

*American Handbook of Psychiatry*

**HYSTERICAL CONVERSION  
AND DISSOCIATIVE  
SYNDROMES AND THE  
HYSTERICAL CHARACTER**

**D. WILFRED ABSE**

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e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 3* Silvano Arieti

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# HYSTERICAL CONVERSION AND DISSOCIATIVE SYNDROMES AND THE HYSTERICAL CHARACTER

**D. Wilfred Abse**

## Terms and Symptoms

Hysteria is a term loosely applied to a wide variety of sensory, motor, and psychic disturbances which may either appear in the absence of any known organic pathology, or accompany organic illness and grossly exaggerate its effects. The term is also used to describe certain forms of group excitement (mass hysteria). Hysterical phenomena, such as convulsions, paresis, and sensory disturbances, often appear among participants in frenetic religious, political, or erotic group activity. Although the term usually designates a type of psychoneurosis, many persons who exhibit hysterical phenomena either in a sustained and solitary fashion or more transiently within a group may also show evidence of psychotic disorder, including paranoid delusions—that is, false beliefs of persecution and of grandeur.

The term “hysteria” is derived from the Greek *hustera*, which means “uterus”, reflecting an ancient Greek notion concerning the sexual nature of the disorder. Related terms are “hysteriform” and “hysteroid,” used often in an attempt at greater precision, the former to designate conditions which in

some respects suggest the hysterical type of psychoneurosis but in others suggest psychotic disorder, the latter to indicate a general resemblance to hysteria. In clinical practice, hysterical symptoms may be found associated with other kinds of neurotic disturbances, or may occasionally occur together with florid manifestations of psychosis. Hysterical symptoms frequently appear in males, children, and elderly people; however, they are most commonly seen in women who are in the early adult period of life.

It is to be noted that the term “hysterical” is often used as a defamatory colloquialism and that this usage is to a varying extent carried over inappropriately into the medical sphere. Various forms of psychic excitement and various inhibitions are sometimes comprised under the folk description “hysteria,” and often the folk description does overlap with the word as it is used as a psychiatric diagnostic term.

In *conversion hysteria* there are dramatic somatic symptoms into which the mental conflict of the individual is “converted,” whereas in *dissociative reactions* there is an attempt to avoid mental conflict at the cost of disturbance of memory and the stream of consciousness. In conversion hysteria there may be gross paralytic, spasmodic, and convulsive motor disturbances, exaggeration, diminution, or perversion of sensation, or dumbness, deafness, or blindness. In dissociative reactions, amnesia, fugue, or somnambulism may first attract attention. Any of these symptoms may occur

together, although there are characteristic ensembles, or a symptom may present separately or in alternation with others. Such flamboyant symptoms may subside temporarily in response to equally striking modalities of magical or magico-religious treatment. Historically, the “cure” of such symptoms has been exploited both consciously and unconsciously in the quest for power over others by the magician, the priest, the king, and the quack, or in order to exalt this nostrum or that god.

### Brief History

The ancient Greeks accounted for the instability and mobility of physical symptoms and otherwise unaccountable attacks of emotional disturbance in women by a theory that the womb somehow became transplanted to different positions. This theory of the wandering of the uterus referred to disease phenomena characterized by mobility and fugacity, especially when the course included the creation of scenes in which strong emotions were expressed. In accordance with this view, Hippocrates (460-375 b.c. ) considered such states as peculiar to women. In Plato’s *Timaeus*, it is stated more even-handedly:

In men the organ of generation—becoming rebellious and masterful, like an animal disobedient to reason, and maddened with the sting of lust—seeks to gain absolute sway; and the same is the case with the womb of women; the animal within them is desirous of procreating children, and when remaining unfruitful long beyond its proper time, gets discontented and angry and wandering in every direction through the body, closes up

the passages of the breath, and by obstructing respiration, drives them to extremity, causing all varieties of disease.

Hippocrates also held a naturalistic view of those priestesses, allegedly afflicted with the “sacred disease,” who chanted their oracles after convulsing. In many cases, the sacred disease was not epilepsy but hysteria; however, Hippocrates, like many a modern physician, found it difficult to distinguish convulsive hysteria from idiopathic epilepsy.

In the second century a.d., Galen noted that similar kinds of mental and physical distress occurred in men; in these cases, he assumed that the cause was retention of sperm.

The physiological idiom in which these ancient theories are couched indicates an emerging understanding, clouded during the Middle Ages, but developed in modern times by Freud, that hysteria is derived from a disturbance of sexuality resulting from an impediment to adequate sexual expression.

During the Middle Ages, the naturalistic viewpoint of the ancient Greeks was overshadowed by the attribution of hysterical phenomena to demonic possession, sometimes associated with witchcraft. This belief in the demoniacal origin of hysteria was widely held in Europe, and with associated superstitions attained epidemic proportions, resulting in an outbreak of



persecution that might be interesting to compare with the rapid and widespread diffusion of popular delusions by means of mass communication in our own time. In the medieval witch trials, the hysterical “stigmata” were relied upon as a method of ascertaining possession by the devil, or else of a pact with him. Later, at the close of the seventeenth century, the populace of Massachusetts (with notable exceptions) became convinced that the Devil had achieved a foothold in Puritan New England, and a witch-hunt ensued. Available accounts indicate strongly that the alleged witches and those who were “bewitched” suffered from hysterical disorder. Some of the “witches” apparently practiced black image-magic. This witchcraft, centered in Salem, engendered the wider communication of hysterical disorder within the community of Massachusetts.”

With the resurgence of an age of reason, the more educated and influential rejected these medieval notions. Although the womb theory of Hippocrates could no longer be maintained in its crude form in the eighteenth and nineteenth centuries, many observers continued to find a connection between hysterical symptoms and the sexual emotions. According to Ellis, Villermay asserted in 1816 that deprivation of the pleasures of love, griefs connected with this passion, and disorders of menstruation are the most frequent causes of hysterical symptoms.

The development of the sciences of anatomy and physiology in the

nineteenth century created a tendency in medical circles to interpret all mental phenomena in terms of diseased structure of the brain. The main current of opinion agreed with Briquet, who denied any connection between hysteria and sexuality. In short, after two thousand years of discussion, hysteria came to be regarded as an organic disease rather than as primarily a mental ailment, and the role of sexual disorder in its pathogenesis was minimized. However, this narrow conception of the disease was soon challenged by the work of Charcot. The traumatic power of emotional disturbance in provoking the manifestations of the disease, and the elimination of the manifestations through suggestion under hypnosis, were clearly demonstrated by Charcot's work. Thus, the ground was laid for renewed investigation of the psyche of the patient suffering from hysteria.

Janet, a pupil of Charcot, proceeded to investigate with great care the psychological aspects of hysteria. As a pertinent example of his case studies, here is an abridgment of the report he gives of his patient, Irene.

This girl nursed her mother assiduously during terminal illness, at which time she also toiled away at a sewing machine in order to earn a livelihood. The mother died, and Irene attempted to revive the corpse. The body slipped to the floor and she desperately attempted to drag it back into the bed. Shortly after these events, Irene commenced to have somnambulistic attacks. Janet writes of these attacks:

The young girl has the singular habit of acting again all the events that took place at her mother's death, without forgetting the least detail. Sometimes she only speaks, relating all that happened with great volubility, putting questions and answers in turn, or asking questions only, and seeming to listen to the answers; sometimes she only sees the sight, looking with frightened face and staring at the various scenes, and acting accordingly. At other times she combines hallucinations, words and acts and seems to play a singular drama. [Janet writes of his patient between such attacks:] We shall soon notice that even in these periods she is different from what she was before. Her relatives who had conveyed her to the hospital stated: "She has grown callous and insensible, she has soon forgotten her mother's death, and does not remember her attacks." That remark seems amazing; it is, however, true that this young girl is unable to tell us what brought about her illness, for the good reason that she has quite forgotten the dramatic events that took place three months ago.

Janet concluded from cases of this kind that one series of ideas had become isolated from consciousness generally, in a process of dissociation. Thus, in the case of Irene in the periods between attacks, she knew nothing of what had happened at the time of her mother's death. There was a gap between the idea of her mother's death (and associated ideas), and the system of ideas she evinced in the intervening periods.

Janet concluded that hysteria may be defined as "a malady of the personal synthesis." He emphasized the factors of retraction and of dissociation of consciousness evident in the disease. These he thought to be essentially due to a "preliminary ailing tendency." In postulating this inherited ailing tendency, he followed the view of his master, Charcot, who had insisted upon the hereditary predisposition of the nervous system of

sufferers from conversion hysteria, both in its convulsive and non-convulsive forms, and in the forms of the disease now designated as dissociative reactions. Janet, however, proceeded to connect this inherited predisposition with a failure of mental tension to hold together under conditions of stress (toxic, exhaustive, or psychological) partial systems of thought, which thus separated from the main body of consciousness.

In 1893, Breuer and Freud published an account of their experiences in a new method of investigation and treatment of hysterical phenomena. This preliminary communication, entitled "The Psychic Mechanism of Hysterical Phenomena," was followed by a series of case histories and theoretical explanations, constituting the *Studies on Hysteria*,<sup>14</sup> published in 1895. These studies presented evidence for their view that disturbance of sexuality, as a source of psychic traumas and as a motive of defense in the repression of ideas from consciousness, was of outstanding importance in the pathogenesis of hysteria.

Breuer and Freud found that individual hysterical symptoms subsided when, in hypnotherapy, they had succeeded in thoroughly awakening the memories of the causal process with its accompanying affects, and when the patient in a detailed way discussed circumstantially the emotionally exciting situations, giving verbal expression to the affects. It was necessary that the original emotionally exciting memories be reproduced as vividly as possible,

so as to bring them back *in statu nascendi*, whereupon they could be thoroughly “talked out.” Recollections without affects were of little therapeutic value. Thus, they found that “the hysteric suffers mostly from reminiscences.” Often the critical experiences dated back to childhood, and were experiences that had established the soil out of which further emotional excitation in later years could produce more or less intensive morbid phenomena.

It is apparent that in their joint work on the problem of hysteria Breuer and Freud were opening up a path to the crepuscular field of psychoanalysis, a path shortly to be followed energetically by Freud alone. They found, in brief, that the pathogenic efficacy of the original non-abreacted ideas was abrogated when strangulated affects were vented through speech, and brought to “associative correction by drawing them into normal consciousness.”

