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Paraphilia as a Sexual Disability: Outcome Study in a Female with a History of the Kaspar Hauser Dwarfism Syndrome

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A longitudinal case study exemplifies paraphilic masochism as the sexological outcome in a female with a childhood history of the Kaspar Hauser syndrome of psychosocial or abuse dwarfism. The case is theoretically important with respect to the origins of paraphilia, and to case management.

KEY WORDS: paraphilia; Kaspar Hauser syndrome; case management.

INTRODUCTION

In current usage, when sexuality is considered in connection with disability, it is more or less taken for granted that the disability is not, per se, sexual, but rather that it is an extraneous source of handicap superimposed on otherwise healthy sexual functioning. One of the exceptions is genital malfunction, for example, impotence, secondary to spinal cord injury. However, impotence in general does not feature in the literature on "sexuality and disability." Nor, surprisingly enough, do disabilities secondary to birth defects or traumatic injuries of the sex organs themselves. The paraphilias belong to another class of sexual dysfunction that does not get included in the "sexuality and disability" literature. Nonetheless, paraphilias do constitute sexual disabilities, some of them of major severity and morbidity, witness the case herein reported.

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The case is one of paraphilic masochism combined with paraphilic prostitution as a sequel to a history of the syndrome of child abuse dwarfism. It is one among sixteen cases whose sexological histories have been followed into adulthood (4).

The syndrome of abuse dwarfism is one in which, as a sequel to conspiratorial abuse at home (a form of Munchausen's syndrome by proxy) a child does not grow and mature staturally, intellectually, and behaviorally (1). In the pediatric literature, this syndrome has been variously known as failure to thrive, deprivation dwarfism, psychosocial dwarfism, and reversible hyposomatotropic dwarfism, as well as abuse dwarfism. The confusion of so many alternative terms is resolved by using Kaspar Hauser as an eponym and by referring to all of them as the Kaspar Hauser syndrome. Historically, Kaspar Hauser (1812-1833) is the first person for whom there exists sufficient documentation to permit a retrospective diagnosis of this syndrome in which impaired statural growth is accompanied by impaired intellectual and social maturation (2). All three impairments are subject to reversal by the simple expedient of rescue from the domicile of abuse into a nonabusive place of residence.

CASE STUDY

Clinical Biography

The hometown physician referred this patient for a pediatric endocrine workup for growth retardation when she was aged 4 years 5 months. Her height age and bone age were both 2½ years. The gestational and birth history had been ostensibly unremarkable.

There were two older siblings, a brother aged eight and a sister aged seven, both of whom were smaller than average for their age. A younger brother was born when the patient was six years old.

The mother was said to have had a "thyroid tumor" removed two years before the patient was born, and both grandmothers were reported to have had a history of hyperthyroidism (Grave's disease). Both parents were reputed to use alcohol to excess, as was the maternal grandmother and her mother before her.

The two possibilities for the diagnosis of the girl's growth failure were growth hormone deficiency with dwarfism of either the idiopathic hypopituitary type or the psychosocial (abuse) type with reversible hypopituitarism.

The growth hormone response when tested both physiologically, by the exercise tolerance test, and pharmacologically, by the arginine and insulin tolerance test (AITT), was interpreted as favoring a diagnosis of idiopathic hypopituitarism. The ACTH response to the metapirone test was deficient, but there was no clinical history consistent with ACTH or adrenocortical insufficiency.

The girl was given treatment with human growth hormone (hGH) for a period of 21 months until the age of 6 years 5 months. The statural growth response was somewhat erratic and substandard in velocity until the dosage was doubled during the final 8 months. Treatment was then discontinued owing to unavailability of the hormone.

At the time of the diagnosis, and during the period of treatment with growth hormone, there was no investigation of the quality of family life nor of the possibility of child abuse at home. Thus there was no evidence on record during the first year and ten months in the clinic that might have pointed to a diagnosis of abuse dwarfism.

Then brief entries in the clinical record began to suggest that all was not well, domestically. At the age of 7 years 3 months the child missed an appointment, as the mother was having personal problems with her husband. Five months later the child had five stitches on her scalp, suturing a cut allegedly due to a fall.

At school, despite the claim of having been at the top of her kindergarten class, she failed first grade, with difficulties in handwriting and spelling. Fellow school children teased her about her height. By age 8 years 4 months, according to her mother, she could not wait until school break time to urinate, and drank water excessively. At night she was enuretic.

