they meant. On the other hand, there is a good deal about the hysteric life that is represented most conspicuously by its omission from communication; that is, if one listens with reasonable attention to the communications of the patient, certain gaps in what one expects to be the experiences of average human life become conspicuous. This, again, does not require any intense scrutiny, but rather continued alertness. In connection with these missing elements of average life, one may expect certain fairly characteristic difficulties if one inquires. And these difficulties are to me rather startling in the simplicity of the so-called defense which the patient interposes. Again this lack of refined discrimination which suggests the fraudulent comes in, and one wonders whether the patient is perhaps lying or kidding, or whether he is actually as out of touch with that detail of life as the context shows. The fact is the latter. In the dramatic world in which hysterics play their roles, things are like somewhat undistinguished fiction, and there can be these gaps that are just a bit incredible. One has always to have in mind that hysteria is a very wonderful achievement in the sense that as long as it can be gotten by with, you might say, it solves rather serious conflicts with singularly little apparatus. Even though it looks as if the hysteric is kidding himself, he isn't. The symptom must be thought of as fairly simple in comparison with the symptoms found in other illnesses. So it is that the psychiatrist should approach the patient with certain realizations as to the pattern of communication. First, you must tone down

in your own mind the extravagances of the patient, trying to think what is probable or what was probably observable by an innocent bystander, in terms of the events that the patient is reporting. Second: you must attend, without excitement or chagrin, to the curious gaps in personality that the hysteric's experiences, as reflected in his communications, show. And third: you must realize that any attempt to close these gaps is going to be countered by something that can be frankly provoking. It looks as if the patient is simply lying, evasive, without benefit of any respect for your personality.

The hysteric patient will be able to give an objectively valid statement of his attacks or of the way that the symptoms interfere with his life only after some quite novel relationships are set up—perhaps in an intensive psychoanalysis with powerful transference, or hypnosis, or something of that kind. This comes about, again, not because there is any intention to deceive, but because of the rather rudimentary character of the self-organization by which hysteria is maintained, making it impossible for the hysteric to have data of that kind. Such information about himself would make the maintenance of the disorder impossible, and so of course it cannot be obtained by any ordinary method. Thus it becomes important for the psychiatrist to look to collateral information.

In general the collateral information requires pumping. That is, the really understandable, unwittingly purposive affects of hysteric performances are shown only to those who will overlook the comparatively rudimentary nature of the hysteric personality. On the other hand, a person who questions the hysteric critically, who is obviously skeptical about the hysteric's *bona fides*, or anything of that kind, produces in the hysteric a mixture of the conventional hysterical business plus more or less random dramatizations, which is not particularly helpful data. So it is that any informant who has actually been there—who has suffered, if you please, the suffering of the patient—is unable to give the psychiatrist a penetrating analysis

of what goes on. But nonetheless he will have the facts, and the psychiatrist can get through to them if he can avoid scaring up the informant's anxiety. That is, the informant who has really useful information will react badly to what is so hard for the psychiatrist to avoid, namely, giving some clear impression that the symptom is purposeful.

(2) *What extraordinary phenomena are to be expected from the patient? And to what extent is one to look to the dream life, and so on, for useful and usable data? Now, secondarily to this, What maneuvers will the patient engage in as parataxic evasions of therapeutic situations?*

Since the self of the hysteric is able to maintain security without a great deal of apparatus, it is to be expected that he may dream with relatively little disguise. Therefore, once the proper guarantees have appeared in the relationship of physician and patient, the dreams of the hysteric will provide significant material for the psychoanalytic procedure. From the standpoint of theory, there is no risk associated with the use of dreams in hysteria, in contrast to certain other conditions in which any encouragement of dream processes may, by disturbing the self, be disastrous both to the patient and to the treatment. The hysteric can, in case of need, make a very considerable shift in the field of symptomatology or in the nature of the disordered episodes in order to elude rejection by a critical person. Thus he is in no danger of a grave disturbance of the self. I would be greatly astonished to learn that any type of therapeutic intervention could precipitate panic in an hysteric. True, clumsiness and even many things that are not clumsy may precipitate lots of apparent anxiety. How much anxiety, it is always hard to say because part of the hysteric's structure is that if one has some anxiety, he might just as well have a great deal of it.