### **Clinical Manifestations**

Hysteria is manifest in many different forms, some of which are readily confused with patterns of organic disease. In order to avoid confusing it with organic disease, it is necessary not only to comprehend its characteristics but also to be familiar with the manifestations of organic disease. The protean forms assumed by hysterical disease have given rise to a carnival of literary

expansiveness, whereas the problems of diagnosis have been comparatively neglected. For this reason, only its more common and some of the more dramatic forms are dealt with briefly here; the important related topics of psychopathology and diagnosis will occupy our attention later. In any case, the possible symptoms are so numerous that it would be impossible to discuss them all without making the text encyclopedic. It often happens that the disease is not seen in pure culture; although predominantly hysterical, an illness may, as already noted, simultaneously present features of other neuroses, of psychosis, or of organic disease. This serves only to increase the need for accurate diagnosis. Typically, the clinical features are:

1. A group of physical symptoms without an ascertainable structural lesion.
2. Complacency in the presence of gross objective disability (la belle indifférence of Janet).
3. Episodic disturbances in the stream of consciousness when an ego-alien homogeneous constellation of ideas and emotions occupies the field of consciousness. This may exclude the normative stream of consciousness in the individual so affected.

It is characteristic of hysteria that, whatever the result of dissociation, be it a localized muscular paralysis or an alternate personality, the operative mental function is a homogeneous whole; affect and ideation are not utterly

incongruous, and there is no primary thought disorder, as in schizophrenia. In hysteria, the splitting of the personality is molar—not, as in schizophrenia, molecular. Some cases evince a transition from hysterical disorder to schizophrenia; in transitional phases, it may be difficult to predict the movement, whether in a reaching back to reality accompanied, however, by a consolidation of hysterical symptoms, in a deepening withdrawal accompanied by molecular disintegration, or in integrative progression. The direction of change often depends largely upon management and psychotherapy.

The diagnostic problem of the differentiation of hysteria from organic disease on the one hand, and from schizophrenia on the other, will be apparent from consideration of these clinical features; it is a point of crucial concern to which we will return later. With this general orientation as a background, specific symptoms will now be discussed.

### **Amnesia and Multiple Personality**

The simplest form of dissociation is shown in the absence of recall of a circumscribed series of events in the patient's life, events which later investigation reveals as having been associated with strong emotion. As Freud noted, the temporary forgetting of names is the most frequent of all parapraxes. Examination of such common instances often reveals a need to

repress associated thoughts which would otherwise result in anxiety or other dysphoric emotion. In a circumscribed amnesia, a similar but stronger motive operates to keep at bay the remembrance of a series of events. These events may have been either directly evocative of painful feelings, or, paradoxically, involved at the time with pleasurable ones which would now, however, evoke either a sense of guilt or a painful sense of loss in the patient because of adverse changes in his situation in life.

Thus, a young man who fainted shortly after performing vigorously in a football trial, could later remember little about several years prior to the beginning of the football season; when this gross gap in memory was filled again, he could remember nothing of the short segment of time during which he had tested his athletic prowess at this level of increased competition. As he gradually recalled his fanatical yearnings and hope during high school years for fame as a football player, and his energetic and pleasurable successful practice during that time, there was this curious reversal of amnesia: He became amnesic for the most recent three months of time, but remembered his entire life before that. These three months included the final strenuous time of testing of the prepared metal in the fire. It became apparent that during this time he had been beginning to fear that severe injury might result from his fanatical efforts, as indeed his father had warned him. At the same time, he had wanted to continue thinking of himself as unafraid, and it was this enmeshment in conflict and its associated painful feelings, including



threatened loss of self-respect, that he was seeking to exclude from consciousness by means of repressive forgetting.

Amnesia is sometimes the sequel of a fugue, a restriction of the field of consciousness, which becomes dominated by a homogeneous series of ideas and emotions hitherto excluded from awareness. During fugue, a patient may leave his usual abode and way of life for a journey which has no immediate connection with his former activity. The patient typically complains later of a complete amnesia for this episode. Such cases occur not infrequently under the stress of military conditions. In one case, a soldier was found wandering at a seaside resort by the military police and was unable to give a satisfactory account of himself. Psychiatric investigation revealed that one day he had suddenly left his unit and boarded a train, presumably for his home in another part of the country. However, he changed trains at a junction and made for the seaside resort. This resort had many pleasant associations for him. He had spent his honeymoon there, and he and his wife were in the habit of going there for their annual holiday. In the army, he had become preoccupied with the impulse to leave, to the exclusion of all other considerations. His activity in making for the resort could only be made meaningful to him as an attempt to recapture symbolically the palmiest of palmy days of peace, pleasure, and security. Before the psychiatric intervention, he could give no adequate account of himself to the police, for he could not recall how he had got into the situation with them.

This example demonstrates the usual findings in dissociative reactions limited to a hysterical level. The reaction is not aimless, as the wandering might at first appear, but symbolically purposive. Moreover, the present is exchanged for the past and is met partially as though it were indeed the past. The patient sought to return to a time and place in which gratification had been maximal, and to escape from his frustrating current military situation. Janet's somnambulant Irene, in contrast, combined hallucinations, words, and acts in a dramatic reliving of the traumatic and painful situation which precipitated her illness. Her case demonstrates also the exchange of the present for a remembered situation, in this instance, however, in an effort to master its pain.

When these somnambulant episodes are not spontaneous, they can be evoked in hypnotherapy to help the patient to abreact the strangulated affects, and to bring the memories to associative correction by drawing them into the normative stream of consciousness.

A more complex and extravagant clinical manifestation of severe dissociation than that exhibited in fugue and somnambulant states with amnesia is that of multiple alternating personality. Stevenson's *Dr. Jekyll and Mr. Hyde* is the literary fictional model of this type of severe dissociation. The rarely reported actual cases often achieve comparable fame. William James has given an account of double personality which has become famous: The

Reverend Answell Bourne disappeared from a town in Rhode Island. Two months later a man calling himself A. J. Brown woke up in a fright asking where he was. This was in Pennsylvania, where six weeks earlier he had rented a confectionery shop. A. J. Brown, the confectioner, then started to claim that his name was Bourne, that he was a clergyman, and that he knew nothing of the shop or Brown. Subsequently, he was identified as the Reverend Answell Bourne by his relatives. He remained unable to explain this episode in his life, which seemed to him uncanny.

Morton Prince, who introduced into medical literature the concept of multiple alternating personality, investigated such a case in the person of Miss Beauchamp, who exhibited at various times three separate fragmentary personalities. A self-righteous, moralistic, and masochistic personality was usually dominant, but alternated with a strongly ambitious, aggressive, distinctive character, which created a perplexing cleavage in the life and personality of Miss Beauchamp. In working with this patient, Prince used hypnotherapy. Under hypnosis, a third personality fragment, calling herself "Sally," came to occupy the field of consciousness. Sally was aware of the saintly personality, though the saintly Miss Beauchamp was unaware of Sally, the impish child. Prince, over a period of six years' work, was able to achieve an integration in the character of Miss Beauchamp.

A more recent well-known example, that of a housewife reminiscent of

Prince's Miss Beauchamp, is provided by a study of Thigpen and Cleckley, *The Three Faces of Eve*. Masserman also reported a case of alternating personality. There are, in fact, about two hundred accounts of alternating and multiple personality in the literature of psychiatry and psychology. In some cases, there is evidence from persons other than the patient of the manifestation of two or more personalities that differed significantly before psychotherapy; in other cases, the emergence of multiple personalities has occurred in the course of hypnotic or of other psychotherapeutic investigation. Congdon et al. have described a case studied and treated at the University of Virginia Hospital (also discussed further by D. W. Abse):

This patient was a twenty-three-year-old housewife who had suffered convulsive attacks following proceedings for divorce. In the hospital, the patient recovered from the convulsive attacks and from depression, and was then discharged and treated as an outpatient. During subsequent psychotherapeutic interviews, the patient, Betty, revealed that as a lonely child she had created an imaginary playmate whom she called "Elizabeth." About two months after discharge from the hospital, during one interview, when she was again describing her imaginary playmate, she suddenly sat upright in her chair and then assumed a relaxed and friendly attitude quite unlike her usual self, and said: "I think it's about time I started to tell you about me." The astonished therapist said, "What do you mean?" and the patient replied, "About me, not about her." She then proceeded to describe

herself (Elizabeth) and her career. From this time on until the eclipse of Elizabeth four months later, it was possible for several observers to study both Betty and Elizabeth under a number of different circumstances. Psychological tests of the two personalities supplemented the clinical observations.

### **Hypnoid States**

The phenomena of amnesia and of multiple personality are often associated with distinctive alterations of consciousness, including fugue and somnambulism, and these alterations of consciousness often resemble or are identical with states of hypnotic trance. It is indeed remarkable that notions about and attitudes towards hysterical phenomena have been inextricably interwoven historically with views concerning the nature of hypnosis. In some periods, the art of hypnotizing was regarded as a special attribute of particular persons, a divinely granted and sanctioned power or gift. At other times, it was held to be an instrument of dark powers and a force of evil. Attitudes toward hysteria have similarly and sometimes synchronously oscillated. Sometimes, the relation has been reciprocal, for example, the good power of the priest-physician exorcizing the Devil held responsible for the hysteria.

In the early nineteenth century, Braid eventually succeeded in getting

recognition in orthodox medical circles for the facts of mesmerism. He became convinced that it was essentially a narrowing of the attention, a “monoideism,” that ushered in the trance. He also began to understand something of the nature of the relation between hypnotist and patient, and of the peculiar effects of hypnosis on memory. After Braid’s death in 1860, his discoveries were taken up in France. Soon there were two great schools of thought regarding hypnotism. The Paris School, under the leadership of Charcot, took the view that hypnotism was a phenomenon characteristic of hysteria, and could be induced only in persons suffering from, or at least prone to, that disease. The Nancy School, led by Bernheim and Liebeault, followed more closely the practice and theory of Braid, maintaining that hypnosis could be induced by suitable methods in almost anyone, and that it was a phenomenon dependent on the general psychological trait of suggestibility. They tried to keep the problems of hypnotism and hysteria apart, despite Moebius’ dictum: “Everyone is a little hysterical.”<sup>1</sup>

The fact is that in both hypnosis and in hysterical disease there are phases that show alterations in consciousness. Braid, for example, stressed the restriction of consciousness as a prelude to trance. Both the Paris and Nancy schools emphasized the importance of suggestibility in both hypnosis and hysteria. Again, the effects on memory in hypnosis and in hysterical disease may be those of an extraordinarily restrictive or amplifying kind. Moreover, the stages of hypnosis described by Charcot—lethargy, catalepsy,

and somnambulism—can be seen quite independently of hypnosis as symptoms of hysterical disease. The view that Janet came to espouse, namely, that the hysteric personality is unstable in its integration, so that dissociative phenomena result, is also pertinent, since these phenomena can readily be shown in the trance state of persons who disclose no evidence of hysterical disease in their usual mode of life.