When she was 9½ years old, there was a terse note in the history to the effect that the home situation had been complicated by a fire which destroyed the family dwelling and critically burned the father. Actually he had been immolated by his wife and did not survive.

In the aftermath of this tragedy, the mother and her four children were taken in first by family friends, and then by a relative. Nine months later, the patient was admitted to the hospital for a second diagnostic work-up. On this occasion, her growth hormone response to the AITT had changed to normal (her older sister who, like her, was growth deficient, also had a normal response). The velocity of her growth had also changed. In the ensuing months it was calculated at 6.25 cm (2.5 inches) per year. These two changes confirmed the correct diagnosis to be psychosocial (abuse) dwarfism.

At the age of 11 years 2 months the girl's height was 123.5 cm (48.6 inches), her height age 7 years 0 months, and her weight 24.2 kg (53 lb).

She was not seen in the pediatric endocrine clinic again until brought in by a social worker at age 15 years 2 months. Her menstrual periods had begun in the preceding year. Her pubertal development was registered as complete (Tanner stage 5). Her height was 145.8 cm (57 inches), height age 10 years 8 months, and weight 42.2 kg (92.8 lb).

During the year after her 17th birthday, she had multiple behavioral problems of sex, delinquency, and depression. At the age of 17 years 9 months she was admitted to a community hospital with nightmares of death and dying,

suicidal ideation, and a suicide attempt by overdose with medication (Tylenol). She was given a prescription for imipramine which she used four months later in another suicidal overdose attempt. Subsequently she had a history of self-mutilation, namely burning her forearms with a cigarette, when stressed.

Shortly before she was nineteen, the patient delivered a baby girl at full term. Sixteen months later, the baby was given up for adoption. The patient had not been able to combine the responsibilities of single motherhood with those of a career in prostitution.

At the time of the adoption, the patient, now aged 20 years 3 months, was admitted to Johns Hopkins, referred by a community social service agency, for sexual and psychiatric evaluation. At this time it was ascertained that she required antibiotic treatment for trichomonas and chlamydia. She was HIV negative.

Social Biography

The major formative event in this child's social biography was the death of her father at age 37, when she was 9½. At age 20, she gave the following account: "One night they [her parents] got into a fight. She had caught him [on his fisherman's boat] with another woman. She threw a combination lock at her head and busted it open. When she came home, I guess she was planning what she was going to do to him. When he came home, they fought some more. He fell asleep that night. He was drunk. She got some gasoline and poured it over him, and lit the match."

The four children escaped from the upstairs of the burning house. The father, severely burned, died in a hospital nineteen days later. The fire destroyed the house. During the fourteen months before the mother was sentenced to life imprisonment, she and the four children lived partly with a family friend and partly with a relative, as aforementioned. The patient and her siblings then returned to the household of the same family friend and stayed there in foster care for another 2½ years.

In the month of her fourteenth birthday, the patient was referred to the county department of social services with the complaint that she wanted to leave the foster family and that, in view of behavior problems, the school had recommended a change of environment. A new foster placement was found in the home of a widow with nine year old twin sons. After 18 months the placement was terminated, as the patient wrote sexually explicit notes and left them lying around the house.

It was arranged that the patient would live in the home of her paternal grandmother, and the transfer was effected when she was 15 years 3 months of age. She and her grandmother proved to be incompatible. When her grand-

mother got angry, she would call me "a mother lookin' bitch, damn fool, and stupid," the girl reported. "She said I act like my mother and look like my mother." The grandmother complained that the girl was disobedient, not attending school, setting fires at school, being sexually promiscuous, and using drugs.

At age 17, she was transferred under the supervision of Protective Services, to the first of a series of institutional placements, which included shelters for the delinquent and homeless, a facility for unwed mothers, and a residential drug and alcohol treatment center. Except for institutions, her places of residence have been transient.

She has had no employment, no source of income other than as a prostitute. Her education terminated when she dropped out of eighth grade. Her IQ, tested at age 20 years 3 months on the Revised Wechsler Adult Intelligence Scale, was Verbal IQ, 79; Performance IQ, 76; Full Scale IQ, 76. In the context of her daily life, in the ways of the street, and in the use of language, she gave the impression of being at least average in intelligence.