One expects almost any psychiatric approach to be productive of significant material in the hysteric. But the danger again is that the really significant material may be so conven-

tionally reported that, although you get the inference you should get about it, this inference is of much stronger, greater significance than the reported material. And in one field, where the line between sleep and waking is less sharply drawn, one may have highly significant material that has only an obscure relevance and that requires interpretation the same as the dream does to become simply valid facts of personality. That is the realm of the personal mythology, if you please, or the preferred fantasies of the patient. It is not uncommon—in fact, this has been projected into all psychology, I think, out of some hysterics—to find in these patients carefully preserved continued stories from the earlier years, somewhat different from anything else I know of in psychology. We know that in the early juvenile era persons who by accident are rather isolated fill in the need for compeers with imaginary playmates, and that some of them carry on with the same imaginary playmates through long-continued courses of imaginary events. Well, this is inherent in the structure of human personality and guarantees nothing as to the outcome of the person from the standpoint of clinical entities. But the continued stories that the hysteric has carried on in spare moments, possibly at night in bed, involve real people—actual playmates and so on; and they have gone on well into the juvenile era and are reproduced apropos of alleged simple associations to dreams, or something of that kind, *as valid recollections from the past.* So the psychiatrist can find himself facing for weeks details from the patient about something which finally, with luck, is resolved into a continued story from the juvenile era.

In these continued stories—once one has caught on, which may take an awfully long time—one has no difficulty in separating the fictitious from the real. And the interesting thing from my own very limited experience is that the people who were, you might say, plucked from real contexts and used in continued stories apparently do not have to be particularly significant people in the real life history of the hysteric; they

just happen to suit, in looks or something else, his particular necessity. A lot of effort addressed to solving that problem has convinced me that the actual people who had been borrowed and made over in fiction by the hysteric had been rather incidental in the development of his personality, however deceptively it might appear to be otherwise.

From this ease of dramatization, which characterizes not only the waking life—I mean, the behavior—and the revery processes in formative years but also the development of symptoms and so on, there has come about the notion that one very valuable armament of the physician is to have the patient make up a story or run off an imaginary situation. This notion appeared years ago under "the fantasy method of psychoanalysis," in which there is, I believe, very much more unconscious humor than was ever intended. But that is another characteristic of the patient, as you could infer from what I have said about the appearance of the symptom in my imaginary case. Properly motivated, the hysteric can produce rather sketchy, very dramatic daydreams at any stage in life, and these daydreams are ostensibly of use in therapy because they are almost transparent. But their transparency still probably doesn't make them particularly useful, for the fact remains that hysterics have stayed under treatment, even with fairly well-known psychoanalysts, for years and years and years.

Now what special problems can one anticipate? To me, the major problem of therapy with the hysteric is the extreme ease with which the therapist can make errors in judgment. As long as the psychiatrist comments to the patient on material which is not significant to the patient, there is an excellent opportunity for an elaborate cooperation which, aside from a certain lack of warmth, goes splendidly. And that reduces me to the verge of infant rage because I have to question *everything* minutely, and the game doesn't seem to be worth the candle. But I have learned from others that the same thing happens with them. Given an interpretation before there is

sufficient data for a good interpretation, the patient is off with the physician on a course that is thrilling but unproductive. It finally pales out; there doesn't seem to be anything at the end of it. But by then one is so far from where one took this tangential departure that it is a long time getting back.

The very simplicity of the hysteric's language and experience is baffling in that everything means just what you would expect it to mean—only, of course, much of it doesn't, because much of it is just verbal. Much of it has been picked up bodily, you might say, from other people's experience and from stories and so on which hit the flair for dramatic presentation and may actually have been run off as reveries, as continued stories, in reasonably adult years. So for all you know you may be analyzing somebody else's experience for a while, and of course that isn't profitable. The comparative transparency of the dreams makes them, I think, very important in the psychotherapy of the hysteric. It is as if they were less susceptible to manipulation and therefore do actually function as something of a safeguard in the therapy. I should suppose that if the dreams show no reasonable relevance to what is being discussed in the so-called free associations, the chances are that the free associations are just filling up time; they are a magnificent ride on which the patient and doctor are taking each other. And for that reason I am rather inclined to think that the one place in psychiatry where considerable recourse to dreams is highly advantageous is with the hysteric patient.