Breuer and Freud in their preliminary communication pointed out repeatedly that in hysteria groups of ideas originate in hypnoid states, each state being characterized, as is hypnosis itself, by very emotionally intense notions dissociated from all else that the usual consciousness contains. Associations between these hypnoid states may take place, and their ideational content can in this way reach a high degree of psychic organization. Moreover, Breuer and Freud noted that the nature of hypnoid states and the extent to which they are cut off from other conscious processes varies as it does in hypnosis, ranging from complete recollection to total amnesia. They wrote:

We have stated the conditions which, as our experience shows, are responsible for the development of hysterical phenomena from psychological traumas. In so doing, we have already been obliged to speak of abnormal states of consciousness in which these pathogenic ideas arise, and to emphasize the fact that the recollection of the operative psychological trauma is not to be found in the patient's normal memory but in his memory when he is hypnotized. The longer we have been occupied with these phenomena the more we have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under

the form of *double conscience* is present to a rudimentary degree in every hysteria, and that a tendency to such a dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring together under the term “hypnoid”) is the basic phenomenon of this neurosis.

They presumed that these hypnoid states developed out of reveries, so frequent in everyone, and for which feminine handwork offered so much opportunity. Breuer wrote in the same work:

I suspect that the duplication of psychological functioning, whether this is habitual or caused by emotional situations in life, acts as a substantial predisposition to a genuine pathological splitting of the mind. This duplication passes over into the latter state (splitting) if the content of the two coexisting sets of ideas is no longer of the same kind, if one of them contains ideas which are inadmissible to consciousness—which have been fended off, that is, or have arisen from hypnoid states. When this is so, it is impossible for the two temporarily divided streams to reunite, as is constantly happening in healthy people, and a region of unconscious psychological activity becomes permanently split off. This hysterical splitting of the mind stands in the same relation to the “double ego” of a healthy person as does the hypnoid state to a normal reverie. In this latter contrast what determines the pathological quality is amnesia, and in the former what determines it is the inadmissibility of the ideas to consciousness.

And Breuer observed of Anna O. that the girl seemed in perfect health but had the habit of letting fantastic ideas accompany her usual activities, and that an anxiety affect would sometimes enter into her daydreaming and create a hypnoid state for which she later had an amnesia. This repeated itself on many occasions, acquiring a richer ideational content, alternating with states of normal consciousness.



Later, Freud wrote of their joint theory as follows:

I have gone beyond that theory, but I have not abandoned it; that is to say, I do not today consider the theory incorrect, but incomplete. All that I have abandoned is the emphasis laid upon the so-called “hypnoid state” which was supposed to be occasioned in the patient by the trauma, and to be the foundation for all the psychologically abnormal events which followed. If, when a piece of joint work is in question, it is legitimate to make a subsequent division of property, I should like to take this opportunity of stating that the hypothesis of “hypnoid states”—which many reviewers were inclined to take as the central portion of our work—sprang entirely from the initiative of Breuer. I regard the use of such a term as superfluous and misleading, because it interrupts the continuity of the problem as to the nature of the psychological process accompanying the formation of hysterical symptoms.

Freud was more concerned with those unconscious genetics and dynamics of hysterical symptom formation, which were more startling and alienating to scientific circles. He minimized the notion of “hypnoid states” in order to focus on the resistance with which his inferences were confronted. As will be detailed here, he elaborated and demonstrated the view that the body language of the conversion reaction could be translated back to word language in the process of psychotherapy, and he showed how the partial failure of repressive defense had led to conversion. At this time, he turned away from giving due consideration to obvious and marked fluctuations in the symbolizing, integrative, defensive, and conscious aspects of ego functioning. This was, of course, before he turned his attention more definitively to ego psychology.

Breuer had previously remarked on Freud's interest in defense in the following noteworthy paragraph:

Freud's observations and analyses show that the splitting of the mind can also be caused by "defense," by the deliberate deflection of consciousness from distressing ideas: only, however, in some people, to whom we must therefore ascribe a mental idiosyncrasy. In normal people, such ideas are either successfully suppressed, in which case they vanish completely, or they are not, in which case they keep on emerging in consciousness. I cannot tell what the nature of this idiosyncrasy is. I only venture to suggest that the assistance of the hypnoid state is necessary if defense is to result not merely in single ideas being made into unconscious ones, but in a genuine splitting of the mind. Auto-hypnosis has, so to speak, created the space or region of unconscious psychical activity into which the ideas which are fended off are driven.

Here Breuer suggests that there is a place for understanding the hypnoid state as a way-station which appears during partial repression and before conversion reduces the psychic tension. Thus, the concept of the hypnoid state does not interrupt the continuity of the problem of identifying the psychological processes that accompany the formation of hysterical symptoms. Besides, the concept is based on an actual phenomenon of striking change in the quality of consciousness, one that is important to understand in order to follow more adequately the vagaries of the hysterical personality.

As introspection quickly reveals, there are different levels of intensity of consciousness and different qualitative states of consciousness. The dreaming consciousness, the hypnagogic, the hypnopompic, and others, including the

postprandial, are certainly statistically normal phenomena. In hysterical disorder, there are sometimes decisively pathological alterations of consciousness, including depersonalization and a variety of hypnoid states.

The person afflicted with depersonalization complains that he is no longer the same, that he has somehow changed and is no longer himself. Sometimes, he may complain he is a mere puppet, that things just happen, and that he has no joy or sorrow, hatred or love. He might feel dead, without hunger, thirst, or other bodily needs. The world also appears changed and somehow strange to him. We might sum it up by saying that there is a rejection of ego experience in the autopsychic, allopsychic, and somatopsychic spheres. As Schilder states, however:

All depersonalized patients observe themselves continuously and with great zeal; they compare their present dividedness-within-themselves with their previous oneness-with-themselves. Self-observation is compulsive in these patients. The tendency to self-observation continuously rejects the tendency to live, and we may say it represents the internal negation of experience.

A further paradox is that the depersonalized person continuously observes not only his autopsychic functions but also his own body, and he continuously reports hypochondriacal sensations. Here, too, according to Schilder, a rejection of bodily experience is involved.

In regard to the paradoxical phenomenology of depersonalization, it is

as though there were the cry, "Wolf! Wolf!" before the wolf has yet descended upon the fold. Depersonalization is sometimes a syndrome ushering in schizophrenic disorganization or severe forms of ego loss or constriction. The patient begins to talk as if this disorganization or constriction had already occurred, but also expresses his intensified self-observation both in the autopsychic and somatopsychic fields and in his heightened observation of what goes on around him. He samples, as it were, some degree of impoverishment of ego experience, and restitutionally observes himself and the world around him with heightened vigilance. Besides, in this way he makes an appeal for help, like the shepherd in the fable, who suspects that his sheep are threatened by the wolf. He is, of course, also trying to summon help to prevent dissociation and to enable him to maintain integration.

Wittels has emphasized that the hysteric experiences difficulty attaining actuality as a grown-up human being; in consequence, she confuses fantasy and reality, that is to say, allows the law of the id to enter into the ego. In the depersonalization syndrome, on the contrary, we note the law of the superego entering the ego. The self-observation and internalized threat of negation are pervasive; the strangulation of affect and the unpleasantness of bodily sensations are clearly apparent.

When modalities of function more characteristic of the id enter more completely into the way the hysteric perceives herself and the world, when a

more archaic and even more id-ridden ego functioning begins to emerge in the hysteric, a hypnoid state of consciousness, qualitatively quite different, reflects this state of affairs. Self-observation is deleted, ideation is often vague, affect-charged, and restricted. In this state, ideational and verbal performance becomes quite inadequate. The process of symbol-making departs in varying degrees from the denotational towards greater saturation with the mythic mode.

Goldstein has made us familiar with the clinical significance of the abstract attitude and its relation to speech. From his work with brain-damaged patients, he came to distinguish two ways of using words in connection with objects: the real naming of objects, which is an expression of the categorical attitude towards the world in general, and pseudo-naming, which is simply a use of words held in memory. The incidence of pseudo-naming depends on the extent of the individual's verbal possessions. In it, words are used as properties of objects, just as other properties— color, size, hue—are used; they belong to concrete behavior. Often, in the mild, prolonged hypnoid states of some severe hysterical personalities, treatment has to be modified very considerably because much of the time the patient is incapable of adequately achieving the abstract attitude, as it is involved, for example, in psychoanalytic procedure. This is particularly important, as it relates to the analysis of the transference. Such persons often become completely and concretely involved in the transference, without having

sufficient means to achieve any distance and sense of time that would enable them to realize that they are caught up in a reliving of the past.

We have sketched the antithetical nature of some qualities of consciousness in the depersonalization syndrome and in other hypnoid states. In the former, the phenomenological characteristics of vigilance and anhedonia were briefly outlined. In other hypnoid states, a confusion and haziness of varying degrees of severity are more often obvious. In all human beings, there is from hour to hour considerable fluctuation in alertness and many other qualities of consciousness. The state of mind of a man busily engaged in his professional activities might contrast remarkably with his state of mind at a later hour during a cocktail party; the reality principle might loosen some of its hold even before the effects of alcohol could facilitate the increasing sway of the pleasure principle. In the hypnoid and sometimes (in some fugue states) anoetic qualities of the hypnoid state, the dominance of repetition compulsion becomes apparent. The state of mind is comparatively blind and issues in acting-out, dissociated from previous learning, in accordance with the reality and pleasure-pain principles.

Today, the possibilities for reverie, which Breuer and Freud saw as being present to a woman engaged in handiwork, and conducive to hypnoid states, appear during the well-nigh automatic driving of an automobile, which affords opportunities for musing and for fantasy expansion, first with

increasing id dominance. This accompaniment to driving may sometimes lead to “highway hypnosis” and then to traffic accidents. Myerson recently described a male hysteric who, while driving, sometimes paid less attention to the road than to his rebellious, pleasurable involvement with speed and with the admiring women and the disapproving policemen who focused on him in his fantasy. His preoccupation with the imaginative derivatives and symbols of sadistic phallic wishes of the oedipal situation led him to reckless driving and once to bodily injury, the latter indicating a primitive superego reaction.