She gave the appearance of being younger than her chronological age of 20, chiefly because of her height (4 feet 11 inches) and slender build, but also because of her dress (rolled up blue jeans, striped T-shirt, and brown sandals) and demeanor. She had blonde, shoulder-length hair, and wore no make-up. She was pleasant and friendly in conversation.

She maintained a cordial relationship with her mother whom she visited in prison two or three times a month. She hoped that her mother would be paroled, and that they would live together. Although she missed her father intensely, she did not level statements of blame or condemnation against her mother for having deprived her of him. She recalled that, at the time of his death, the newspaper reported that, of the four children, she took it hardest. At age 20, she said that she had always felt the guilt of responsibility for his death because of something she might have done but could not identify.

Lovemap Defined

The term *lovemap* was coined recently (3). A lovemap develops as a pattern or template in the brain and the mind. Its development begins in childhood. The years around age eight are critical in the shaping of its development as well-formed or malformed. A lovemap registers the ideas and images of the idealized lover, the idealized love affair, and the idealized activities and practices that induce sex arousal and lead to sexual climax. It appears spontaneously in explicit dreams, romantic fantasies, and masturbation fantasies, with or without external stimuli. These dreams and fantasies serve as rehearsal for real-life performance. Disclosure of a lovemap in public is tabooed by those

people who define all erotically explicit stories or pictures as pornographic. For this reason, the specific investigation of lovemaps has seldom been undertaken in sexological research.

Lovemap Biography

On the sentence completion test taken at age 20, the patient's completion for "My greatest mistake . . ." was "thinking I could take care of my baby." Explaining, she added: "I was too young to have a baby. I thought that if I had a baby, the guy I was seeing, Mark, would stay with me. But I was wrong. As soon as he found out I was pregnant, he left me alone with my daughter." She and Mark had been going together for two years when the final break up came.

Before going with Mark, she had discovered that pain could turn into sexual arousal: "I was 16, and I met this black guy and played hooky from school. We went to his house, and while we were having sex, he slapped me on the face, one time. It didn't hurt. It excited me. It felt good. But it really wasn't until I was age 18 that I really got into it. I was going steady with Mark who lived in the same group home that I did. And we would fist fight when we were having sex, or before having sex. It was better when he slapped me. I think he got turned on by it, too."

There was a childhood antecedent to this erotization of fighting. It traced back to the constant fighting of her parents which the patient could recall from as far back as when she was probably five years old. "My father and mother were fighting constantly," she said. "And sometimes it looked sexual to me. One time they were fighting in the dining room. My mother had on this real suggestive, slinky black negligee, and my father was just standing there, calling her a bitch. And he slapped her." When they fought, he would slap her in the face, and push her around, as well as yell at her.

"Sometimes," the patient said, "when I'm having sex with a guy and I ask him to slap me, if he does, I'll get sexually excited and find myself thinking back to that time when my mother was standing there in that black negligee, and my father was screaming at her and getting ready to hit her."

Another childhood antecedent to the erotization of fighting traced back to between the ages of 9 and 12. The mother had already gone to prison and the children had been replaced in the home of family friends. "I was living in this foster home," the patient said, "and the lady had a 16 year old son. He would come into my room at night, and he would undress me and just sit there and look at me. At other times he would touch me. One time he pulled me in his room and locked me in there. It was just me and him in there, and he forced me to have sexual intercourse with him. After that he tried to get me to do it again. He would still touch me and stuff. He'd try to come in the bathroom when I

was in there. One time, I was in my room alone, and he came in and started touching me on my leg. I didn't want to do it [intercourse] no more. So he got really upset and outraged, and started screaming and got kind of rough. He grabbed a hold of me and squeezed my face real hard and told me that I'd better do something to him. Then he got called downstairs . . . He would slap me sometimes in my face. He would punch me on my arm. I would have it all blue."

"At around this same time when I was being sexually abused," the patient added, "there was this girl, a friend of mine, six months older than me. She would take me in her room and slap me across my face . . . She would slap me and make me take off my clothes in front of her boyfriends, and burn me with cigarettes . . . Then one time I was in a wet bathing suit and she thought I had peed on the floor, and she made me lick it up . . . Sometimes she would get sexual with one of the guys, kissing, petting, being fondled on her breasts."