Although the hysteric's flow of words may provide hazards for therapy, his freedom from entrapment in autistic language is his particular facilitation for therapy. The bane of working with schizophrenics and the greatest risk, the most recondite nuisance, I think, in working with obsessionals, is probably the fact that their experience has made some words mean things so far from anything that your experience has made them mean that you will fall into supposedly communicative interchange without talking about the same thing at all. It is almost necessary in the early stages with the schizophrenic to presume that

you don't understand a thing the patient says. Gradually, of course, as you begin to find the limits of the more frequently used autistic terms, all that great caution and questioning of course becomes dispensable. Now this difficulty is probably at its lowest intensity with hysterics. The hysteric's language is apt to be fairly near the dictionary language.

The other facilitation in the hysteric is the fact that the psychiatrist can get at what simply can't be, which is a rather tremendously useful achievement. When you can tell a patient that in your experience things just don't work that way, and you are *right*, the patient has heard indirectly that psychiatry is really a reliable slant on life—a bit of news which cheers the patient especially when he is spending fifteen dollars an hour. Insofar as the dynamism with which one is dealing seems to be pretty definitely hysteric—which is not necessarily always the case even with the most outstandingly hysteric person—then if the thing goes way out of what a consensus of one's suburban neighbors would regard as human and reasonable, the psychiatrist is entitled to great skepticism about the patient's interpretation, often with considerable impression on the patient. That is just rather out of the patient's line. And skepticism about unusual explanations is almost bombproof, just so it is not as fraudulent an attitude on the part of the psychiatrist as many of the performances of the hysteric seem to be to the innocent bystander. In a good many patients—notoriously again, the obsessional who is apt to become schizophrenic—before the psychiatrist says what can't be, he wants to be quite sure that he understands what the patient has been telling him. Sometimes he will reach very bright ideas about what couldn't have been the case, only to discover that the patient was trying to tell him quite a different story which he just didn't follow. That, I should say, is no problem in dealing with persons properly classified under the clinical entity, hysteria.

(3) *What major changes are to be had in mind, and what is the most promising way of getting at them? In other words,*

what are to be regarded as the necessary achievements for great improvement? Note that here I am avoiding the term "cure," since I do not think it applies in the realm of personality.

The presence of the hysteric dynamism as the outstanding way of meeting difficulties in living seems to me to imply that the patient has missed a good deal of life which should have been undergone if he was to have a well-rounded personality with a rather impressively good prospect for the future. Because hysterics learn so early to get out of awkwardnesses and difficulties with a minimum of elaborate process, life has been just as they sound: singularly, extravagantly simple. And so, even if one could brush aside the pathogenic or pathologic mechanisms, one would have persons who are not at all well-suited to complex interpersonal environment. There they just haven't had the experience; they have missed out on an education that many other people have undergone. And under no circumstance could the therapist anticipate that such persons would become as intently observant, subtly discriminating, and perhaps analytically gifted as many a schizoid who has never had any psychotherapy. All the opportunities have been missed, you see; there hasn't been this development. So the therapeutic expectation has to be restricted—in the sense that one doesn't expect the hysteric to become a great student of human personality or something of that kind. The thing, therefore, that the psychiatrist would attach to the entity, hysteria, is that, insofar as the patient tends to seek his livelihood in a realm in which very acute discrimination and careful juggling of alternative hypotheses are necessary for outstanding success—that is a morbid movement which is to be choked off as best one can. And insofar as the patient tends to move, in the therapeutic process, toward a livelihood in which his relation with others is somewhat diagramatically simple, that is perfectly consonant with a movement toward mental health.

CHAPTER

12

Obsessionalism

I TRUST I have made clear how words—verbal propositions—come very early in a person's life to have rather astonishing power to handle some of the situations that are attended by anxiety. Now, if there were no correction of this faith in the power of the right remark, then perhaps the typical development would be the psychopathic personality who feels that if the right thing is said, everything has been done. But most people learn, soon after having been greatly impressed with the power of verbal propositions, that this power is a function of the person who hears the verbal proposition, that a thing perfectly useful with mother does not click so well with father, and that some things which are quite effective with both mother and father lead to anxiety when tried on the maiden aunt who has had some experience in educating children and sees that little Willie is becoming a rationalizer.

The type of situation which leads to this more complicated grasp on the utility of verbal propositions is rather roughly after the following pattern. The child finds himself in a variety of situations, all of which may be said to have in common that they are violations—that is, they collide with something that the child should know better about, should have learned. In these situations the child uses a verbal proposition, picked up from the speech around him, of course, which, although it works, does not work satisfactorily. That is, the parent is suf-