### **Convulsive Hysteria**

Charcot categorized hysteria into two types, convulsive and non-convulsive, indicating the high incidence of hysterical convulsions in the patients who came to his notice in Paris in the last decades of the nineteenth century. Briquet earlier showed in his statistics that nearly three-quarters of his hysterical patients suffered convulsive attacks. From 1942 to 1945, the present writer found convulsive attacks to be a frequent manifestation of conversion hysteria in Indian soldiers, in contrast to their occasional incidence as a manifestation of hysteria in British soldiers during the same time in India. Janet traced the connection between convulsive attacks and somnambulisms, showing that convulsive attacks were merely degraded forms of somnambulism where the outer expression of the somnambulant idea

in physiognomy, attitude, and act was no longer clear. He showed also in his case studies that hysterical convulsive attacks have the same “moral causes” as somnambulisms, or other expressions of hysteria, and that these hysterical accidents, like others, “begin on the occasion of particularly affecting events, genital perturbations, sorrows, fears, etc.”

Although hysterical convulsive attacks may be relatively infrequent in the United States, as compared to their reported incidence in Paris a century ago, there is clinical evidence of an increment in their actual incidence, or at least of their detection, recently. For example, Bernstein reports case examples of adolescent girls from the Massachusetts General Hospital, who presented to neurologists complaints suggesting epileptic disorder. These young women were struggling with sexual pressures and severe anxieties, and their symptoms served as an angry dramatization of their plight.

Convulsive hysteria may indeed closely simulate idiopathic or symptomatic epilepsy. Hysteria may sometimes be suspected on the following grounds: The patient is not completely unconscious during the attack; the attack occurs only in the presence of onlookers; the patient does not fall in a dangerous situation; the corneal, pupillary, and deep reflexes are present; the patient does not bite his tongue or micturate; he becomes red in the face rather than blue or white; attempts to open the eyes are resisted; pressure on the supraorbital notch causes withdrawal of the head. However, it must be



stated that hysteria is manifest in so many forms, some of which so closely imitate organic disease of the nervous and other systems that without the distinctive marks of its etiology and psychopathology symptomatology alone can be misleading. Where epilepsy is associated with the development of abnormal rhythms in the cerebral cortex, the electroencephalograph can be helpful in making a differentiation.

It is often clear on investigation that the hysterical fit represents partly a rage reaction or temper tantrum due to frustration or fear of genital sexual wishes. Often, too, one can find evidence of erotic discharge in the form of the attack (*attitudes passionelles*, ecstatic poses, etc.). The case of a young woman of nineteen who suffered frequent "fits" provides an illustration: The fits occurred about 6:30 p.m. every evening when she was listening to the radio. The attacks had commenced following the dissolution of a love affair. The young man, it was ascertained, had formerly appeared at her house regularly at this time and had listened with her. The fit was preceded by painful sensations in the right side of her body. Here she had formerly experienced pleasurable sensation, for her boyfriend had sat closely at her side. In conversation, this patient at first expressed the view that she did not care at all about her friend's defection. This defense against her affective disturbance had proved adequate during the day when she was at work. Returning home in the evening, she was assailed by her memories of the young man, and the convulsive attack then provided the outlet she required for her outraged

feelings.

Kretschmer points out that in living beings the “tantrum violent-motor-reaction” is a typical reaction to situations that menace or impede the course of life. He sees its purpose as basically enabling the organism to make a rapid selection, from among the many at its disposal, of that motion which will meet the situation. Should one of the many irregular motions by chance separate the animal from the zone of danger, this single motion will be continued, with a speedy resumption of quietness. Being an instinctive reaction which expires quite schematically, it may either disappear or become directly harmful. In the course of evolution, the “violent-motor-reaction” as a biological defense reaction retires more and more into the background. More recent and more expedient formations replace the older reaction type. In adult human beings, selective voluntary action is the chief reaction type to new situations. In panic, shocking experiences momentarily paralyze the higher psychic functions, and a phylogenetically older adaptive mechanism, the “violent-motor-reaction,” comes once more automatically into activity in their place. In an earthquake or other catastrophe, a crowd will display “headless” hyperkinesias—screaming, trembling, convulsions, twitchings, aimless running. If among the many motions initiated there is one which by chance takes the person away from the sphere of tumbling houses or the zone of danger, quiet ensues; the “violent-motor-reaction” has attained its regulative aim. In children’s response to painful stimuli, the “violent-motor-reaction”—

pushing, screaming, sprawling, striking—is often evident, instead of the deliberative speech and deportment of adults.

Alongside these two groups of responses—panic and childish behavior—are the hysterical hyperkinesias—the twilight-like running away, the tremors, and the convulsive paroxysms. The hysterical convulsive attack, Kretschmer insists, represents an atavistic “violent-motor-reaction.” He points out that in general such psychogenic reaction forms are hysterical where psychic aims in man avail themselves of reflex, instinctive, or otherwise biologically preformed mechanisms.

### **Paralysis, Involuntary Movements**

Many varieties of hysterical paralysis occur. In some, the paralysis is more or less complete. Sometimes, it is associated with tremor of the affected limbs, or contractures; it often takes the form of astasia-abasia (inability to stand and to walk). In this condition, movements may be carried out when lying down or even when sitting down, although standing and walking cannot be performed. Such a symptom as astasia-abasia may thus provide clear evidence of a dissociation characteristic of hysteria. In other cases of conversion reaction, a number of signs that occur in organic paralysis are absent; among these may be mentioned those elicited by testing the tendon reflexes. Dyskinesias, such as tremor, may often accompany paralysis or

paresis, and there may be an accompanying bizarreness of gait. Tics and muscular spasms may accompany a paresis, or may occur alone. Disturbance of speech is another common type of hysterical motor disturbance. Sometimes, this is limited to one language, whereas another language (usually the mother tongue) is spoken without difficulty. In such a case, a dissociation characteristic of hysteria is already evident on the basis of symptom observation. Usually, however, the certain diagnosis of hysteria requires closer investigation than is afforded by the mere observation of symptoms. On the one hand, most symptoms are readily confused with the manifestations of other diseases; on the other hand, hysteria frequently occurs in concert with other diseases and its contribution to the manifestations of disease has to be determined.

Kretschmer points out how widely spread in nature is the immobilization or “sham-death-reflex”—the occurrence in animals of motor rigidity in response to threatening danger. As previously stated, he groups convulsive hysteria around the biological radical of the primitive violent-motor-reaction. Immobilization, on the other hand, in one form or another, he groups around the biological radical of the phylogenetically important sham-death-reflex. Hysterical paralysis is often accompanied by an obvious restriction of the field of consciousness. Sometimes, this reaches the degree of stupor. These hypnoid-stuporous hysterical states, together with paralytic conversion reactions, Kretschmer thinks are anchored in the old, general,

animalistic reflex mechanism of sham death. Thus, he believes that hysterical reactions group themselves around these two fundamental animal reactions to danger. He further believes that in human beings the danger may be external and/or may be bound up with the emotions and conflicts which accompany the sexual life. He states:

Wishes, struggles, and disappointments of an erotic nature form the large main group of experiences which produce hysteria in ordinary civil life, especially in women; the war neuroses, and a part of the accident neuroses, contribute the other very large half of hysterical reactions.

Such a dichotomy, however, is apt to be misleading, as actual experience of physical violence is also resymbolized following the mobilization of mnemonic traces of anxious fantasies linked with the forbidden erotic wishes of early childhood.

In order to illustrate characteristic findings in a case of conversion paralysis, the following case summary shows how the diagnosis may be established on positive grounds from the point of view of symptom observation and etiology, as well as psychopathology:

The patient, a married man, aged fifty-nine, complained of paralysis of the left leg and weakness of the left arm. Examination disclosed the left upper and lower limbs to be slightly spastic. When the patient was encouraged to flex the left thigh at the hip joint, the antagonistic muscles went into increased

spasm. The patient was next required to raise himself into the sitting position in bed, his arms being folded and his legs separated. Under these conditions the paralyzed left leg remained firmly on the bed. (The paralyzed leg rises higher than the other under these conditions in organic disease of upper motor neuron type—"Babinski's second sign.") The plantar reflex was flexor (Babinski's sign negative), and the tendon reflexes were present and equal on both sides.

In discussion it was ascertained that the patient's illness commenced during the bombing of London, at which time he had become acutely fearful. Moreover, the illness required giving up work just as he was approaching the time for retirement on full pension. The only other noteworthy item of information in this discussion was that his father had died in his eighties of cerebral thrombosis with left-sided paralysis. This patient was later given sodium amytal intravenously for the purpose of further psychological exploration. Under narcosis, he prayed for the forgiveness of his sins, giving an account of the use of contraception since the birth of his second son (twenty-five years of age). The doctors had at that time advised against further children on account of his wife's ill health, and he had since used contraceptive techniques, although this was against his religious convictions and those of his father. He also spoke of his struggles against masturbation prior to marriage, and wept bitterly. He felt he had committed grave errors and was not entitled to enjoy retirement, as his father had before him. During

the bombing he had felt convinced that retribution was at hand. In further discussions without narcosis, the patient at first denied any sense of having done wrong, and defended his conduct during marriage on the grounds that he had to think of his wife's health, and that in any case she was quite satisfied with her two boys, etc. He appeared quite reasonable in his attitude toward his sexual problem, although he admitted he had always spoken in public against any form of contraception, and went on to talk of moral dangers.

Interview with his wife disclosed his great dependence on her in all respects, including an incapacity for decision without her. Moreover, she gave an account of her honeymoon thirty years before, which had been marred by her husband's worry lest he had cancer.

In this case, the signs were characteristic of hysteria. We may also note that there was a temporal connection between the onset of his paralysis and the dangerous situation of bombing. A conflict of a sexual nature evoked by this stress was uncovered, and the meaning of the symptoms became clearer. Moreover, his personality background showed evidence of overdependence and neurotic traits, the latter presenting chiefly in the form of hypochondriasis at the time of his marriage, which, incidentally, he had delayed for a considerable time. (The diagnostic importance of the chronological correlation of stress and conflict with the onset of symptoms in

the setting of hysterical character background will be emphasized later.)