"When I was younger, I felt guilty about being sexually abused," the patient wrote on the sentence completion test. Later, she explained, "After everything happened between him [the 16 year old foster brother] and me I was scared. I thought I was being the one to blame." Eventually the boy's girlfriend found out what was going on. The girlfriend spoke about it with her boyfriend's mother, the patient's foster mother, who acted in disbelief. The patient recalled, however, that her foster mother had subsequently threatened her with a hysterectomy, "if anything happened."

From then onward, the patient gravitated toward frequent sexual encounters with multiple partners. By age 19, her lifestyle as a prostitute made it impossible for her to look after her baby in a settled household with a relative or friend, or even in a shelter for the homeless. "I've been in every shelter in the county," she said, "and got kicked out of every one because of having sex with the people there . . . They say I have a sexual addiction."

She was quite articulate about the lure of street life. "I guess it's the excitement I like," she said, "the pimps trying to get you, the cops after you, the drug dealers trying to chase after you. The cops are looking at you all the time, because they know you're a prostitute, and that's illegal. That alone is excitement to me. So are the fights. Some of the girls get into standing around, watching. A girl who's not a prostitute will ride by and make fun of us. A prostitute will pull her out of her car and start messing her up, and all the other prostitutes will start beating her up. That's exciting. The threat of getting put in jail is exciting, but not actually getting in jail . . . And just going in and out of bars, and everything in there is exciting. The city, and the night time, and how people might get wild sometimes, it's thrilling, I guess."

Some of the tricks whom she picked up "just treated me like a piece of shit, after they got done with me," she said. That type she did not want to see again. By contrast, there was a trick with whom "it was enjoyable for me,

because he was my type, which is important. He was a young black man, and he looked nice to me. I enjoyed it."

Though white herself, she felt particularly attracted to young black men. "I guess, for one thing it's because they're more aggressive. I just feel they know how to express themselves better, doing sex. I just feel an attraction toward them. It's almost an obsession . . . I haven't come across any who didn't have a big dick. You can feel it more. It just feels better to me."

Her ideal was to have a black man who would treat her rough and slap her around, on the face and arms or legs. "There was this incident with a drug dealer whose name was Black Jack. At a bar, one day, he asked me if I wanted to have sex with him . . . I went up to his room. We got undressed and we started having sex. It seemed to me that the more he got excited, the more violent he became; and right before he was going to reach orgasm, he started hitting me. After we were finished, I said, well, what did you do that for? And he said, well, because it gets me more excited."

For her, it was exciting also. It did not hurt, but was sexually arousing. In fact, it was possible for her to reach orgasm just by being slapped, without intromission. She had had no history of difficulty in reaching orgasm, and was able to do so two or three times in 15 or 20 minutes. After finishing having sex, she would be ready to begin again in about ten minutes. She estimated that, if she would try to set a record, she might be able to service 25 men between 9 p.m. and 3 a.m. In actuality, the maximum number of tricks had been 3 or 4 in one evening.

Under such circumstances as being in the hospital without an accessible male partner, she would masturbate at least once a day. She found no interest in a female partner, though she had engaged a few times in orogenital lesbian activity to oblige a fellow prostitute who enjoyed it.

She did not think of herself as being sexually weird or kinky. The wildest fantasy that she could report was brought on, as she recalled, from a magazine article: "I was with this group of guys. We were all friends. They were people who worshipped the devil. They made me dress up in this black costume, shorts and halter top, and have sex with them while they were holding me down and beating on me, hitting me a lot."

The most sadistic experience she had had in real life was in an automobile with a young black man who picked her up and drove to a secluded spot: "He pulled out a knife and I said, What's that? He said, shut up bitch. He did it probably more to scare me. He told me to take off all my clothes. So I took them off, and started having sex with him. He hit me hard, and slapped me on the face. He called me names. Then he told me to put on my clothes and told me, shut up you bitch, I'm going to slice you with this—referring to the knife. I laughed at him. I wasn't scared, because I had a razor blade in my pocketbook, and also because I didn't think he was capable of doing anything to me. He said, what are you laughing at? He slapped me across the face, and that got

me extremely aroused, sexually excited. So he told me to get out of the car, and he threw my clothes out of the car. I got dressed and went back to 19th Street."