### **Further Notes on Involuntary Movements**

As has been emphasized, observation of symptoms may not in itself be sufficient to diagnose hysteria; for this purpose further investigation along both psychologic and physical lines may be requisite. For example, in a child, the distinction between the diagnosis of a relapse of Sydenham's chorea and that of a hysterical mimesis is sometimes extremely difficult to make, and quite impossible on the basis of symptom observation alone. Not uncommonly, hysteria is responsible for evanescent hyperkinesis definitely choreiform in type in young children. In such children, an impression of choreiform movements may have been previously produced by an attack of rheumatic chorea, or the child may have observed such an attack, usually in hysterical cases in another member of the family. Sensitivity of the physician to the underlying psychodynamics of the neurosis is essential in arriving at such difficult differentiations, and the psychopathology of conversion reactions is discussed below.

Nonchoreiform movements, that is, typical movements which might be performed normatively but which are performed excessively and inappropriately, may also, of course, be part of hysterical disorder. When such movements are circumscribed, single, or few in number, and have become



stereotyped by repetition, the terms "tic" and "habit spasm" are often synonymously applied. In older children and adults, systematized tics are usually found in the setting of obsessive-compulsive neurosis or of severe obsessive character disorder. It seems that in such cases of persistent tics the original hysterical symptom has become assimilated within the deeper regression of compulsive disorder. Tics frequently involve the head and neck; spasm of some of the facial muscles or rotation of the head are often observed. The latter symptom may present in full flower as "spasmodic torticollis." Frequently, this is a symptom of conversion hysteria as revealed in intensive investigative psychotherapy.

A man, age forty-four, was suffering from severe spasmodic torticollis. The conditions had been present for a year and had gradually worsened. During this time, he had received thorough physical investigation, including radiographic and neurological examinations with negative findings. He presented a pathetic picture. The head and neck would twist to the right about eight times a minute, the neck appeared swollen, and his face wore an anxious pained expression. In conversation, he complained bitterly of the pain and the impossibility of his attending to his work as chief clerk in a large office. A careful history showed the following facts: His illness had begun at a time when he was greatly worried about his son, aged fourteen. The boy had been ill with acute appendicitis and had been removed to hospital. Following appendectomy, his life hung in the balance. The patient frequently telephoned

to the hospital to ask about his son's condition, and he persisted in this when the boy was already out of danger and after repeated reassurances of the boy's recovery. It was indeed at this time that the neck movements commenced. He was working at his desk in the office when he found that his head moved to the right so that he could not keep his eyes on his work. It was further elicited that his marriage presented considerable difficulties. At first, in the early days of his marriage, he had enjoyed passionate happiness. Following the birth of this only child, his wife's attitude changed. She had, for example, informed him that they now had something serious to occupy their attention, and that the "nonsense" of their mode of life must now cease. She renounced sexual intercourse, and in consequence he had been sexually abstinent since.

From this short account it will be clear that the patient had been subject to protracted stress, and that the spasmodic torticollis had crystallized in response to further stress.

In such cases, obsessive-compulsive features are usually also prominent, and one is obliged to use in diagnosis the inelegant term "mixed neurosis," or some synonym. Similar considerations apply frequently to "occupational cramp." This is a progressively severe disability due to spasm of the muscles employed in finely coordinated movements essential to the fundamental skills of the particular occupation of the patient: "writer's

cramp” is but one example. Occupational cramp often yields to psychotherapeutic intervention when the hysterical nature of the symptoms becomes apparent. Sometimes, such cramps also yield in response to favorable shifts in the patient’s life situation when the increasingly incapacitating course is dramatically interrupted and reversed.

### **Sensory Disturbances**

Somatic conversion symptoms often include subjective and objective sensory disturbances. Pain is the most common and persistent complaint, occurring anywhere in the head, body, or limbs, and described sometimes in quite horrific terms, though the patient may at the same time evince a complacent attitude. At other times, florid histrionic behavior accompanies the complaint of pain. Severe pain and hyperesthesia of the scalp may be localized in the temporal or parietal regions and described as a sensation of a nail being driven into the head (clavus). Pain in the back is common, sometimes accompanied by rigidity of the muscles and curvature of the spine, as in bent back (camptocormia); this often follows minor trauma to the spine. Abdominal pains may simulate organic disease, leading to erroneous diagnoses and useless surgical interventions. The symptom of localized hysterical tenderness gave rise to the concept of hysterogenic zones, formerly utilized alternatively to stimulate or terminate a hysterical attack. These tender spots are sometimes found over the breasts, the inguinal regions

(ovarian), the head, or the spine. Allochiria, the perception of sensation on the opposite side of the body corresponding to that stimulated, is sometimes elicited.

Diminution of sensation is common, sometimes amounting to more or less complete anesthesia. These anesthetics do not follow typical neural distributions but involve, for example, a limb or part of it (glove and stocking), or may be sharply limited by the midline to one half of the body.

The so-called stigmata sometimes accompany other symptoms of hysteria, and consist mainly of sensory disturbances. Localized reduction of cutaneous sensation, or pharyngeal anesthesia may be discovered. Hyperesthetic spots on the abdominal skin over the ovaries and absence of reflex closure of the eye when the cornea is touched, have often been described. Concentric contraction of the field of vision and the feeling of a lump in the throat (globus hystericus) are other anomalies. Traditionally, these anomalies were held to be characteristic of hysteria and, on this account, were designated stigmata. They came to form the positive grounds for the diagnosis of hysteria. Babinski, however, weakened this base for diagnosis when he showed that they often arose as a result of iatrogenic suggestion (pithiatism). Sometimes, one or more of the stigmata do occur independently of the physician's examination, and accompany other symptoms of hysteria. Ferenczi has shown that the body sites where they

occur are peculiarly adapted for the symbolic representation of unconscious fantasies, and it is for this reason that they may occur, or readily arise, on suggestion.

### **Affective Disturbance**

Patients suffering from conversion reaction are often quite complacent in the presence of gross objective disability, presenting a proverbially puzzling paradox which is encountered in the early phase of psychotherapy. Usually, if pain is prominent, much anxious concern is focused upon this, although a complacent attitude about the accompanying disability, or the possibilities of organic disease which the patient often suggests himself, may remain. *La belle indifférence* simulates, sometimes, the flattened effect of some forms and phases of schizophrenia. Janet noted the disposition to “equivalences” in hysteria. When, for example, a somatic conversion symptom was deleted following suggestion, anxiety or depression or, in some cases, confusion appeared in its place, shattering the façade of striking indifference which had formerly accompanied the somatic symptom. Seitz has more recently investigated the conditions of replacement of one symptom by another. Somatic symptoms may be replaced wholly or in part by the expression of anxiety or depression or, in some cases, by feelings of victimization. Symptom formation in hysteria represents the unconscious solution, or attempted solution, of emotional conflict. The symptoms serve

more or less as a protection against the perception of anxiety and depression associated with this conflict. When the somatic conversion reaction is incompletely protective, anxiety and/or depression are then also apparent. It is to be noted, too, that anxiety which arises on recession of somatic conversion symptoms, or which accompanies such symptoms, is usually displaced from its source in the conflict and may be displayed in phobic reactions. Freud termed such displaced anxiety, specifically connected with a special situation, anxiety hysteria.

As will be detailed later, the physical disorder in conversion hysteria is sought partly as a protection against dysphoric affects. However, it must be emphasized that the development of these affects is inextricably bound up with the excitement of instinctual strivings, or symbolic derivatives of them, which produce inner mental conflict. In any event, the somatic symptoms are seldom sufficiently persistently protective under all circumstances.

Anxiety may be exhibited as a vague fear of impending disaster or, more specifically, of death, heart failure, or insanity. In such cases, the somatic accompaniments of anxiety, such as dilated pupils, sweating, palpitations, and digital tremor, may be apparent in addition to the conversion symptoms. Other patients exhibit their martyrdom and resignation with a keen sense of the dramatic value of pathos, expressing feelings of sadness and self-pity. Indeed, some patients, in sharper contradistinction to the usual classical

indifference, exhibit periodical affect storms. Many of these patients secondarily come to utilize an imperfect and reduced image of these uncontrolled and uncontrollable emotional floodings as a means of controlling others and of impressing them. This latter kind of emotionality was described by Seigman as a hysterical character defense. Later, the term "affectualization," coined by Bibring et al., was explained as the overemphasis on and the excessive use of the emotional repercussions of unwelcome issues confronting the patient, in order to avoid a rational understanding of them. Valenstein" has pointed out that affectualization usually occurs in hysterics who not only have a strong propensity for fantasy life and acting out, but who also are prone to have powerful and relatively primitive affect responses. Volkan recently discussed the significance, the usefulness, and the relationships of abreaction, affectualization, and emotional flooding, especially in treatment sessions with hysterical, borderline, and schizophrenic patients.

Severe and protracted attacks of copious weeping in response to an adverse situation sometimes belong to the category of spuriously exaggerated feelings of sadness, an appeal for help and sympathy, over which, however, the patient may entirely lose control. In one such case, that of continuous, copious weeping by an accountant newly inducted into the army, the momentum of the crying persisted beyond the time of induced favorable change in his situation, namely, his release from the army and return to his

usual employment.

## **The Nature of the Symptoms of Hysteria, and Freud's Discovery of Psychoanalysis**

Psychoanalysis connotes the techniques devised and evolved by Sigmund Freud for investigating the human psyche, and the body of theory that has emerged from the data thus collected. Its beginnings can readily be traced to the working association of Breuer and Freud at the close of the nineteenth century, when together they worked out a method of treating hysterical phenomena. It was found that if instead of being hypnotized and receiving direct suggestions of cure the patient was simply encouraged to talk while under hypnosis, hysterical symptoms were often more effectively relieved. It was found, too, that this talking out under hypnosis was laden with emotional charge, whereas the same patient would be lacking in affective expression under waking conditions. More than this, it was discovered that important events connected with the emotional life of the patient which were otherwise forgotten, were recalled and expressed under hypnosis. This method of talking out of emotionally charged and otherwise forgotten events was called "mental catharsis," as it operated to eliminate from the psychic system sources of disturbance that would, without this, result in symptoms. The process of affording an outlet for emotion in talking was called "abreaction."



The fact that a patient suffering from hysteria was unable in the waking state to recall significant and emotionally charged events that would, with encouragement, appear under hypnosis, gave rise to the psychoanalytic concept of resistance which opposed such recall, and which was lessened by the hypnotic procedure. The fact that the patient came to develop an intense emotional relationship to the physician was one component of the concept of transference. Freud found that this development in the patient-physician relationship was due to the transfer of emotion from earlier objects of the patients' feelings to the personality of the physician. Later, Freud used the technique of "free association" to replace hypnosis as a method of lessening, or attempting to lessen, resistance, and thus psychoanalysis emerged. Although, in general, the method of free association accomplishes less than hypnosis in the factual recall of early events and experiences even when the resistances are unveiled, emotional revival is, in the long run, facilitated. The emotional revival involved in transference became the prime means of success in Freud's later psychoanalytic work. The technique of psychoanalysis has encompassed ways and means of developing and utilizing transference, of effecting its dissolution by interpretation, and of unveiling resistances in the process of resolving emotional difficulties out of the range of the patient's awareness. This technique has emerged from the mental catharsis method of treating patients suffering from hysteria.

In the foregoing brief genetic account of the formulation of the concepts

of resistance and transference apprehended from clinical work with patients suffering from hysteria, it will be noticed that these same findings have additional implications. Thus, the fact that certain events of the past were recalled under hypnosis, or as a result of analytical work, indicates that such events were somehow and somewhere recorded and stored within the psyche, though not immediately available to consciousness. Access to consciousness was at first barred by resistance. Such exclusion from consciousness as a result of the operation of an inner resistance is known as repression and is an important manifestation of resistance.

With Freud's theory of dreams, psychoanalysis was enlarged from a psychotherapeutic method to a psychology of the depth of human nature. Freud showed that dreams were meaningful, that each one represented the disguised expression of an attempted wish fulfillment. He contrasted the manifest content, that is, the dream as related directly, with the latent dream thoughts reached by the techniques he devised to deal with resistance. In the young child, the manifest and latent content may be identical, the dream plainly representing the imaginary fulfillment of an ungratified wish. Usually, in adults, the wish is a repressed one, disguised in the manifest dream because of resistance. Freud showed that human life was dominated by conflict between conscious appraisal of reality plus ethical values (including the unconscious conscience), and the repressed unconscious. In sleep—a temporary withdrawal from the external world—the energy of repression-

resistance is diminished, so that the unconscious forces obtain some degree of hallucinatory satisfaction. This is "safer" during sleep, since the avenues to motor expression are then blocked; in any case, some degree of repression-resistance persists, so that even in hallucination the latent thoughts are disguised. In this way, disturbance emanating from ungratified unconscious conative processes is drained off, and sleep is safeguarded. Of course, this function of the dream sometimes fails; the disguise is not sufficiently heavy, and the watcher awakes in anxiety. On the other hand, when the disguises have worn too thin, there can be the comforting thought, in sleep, "After all, this is only a dream." Thus, sleep is permitted to continue despite the threat of revelation.

The following is a clinical example to illustrate some of the foregoing points and their connection with the psychopathology of hysteria:

A middle-aged male patient was brought to psychiatric interview on account of total paralysis of his legs. Seated in a wheel chair, he explained calmly that two weeks previously he had awakened in the morning to find himself paralyzed. In view of the prevalence of an epidemic of poliomyelitis, he assumed that he had the disease and summoned his physician. He now understood that the diagnosis was in considerable doubt, and that, following intensive organic investigation, no definite organic basis was discoverable. The patient expressed this situation in his own way, and at the same time

expressed his doubt concerning the opinion of the physicians. During the further course of interview, the patient explained that he had had considerable difficulty in getting to sleep since his wife had left him three months previously. He also expressed the view that he did not care very much about this, and spoke with bitterness about the faithlessness of women. The events of the day before the paralysis were recounted as having been routine, but a dream had occurred during the night. In this dream, the patient went away from his house and found himself struggling with two people in a strange neighborhood; shots were fired, he had a gun in his hands, and then he woke up in anxiety to find himself paralyzed.

During the course of treatment, this dream was further investigated and was found to represent his wish to pursue his wife and wreak revenge upon her and her lover. Consciously, he was very much against any such course of action. It was, indeed, found that his paralysis was a massive defense against any possibility of his moving to kill his wife and her lover, and the massive nature of the defense was partly a measure of the intensity of his vengeful wishes. The "strange" neighborhood turned out, in fact, to be the old familiar neighborhood of his childhood at a time when the patient thought himself to be an unwanted child, because his father had been released from the army and his mother had given over all her attention to the father.

This fragmentary account, illustrates that a forceful repressed wish

found hallucinatory satisfaction in his dream, and that, the disguise being too thin, he awakened in anxiety. His inability to get to sleep showed his need for inner vigilance to ward off these dangerous wishes, which were being repressed with increasing difficulty. Later, the repression partially failing, it needed to be supplemented in the waking state by the conversion reaction of paralysis. There was much self-punishment in this paralysis, too, as became apparent from the patient's associations in the process of psychotherapy. It is noticeable here that the dream is the first member of a series that includes among its members the hysterical symptom, the obsession, and the delusion. As Freud states, it is differentiated from the others by its transitory nature and by the fact that it occurs under conditions that are part of normal life. In this pathological case, the connecting link with a hysterical conversion symptom is clear.

It is also clear in this case that the dream was related not only to current events in the life of the patient but also to childhood experience. The patient in his childhood had found his passionate wish for exclusive possession of his mother's love threatened by the return of his father from a lengthy absence in the army, and this threat turned out to be well grounded in reality. In later years, this experience led to his very reserved attitude toward women, and it was only in middle life that he had found his way to marriage with a much younger woman who later deserted him for a younger man. This had revived all the emotions constellated around his childhood oedipal-phase

experiences, the murderous wishes being transferred from his “faithless” mother and his father to his wife and her lover. Sleep became difficult, because he was afraid to relax lest these ego-alien wishes should succeed in breaking through from repression. In the dream, the disguise was not sufficiently heavy to safeguard his sleep adequately, and he woke in anxiety. The succeeding hysterical symptom was a compromise formation compounded of the repressed wishes and the repressive forces, including those of unconscious conscience. In this case, some of the repressed wishes are more obvious in the dream, are the defense against them and the self-punishment in the symptom of conversion paralysis. It is also to be noted, in this particular case, that the symptoms of paralysis defend against the expression of hostile wishes which result from the frustration contingent upon the disruption of the patient’s marital life. In many cases, the symptom has a more clearly evident sexual-symbolic reference. In this case, too, however, the paralysis symbolically represents castration—loss of the power to satisfy genital-sexual needs through their unconscious acquisition of a forbidden character by association with earlier incestuous wishes.

### **Psychopathology of Hysteria**

Following consideration of the dream of the patient with conversion paralysis, we are in a position to take more fully into account the previously described case of spasmodic torticollis. In this case, on account of the neurotic

attitude of his wife following the birth of their only child, the patient was confronted with sexual abstinence unless he ventured into extramarital digression or divorce. Analysis revealed that he submitted to sexual abstinence in these restrictive circumstances because of an awakening of a deep-seated sense of guilt in relation to genital sensual enjoyment, a sense of guilt founded upon a grossly inadequate resolution of the Oedipus complex. In brief, his wife, by becoming a mother and proclaiming a sexual taboo, combined to activate this unconscious complex and to re-establish inappropriately the old prohibition of sensuality, namely, the exclusion of genitality, which had been achieved with difficulty in his relationship with a possessive and controlling mother in childhood.

The normal wish for sexual intercourse with his wife was repressed only with the greatest difficulty, and the patient required another defense mechanism to support this repression. For years, since the adoption of sexual abstinence, he had suffered from difficulty in going to sleep. When lying in bed with his wife, he would concern himself in largely unproductive preoccupation with office problems. As he said, he had kept his mind very closely on his work. This was obviously a heroic effort to continue to exclude from consciousness, to crowd out, any ideational representation of genital sexual craving, an effort which indicates that the repression was only tenuously held in operation over the fourteen years that preceded the outbreak of his painful torticollis. The symptom was due to a partial

breakdown in his repressive resistances, brought about, as we have seen, by the illness of his son. Analysis further revealed that he had unconsciously come to resent the intruder who had upset his affectionate and sexually gratifying relationship with his wife, much as he had resented his father. Indeed, unconsciously, he had wished his own son out of the way. This wish, too, remained excluded from consciousness, and this exclusion was supported by another defense, namely reaction formation. He had always consciously felt and expressed excessive anxiety about the health and welfare of his son.

The severe illness of his son resulted in erosion of the repressive barriers, because the unconsciously charged sadistic wish to get rid of him came near to realization. In fact, he became very anxious, redoubled his efforts to care for his son, whom, it must be added, he also basically loved and identified with. He made a nuisance of himself with the hospital personnel, and continued to question the surgeon even when the son was out of danger.

Closer investigation came to reveal that the torticollis was a disguised expression of his repressed phallic sadistic impulses, and that the repressive resistances had been sufficiently overcome by the increased charge of these impulses, resulting from a complex reaction to his son's appendectomy, to permit this expression. The movements of his neck were of an autoerotic nature, that is to say, he had pleasurable sensations on account of them. The



neck had come to represent the erected genital organ, was a symbol for it. Vasomotor disturbances resulted in swelling, and the rhythmic movements aped those in coitus, an upward displacement anatomically. The symptom represented more than this, for it also condensed elements derived from his sense of guilt and need for punishment. He also suffered considerable pain. In short, he was punishing himself also, and the fury of this punishment had the quality of his repressed hostility toward his son. He was turning his hostility against himself. Thus, the symptom was a compromise formation between the two vectors of his unconscious conflict. More than this, it had an attention-attracting function. It was a dramatic expression also of his wish for sympathetic acceptance of his appalling psychological situation, a wish at first directed especially toward his wife. A complex state of affairs is indeed covered by a hysterical flight into illness, and uncovered during analytic types of psychotherapy. The symptoms of hysteria should be treated with respect, for they represent a deep disturbance in the psychic life of the suffering patient. It is remarkable with what contempt these symptoms may be treated by some physicians because they cannot find any anchorage for them in organic nosology.

When traced to its roots, hysteria in all its forms is predominantly related to the climax of infantile sexuality, the Oedipus situation, with the struggle to surmount incestuous genital-sexual and hostile strivings. Some conversion symptoms represent a materialization of unconscious fantasies

concerned with forbidden genital-sexual wishes. Genitalization may consist in tissue changes, including hyperemia and swelling, representing erection, or of muscle spasms, representing the movements of coitus, or of sensations resembling genital sensations, although these are often complicated by the perception of pain. On the other hand, as in the cases described above, the symptoms may also represent the reactive hostility to frustration of genital-sexual wishes, and in such cases anal-sadistic fantasies may find expression. Sometimes, pregenital expression of predominantly genital wishes may also occur; bed-wetting, a frequent masturbation equivalent in children, is a common example of this. Often interpolated between the original oedipal experiences and fantasies, and the symptoms of the adult, are daydreams connected with masturbatory activities.