There were some incidents in the patient's sex life that, considered in isolation, might have been misconstrued as paraphilic, whereas, considered in context they were properly construed as manifestations of hyperphilia that expressed itself predominantly in prostitution. For example, there were two incidents that were ephebophilic, but only legalistically. They involved the solicitation and seduction of two males who were legally minors, one aged 17 and the other 13. Both were residents of the shelter in which the patient was living shortly before giving her baby up for adoption.

Another incident was legalistically exhibitionistic, but actually the solicitation of a construction work crew by nude self-exposure. There were also on some occasions, telephone calls to strangers which were legalistically telephonicophilia, but actually solicitations of strangers in sexually explicit language.

On the sentence completion test, the patient wrote: "The worst thing that I ever did was to be a prostitute." Contradicting herself, she also claimed that she didn't find anything wrong with being a prostitute. Rather, it was getting paid that made her feel bad, she conjectured. She had sometimes felt that she should be paying, especially those men who, honoring her request to slap her up, gave her the most ecstatic orgasms of all, without themselves being turned on by slapping a masochist.

With respect to the future, the patient was candid in saying that prostitution as a lifestyle continued to appeal to her. Though she had no other prospects of financial support, her plans included another pregnancy. "I'm upset," she said, "because I just gave my first child up for adoption. I figure if I get pregnant again, I keep saying to myself, this time I want to get pregnant by a black man, and this time I can keep my child. Social services won't be involved. I feel like having a child is—it's something that I could have that would love me and depend on me."

DISCUSSION

This case is of particular interest insofar as it is an example of a paraphilia, namely masochism, in a person who, contrary to what is commonly expected, is not male but female.

In addition, the case is of particular interest as an example of paraphilia in a person with a history in childhood of the Kaspar Hauser syndrome, also known as the syndrome of psychosocial dwarfism or abuse dwarfism.

A follow-up study of 16 patients with this syndrome showed that the sexological outcome was paraphilic in 5 cases, normophilic in 5 cases, hypophilic

in 5 cases, and hyperphilic in 1 case (4). In 2 paraphilic cases there was also a disposition toward hyperphilia.

Hyperphilia is synonymous with hypersexualism. Paraphilic hypersexualism is responsible for the idiomatically popular, though nosologically erroneous characterization of a paraphilia as an obsessive-compulsive disorder, or as a sexual addiction.

In yet a third way, the present study is of particular interest, namely that it is developmental. It traces some of the phenomenology of a sexological disability, namely paraphilic masochism, to its antecedents in childhood and adolescence. Developmental phenomena may represent chronological contingencies, or possibly spatial contingencies, but not necessarily causal contingencies. In other words, they may be effects in search of a cause, rather than a cause producing an effect. Nonetheless, when antecedent and existent paraphilic phenomena resemble each other, they do suggest a hypothetical link from which to base new hypotheses and investigations, for example, of the influence of early sexologic experiences on the neurochemistry of long-term memory.

The paraphilia exemplified in the present case is phenomenologically a paraphilia of masochism in combination with hyperphilia manifested in the lifestyle of prostitution. The name for paraphilic prostitution, per se, is chrematistophilia. It is defined (5) as: a paraphilia of the mercantile-venal type in which sexuoerotic arousal and facilitation or attainment of orgasm are responsive to, and dependent upon being charged or forced to pay, or being robbed by the sexual partner for sexual services [from Greek, *chremistes*, money dealer + −philia]. There is no technical term for the reciprocal paraphilic condition of forced charging or robbing.

In the present case, there was no erotic turn-on either from being paid or from robbing the client. Prostitution was an outlet for hyperphilia rather than for paraphilia. The pay-off lay in the danger and excitement of the lifestyle of the street prostitute, and of sex with strangers. It included the maximum sexuoerotic ecstasy of being slapped and beaten up by those who would cooperate in the ritual of paraphilic masochism.

Paraphilic masochism is defined as a paraphilia of the sacrificial/expiatory type in which sexuoerotic arousal and facilitation or attainment of orgasm are responsive to and dependent upon being the recipient of abuse, torture, punishment, discipline, humiliation, obedience, and servitude [named after Leopold von Sacher-Masoch, 1836-1895, Austrian author and masochist]. The reciprocal paraphilic condition is sadism (5).