The symptoms consist of an autoplasmic attempt to discharge the tension created by intrapsychic conflict, and express drive and defense simultaneously, short-circuiting conscious perception of conflict related basically to the Oedipus complex. This last statement covers the primary or paranoic gain. Secondary or epinoic gain is involved in the alloplastic ego endeavor to utilize the symptoms for manipulating other people and the current life situation. Often the attention-attracting function is conspicuous: By physical symbolic exhibition of conflict, the patient indirectly attracts sympathy for his plight. The flight into illness may provide escape from an intolerable job or family situation, or from military service. In other words,

some gain might sometimes be related to a precipitating factor. In the latter event, a passive mastery might ensue, with later recession of the symptoms. Following injury, hysterical perpetuation or exaggeration of symptoms may have a conspicuous secondary gain factor motivated by the wish for compensation. In some cases, the secondary gain persists only as long as the symptoms persist, and in such a situation the disease may become chronic and present an additional important resistance in treatment.

### Further Considerations

#### Orality and Hysteria

As indicated earlier, in the study and treatment of hysterical phenomena Freud invented the method of psychoanalysis and its basic concepts. The concepts of fixation and regression also grew out of these early studies, and there arose a formulation that the personality of those liable to exhibit hysterical symptoms when frustrated was fixated at the phallic or early genital phase. In the onset of neurosis, regression to this point of fixation, with its infantile object relationships and its attendant castration anxiety, took place. The anxiety had motivated repression which, however, later failed to be effective, and symptom formation ensued.

Marmor has emphasized that, in many cases of hysteria, fixations in the

oedipal phase of development are themselves the outgrowth of pre-oedipal fixations, chiefly of an oral nature.

The kind of parent whose behavior keeps a child at an "oral" level is apt to be the kind of parent whose behavior favors the development of a strong Oedipus complex. The pre-oedipal history of most of the hysterics I have seen has revealed one of two things—either intense frustration of their oral-receptive needs as a consequence of early defection or rejection by one or both parent figures, or excessive gratification of these needs by one or both parent figures.

Fitzgerald emphasized early "love deprivation" and consequent "love craving" as a basic character trait of the hysterical personality. Similarly, Halleck, in discussing the personality traits of adult female hysterics, brings into special prominence, from his clinical experience, the view that the hysterical patient has usually suffered severe maternal deprivation. Accordingly, she never develops an adequate basic trustfulness, and is incapacitated in her search for intimacy. Seeking the satisfaction of basic oral needs from her father and later from other males, she has learned to use seductiveness and helplessness to control men. Halleck stresses the hysterical woman's search for the answers to life in the strength of an ideal man. However, she uses her femininity as a weapon to control the man she finds, destroying the possibility of finding the strength she seeks. Her troubles are aggravated when men disappoint or reject her. Complaining of physical symptoms, she may then visit a physician.

The concept of multiple points of fixation, and, in particular, in hysteria, of the importance of oral fixation, explains psychodynamically the clinical associations noted in many cases between hysteria and schizophrenia, hysteria and depressive disorder, and hysteria and addiction, especially alcoholism. There is often a narrow margin between hysterical introversion or dissociative reactions and schizophrenic autism, or between hysterical materialization and schizophrenic hallucination; under certain circumstances, as already noted, the transition from classical conversion hysteria to florid schizophrenic psychosis takes place. Where the oral fixation factor is of greater importance, the ego-integrative capacity is weaker, and psychotic regression occurs more easily.

It is to be noted, too, in the opinion of this writer, that the importance of secondary gain factors in the psychoeconomy of the patient is often underestimated because of inadequate realization of the quantitative loading of pregenital fixation. For attention-attracting and sympathy-gaining, the compensation-managing and the acquisition of dominance are related, in the complex stratification of psychic life, to the frustrated oral dependency and anal-manipulative needs for, respectively, narcissistic supplies and mastery.

## **Language and Hysteria**

We have noted above that in conversion reactions the symptomatic

changes in physical function unconsciously give distorted expression to the instinctual strivings that had previously been more fully repressed. At the same time, the symptoms indirectly represent the defensive force in conflict with the derivatives of instinctual impulses, and the retribution or punishment for forbidden wishes. Freud found that the symptoms are substitutes for ideational representation of these strivings and of the forces opposing them, and that, accordingly, the symptoms could be gradually translated into word language from their "body language," with accompanying affective expressions. Sometimes this translation is partly but a retranslation into the patient's own actual words, comprising a thought formation, during the incubation period of symptom formation. The following example illustrates:

Mrs. X, a thirty-five-year-old white, married, and physically very attractive woman was admitted to the medical wards of a large university hospital, referred by her family physician for repeated fainting attacks and complaints of severe pain in the neck. At the time this patient was first interviewed by a psychiatrist, she was in bed, constrained by an ingenious traction apparatus which pulled on her neck muscles. There was considerable spasm of these muscles, although exhaustive physical examinations had failed to reveal any basic organic pathology. The patient complained that despite the apparatus and the various medications, she still had a severe pain in the neck. She proceeded to say that before admission to the hospital, in addition

to this neck pain which had progressively worsened, she had had alarming "blackouts." She was asked what she meant by a "blackout," and the patient, looking puzzled by the psychiatrist's apparent ignorance of the vernacular, explained about her faints. It was indicated that this was understood, but attention was directed to the phrase "blackout," and inquiry was made as to whether she herself had thought of using this expression. It seemed the patient was not at all sure as to the first application of this term to her faints, whether by her husband, herself, or one of the doctors. She was then asked whether when she was "out" in the faint, did she see black? Hesitating a moment, the patient stated thoughtfully, "No, in fact, I pass out and see red." In further conversation, she gave a restrained account of her widowed mother-in-law who was living in her home. The patient's husband was this woman's only offspring, and there ensued a talk about the close attachment of this woman to her only son, the patient's husband, and the possible difficulties this might have led to. The conversation became increasingly animated, and at one point the patient was told that despite her conciliatory and laudably understanding attitude towards her mother-in-law, in fact this lady had begun to give her a pain in the neck, and the first occasions when she had seen her mother-in-law breakfasting alone with her husband had made her see red.

As the emergency psychotherapy progressed in later interviews, more adequate affective expression of her rage against and jealousy of her mother-

in-law became clearly evident, as well as expressions of guilt feelings. These strong feelings were the affect indicators of strong and conflicting conative trends, which had roots, it was later revealed in analytic psychotherapy, in her early family drama with a tyrannical mother who excluded her even from expectable communication with her father as she was growing up.

It became evident that her wish for her mother-in-law to live elsewhere, if she was to live at all, came into conflict with her sense of duty. Once there were beginnings of translation of her symptoms into affect-laden metaphoric language, she protested that she ought to be able to get along with her mother-in-law, whom she respected, though the presence of this lady disturbed her feelings of wellbeing. She soon acknowledged that she herself had thought what a pain in the neck the good woman was, and that sometimes she had made her see red. Thus, this translation of her symptoms into word language was but a retranslation back to the unspoken language of her own thoughts, thoughts that had later become forbidden. Later, this conflict was found to have many ramifications, including the fact that it was but a re-edition of an older unresolved conflict with her own mother.

As discussed elsewhere, the acquisition of discursive language, with its power of generality and abstraction, is the result of a complicated series of developments. From primitive naming, that is, basic phonetic-symbolic representation, there is a semantic movement through metaphor and the



fading of metaphor. We are not concerned here with these complicated developments; we are concerned with the sort of metaphoric symbolism that functions largely to convey feelings. Its adequacy depends on how well it performs this function. Often, in the preliminary retranslation of hysterical somatic symptoms to word language, it performs this function vividly and only less dramatically than the symptoms themselves. The essential messages in a conversion reaction are embodied cryptically in the somatic symptoms, which do not involve primarily any words at all, and only relatively infrequently the laryngeal apparatus. Word language is reduced and compressed in inaudible symbols of a more primitive character, in such a way that the subject is unaware of their essential meaning, and his reference group is very likely misled. We have, of course, the concepts of repression and of the unconscious (of the repressed unconscious), as well as of regression, to aid us in our quest for understanding. The disorder of expression and of communication, internal and external, is indeed a function of pathological disturbance in repression and regression, as we have learned from Freud. Besides the messages readily translatable to a verbal metaphoric symbolic level, other messages are couched in a more primitive (cryptophoric) symbolism, as when the neck indirectly represents another part of the body, the erect genital—as noted in the case of spasmodic torticollis.

The somatic symptoms of conversion hysteria condense a variety of levels of meaning and a variety of messages, the emphasis differing in various

symptomatic expressions. The following example will illuminate this statement:

A middle-aged Negro woman whose life had become one of increasing hardship, economically, socially, and sexually, developed a clouded (hypnoid) mental state associated with peculiar movements of the arms and fingers. She was referred for neurological investigation for the possible determination of brain tumor or a presenile organic dementia. This investigation, which was quite thorough and included air-encephalography, yielded no positive pathological findings. The resident conducted a conversation with her while she was in amytal narcosis, at which time she discussed in a vague and disconnected way her father's encouragement of her education and her once-upon-a-time interest in the piano. At first sight of this lady, the psychiatrist said to the resident who had reported the ramblings of the patient in amytal narcosis, "But she is now playing the piano." In the ensuing short interview, the patient, with initial direction, went into considerable and vivid detail about her father's looking at her admiringly as she was playing the piano, and about how proud he was of her at this time during her school years—all described by the patient in the present tense.

In brief, in response to adverse life circumstances, this patient had retreated to a time of maximal happiness in her life, a time effectively symbolized by her piano playing with an encouraging, admiring, affectionate

father at her side, with whom she confused the psychiatrist. Clinically, this case was a hysteriform borderline state, the conspicuous features being a hysterical pseudodementia, and apparently weird movements of the arms and fingers. These movements were in fact pantomimic in their essential nature. In discussing hysterical symptomatic attacks in 1909, Freud wrote:

When one psychoanalyses a patient subject to hysterical attacks one soon gains the conviction that these attacks are nothing but phantasies projected and translated into motor activity and represented in pantomime.