The erotosexual ecstasy of paraphilic masochism has its parallel in the religious ecstasy of penitential masochism. The procedures of both may be identical as in flagellation, cutting, burning, piercing, hanging from flesh hooks, and otherwise mortifying the flesh.

It is difficult for the ordinary citizen to comprehend that pain can be trans-

mogrified into either paraphilic or penitential ecstasy. The most likely scientific explanation is that of opponent-process theory (6). Opponent-process is like a sudden enlightenment whereby that which was formerly negative, aversive, and avoided becomes switched to positive, attractive, and addictive. For example, sky-diving suddenly loses its initial terror and becomes ecstatic. The sky-diver becomes addicted to this sport. Neurochemically, though it remains yet to be proved, the brain releases a flood of its own opiates, the endorphins for example. Thus, quite literally, the sky-diver becomes high on his brain's own euphoric chemistries.

In the Kaspar Hauser syndrome of abuse dwarfism, negative reverses to positive, and the children become addicted to abuse (1). In some cases, like the present one, addiction to abuse becomes erotosexualized, and is experienced not as the pain of being hurt, but as the orgasmic ecstasy of masochism.

Not all masochists have a childhood history of dwarfism. The majority do not. The extent of abusive injury in their childhood has not yet, however, been systematically investigated.

It is not yet known why some but not all children respond to abuse at home by having a shut-down of their pituitary glands so that they no longer secrete growth hormone. One must, therefore, presume that there is a specific vulnerability factor which has not yet been identified.

In all probability, there is also an unascertained vulnerability factor responsible for the development of paraphilic masochism in the lovemap of some children, but not others who are exposed in childhood to similar sexological experiences. Herein lies a topic for 21st century research.

When the development of the lovemap goes awry in prepubertal childhood, it may do so in response to neglect and deprivation of normal juvenile sexological development, or to excessively abusive punishment and humiliation in response to phylogenetically normal sexual rehearsal play, or to mistiming and age-mismatching of sexual encounters. In all three instances, children become entrapped in a Catch-22 of being damned if they do, and damned if they don't disclose what might be in need of disclosure. That is one of the inestimable costs of the sexual taboo that clouds our social heritage.

In girls, according to presently available evidence, the cost is more likely to be paid in the coin of hyposexuality, i.e., genital phobia, aversion, and anorgasmia, in which love and affection displace lust and carnal delight. In boys it is more likely to be paid in the coin of hypersexuality, i.e., genital usage, attraction, and orgasmia, in which lust and carnal delight displace love and affection.

Hypersexuality is a common accompaniment of paraphilia. In paraphilia, lust is preserved by becoming circuitously rerouted as, for example, when it can be expressed only in the context of a masochistic sacrificial penance of the flesh. The sacrifice then becomes an obsessive or hypersexual ritual.

The epidemiological incidence of ritual masochism in females remains to be ascertained, as does its existence in fantasy alone. Fantasies of abduction by a superstud are common female orgasmic fantasies, some of which include a masochistic element.

Women's paraphilic fantasies appear to be more tactual than do men's, whereas men's fantasies are more visual. The basis for this difference may be phylogenetic, rather than sociocultural. If phylogenetic, it is probably a function of sex-hormonal influence on precursors of tactual versus visual sexuality in brain differentiation, beginning in prenatal life, onto which postnatal differentiation, is superimposed. The importance of the present case is as a demonstration that male/female differences with respect to paraphilia are not absolute.

There are probably more female paraphilias than are presently suspected. They present a problem of sexual disability in women that is not sufficiently recognized in today's sexology. There should be a specialty of the sexology of woman. With the existence of such a specialty, one might expect the development of more efficacious programs for both prevention and treatment.

In the present instance, treatment was directed primarily toward rescuing the patient's infant daughter, by separating her from her mother, permanently, in adoption. The mother was given what might be called morality modification therapy regarding the wisdom of not being a prostitute.

The mother's own prescription for herself was to have another baby and keep it as someone to love and depend upon her. If society through its agencies could have used its resources to rehabilitate and finance this woman as a single mother, instead of intensifying her failure as a mother, then the long-term outlook might well have been more auspicious than it currently appears to be for not only mother but the child also.

Enforced severance of a baby's pairbondedness with the mother has dire consequences for the remainder of the child's life. It is an imposed separation and loss that is, de facto, a form of child abuse and health-care malpractice. It transmits the legacy of pathology to yet another generation.

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