It sometimes happens, too, that there is a revival in memory of actual events, rich in associated fantasy and feeling, a revival which in a truncated way is pantomimically expressed in body movements, as in the piano playing of the patient in the severe dissociative reaction just described.

In summary, clinical experience indicates six interrelated aspects of movement and of sensory phenomena in conversion reactions:

1. Sexual symbolic references.
2. Distorted affect expressions—e.g., of appeal, rage, resentment, weeping, joy, etc.
3. Condensation of identifications (see below).
4. Associated connotations relating to wish-fulfilling and punitive fantasies.

5. Denotative propositional pantomimic movements—often truncated, or with reversals in sequence, or other disguises.
6. Metaphoric embodiments.

### **Identification in Hysteria**

It is a notorious fact that hysteria is a great imitator and may thus set an awkward trap for the unwary medical diagnostician. The sensations or movements constituting the conversion symptoms may relate to observations of others made by the patient. For example, Freud's patient Dora developed a cough which was found to be traceable to her observations of Mrs. K's coughing attacks. She unconsciously wished to put herself in Mrs. K's position as the wife of Mr. K, but felt guilty about her rivalry. She selected Mrs. K's affliction as the point of identification, thus caricaturing her envy in the service of self-punishment. Oedipal wishes may, however, result also in an identification with the significant person of the opposite sex. When the forbidden and desired object must be relinquished, a partial identification with the object may ensue. Multiple identifications often occur. Freud deciphered the movements of one patient as an attempt to take her clothes off with one hand, while trying to keep them on with the other. While identifying with a woman being sexually assaulted, she identified partly, too, with the male sexual aggressor. Bonnard, similarly, has interpreted the peculiar gestures of some disturbed children as partial identifications with both an

aggressor and a victim. These children had been exposed repeatedly to the severe quarreling, including physical combat, of their respective parents.

Multiple identifications may assume dimensions of partial personality systems in more severe dissociative reactions, as described previously.

Pathological identification with the physical infirmity of another person frequently occurs in group situations. Freud cited a hysterical epidemic in a girls' school as an example. One girl who received a love letter fainted, whereupon other girls soon fainted, too. In this instance, the purpose of the symptom identification was vested in the other girls' wishes for the same experience; they thus dramatized forbidden wishes, and accepted punishment as well. Indeed, in such group situations, anyone who offers some libido-economic advantage as a prototype, at a time of heightened inner conflict and tension, may be thus imitated. More recently, Moss and McEvedy described an epidemic of over-breathing among schoolgirls in Britain. Approximately a third of a total of 550 girls were affected, and about a third of these required inpatient care. It became apparent that the epidemic was hysterical. A previous polio epidemic had rendered the schoolgirls emotionally vulnerable, and a three-hour parade, producing twenty faints on the day before the outbreak, had been the precipitating cause. McEvedy et al. contrasted two other school epidemics, one of vomiting, the other of abdominal pain. One (hysterical) occurred in a school for girls; it was

manifest almost exclusively in school hours, its maximum incidence showed a swing from older to younger classes, and it correlated with conduct disorders. The other epidemic did not show accord with any of the circumstances noted, and was found to be due to infection with *Shigella sonnei*.

The important role of identification in the sociology of the body image is discussed by Schilder, who emphasized that the image of the body is not static but in constant flux, changing according to reactions to circumstances. There is a continuous process, underlying the evident changes of experience—a process of construction, dissolution, and reconstruction of the body image. Unconscious processes of identification, and of projection, are of considerable importance in bringing about such changes. In hysteria, the mechanism of identification expresses the close relation of the patient to different postural models of different persons. Innumerable condensations of object relations may be expressed in a hysterical change in one organ of the body. Schilder draws attention, too, to Freud's patient Dora. Her coughing attacks, it seems evident, also expressed genital wishes to be infected and to take the place of her mother, who had vaginal catarrh.

Fenichel states that identification is the very first type of reaction to an object. All later object relationships may, under certain circumstances, regress to identification. The hysterical identification is characterized by the fact that it does not involve the full amount of cathexis available. Jacobson

and, earlier, Foulkes, attempted to show the relation between less (hysterical) and more regressive forms of identification. In the opinion of this writer, it is often by study of the types of identifications the patient has made, and of the correlative fate of the object relationships involved, that it is possible to obtain a better notion of how far from psychosis a particular case of hysteriform disorder may be. Identifications may, however, elude understanding, especially in short-contact work with a patient, or when psychotherapy is of a “repressive-inspirational” type, utilizing, perhaps unwittingly, further primitive forms of identification in the suppression of symptoms.

### **Group Hysteria**

The suggestibility of individuals is basically of varying degree; that is to say, there are marked individual differences. Moreover, in regard to a particular individual, his suggestibility varies considerably both with factors that are internal and physiologically based (e.g., fatigue, degrees of mental alertness related to circadian rhythms), and with external factors that notably include the behavior of people in his immediate environment. The strongest suggestibility is often a feature of the hysterical personality. So much has this feature impressed clinicians that in the early part of the century, one of the foremost accepted theories of hysteria, that formulated by Babinski, defined it along this parameter alone. Hysteria was held to be basically a mental

disposition to be affected by the suggestive force of imagination, and hysterical symptoms to be the result of suggestion. Moreover, pithiatism, that is, forced suggestion, was the method prescribed by Babinski for the removal of hysterical symptoms, the idea being to fight fire with fire. It happens, however, that some hysterics are under many circumstances especially resistant to suggestion. As will be detailed later, there are variations in the compendium of manifest traits that characterizes the hysterical personality.

High suggestibility is very largely the result of uncontrolled processes of unconscious identification and is associated with a fragile ego fundament; sometimes a hyperexic defense against vulnerability to suggestion includes an emotional detachment. Even in the latter eventuality, however, the impact of events in a group may rupture such a massive defense.

In the formation and maintenance of groups, primitive processes of unconscious identification may become very active and may escalate beyond the control of many people. Moebius' dictum that everyone is a little hysterical is frequently illustrated by behavior in groups. We can but briefly consider here simple crowds and highly organized groups, but there are, of course, many varieties of grouping of human beings. The character of both simple crowds and more permanent organized groups also varies considerably. Often, the individual in becoming one of a crowd loses in some degree his self-consciousness and he may even become depersonalized.



Enveloped and overshadowed and carried away by forces he is powerless to control, he may fail to exercise self-criticism, self-restraint, and more refined ideals of behavior. It is often the case, too, in simple crowds that the order of reasoning employed is that of the lowest common denominator, and this facilitates suggestibility. A further ground of heightened suggestibility in a crowd is the prevalence of emotional excitement. The kinds of regression in the collective ego adumbrated above are, of course, contingent upon many factors, including the type of leadership. In the highly organized group, with its greater control of impulses and with a continuity of direction of activity, with a differentiation and specialization of the functions of its constituents, emotional excitement may yet be periodically evoked, with accompanying hysterical excrescences. The hysterical phenomena are then apt to occur in a setting of group paranoid formations, which serve to enhance group narcissism and to direct hostility outwards. We are, of course, here considering only the pathological aspects of group functioning, often associated with pathological, especially hysterical and paranoid, leadership, and frequently with the occurrence of hysterical phenomena.

Hypnoid alterations of consciousness occur transiently in group religious excitement. Although these dissociative reactions are for the most part temporary, sometimes they issue in a persistent conversion reaction or in psychotic disturbance. Thus, for example, following each periodic visit to Raleigh, North Carolina, of a world-famous revivalist, several casualties of the

mass meeting are admitted to the Dorothea Dix Mental Hospital. Another North Carolina example, glossolalia, the “speaking in tongues,” which occurs in a state of happy excitement, may persist beyond its due time with a particular religious group and its evangelical leader. It requires note, too, that sometimes a conversion reaction abates following a hypnoid state induced through group religious excitement. Thousands of sick come to pray at the feet of Our Lady of Lourdes. Some, after participating in the procession of the Holy Sacrament, others after worshiping at the famous grotto, find their prayers answered.

In the ceremonial rites of religious groups as, for example, in the Voodoo cult in Haiti, the trance state is a sanctioned means of release and communication within the group. Only when the activities generated during the hypnoid state persist beyond, originate outside, or exceed the ritual, do they communicate anything abnormal, or sickness, to other members of the group. In particular, the phenomenon of possession usually occurs within the context of ritual exhibition, as the dances and roles become increasingly frenetic; often, the priest himself enacts the spirit-role, sometimes another member of the group does so. However, this socially sanctioned mode of behavior is occasionally made use of in an individual attempt to express and reduce mental conflict. Such cases have been reported in many parts of India where an individual so “possessed” may be designated as a patient and brought to a psychiatric clinic. The phenomenon was encountered mostly in

young women of low socioeconomic and educational class. Such symptoms of possession, of governance by a strange soul, occurred alone in hysterical instances, and the abnormal behavior was readily understandable as a response to a frustrational life situation. In other instances, the symptoms of possession formed only a minor part of the total clinical picture of schizophrenia or of mania. The authors of the Indian study separate "hysterical psychosis" from the major psychoses.

Hysterical possession symptoms are sometimes a feature of many culture-bound syndromes. Besides Voodoo, the Piblokot of Eskimos and Whitiko of Ojibwas may be cited; in the latter, a morbid craving for human flesh is accompanied by a conviction of transformation into a supernatural being.

Extremist political meetings and avant-garde encounter group therapy sessions also precipitate their quantum of hysterical acting and behaviors and of later conversion and dissociative reactions. We have already noted the occasional occurrence of an epidemic of hysteria in girls' schools.

### **Hysteria in Childhood**

Abstracting data from the charts of all inpatients treated and discharged with a diagnosis of conversion reaction in the North Carolina Memorial Hospital at Chapel Hill between September 1952 and September 1958,

Somers, working with me, noted that there were 612 such recorded conversion reactions. The majority of these patients had been on the medical service and a high percentage of these had been diagnosed and treated with psychiatric consultation. The next group in size had been on the psychiatric service itself, with the pediatric, obstetric, and surgical services contributing smaller groups of patients with this diagnosis on their charts. The ages of these patients ranged from seven to seventy-two. There were 22 patients under sixteen years of age, that is 4 percent of the total number. Proctor, during this same period, reviewed 191 unselected, consecutively diagnosed cases in the child psychiatric outpatient unit of the Department of Psychiatry, and 25 cases of frank conversion and/or dissociative reactions were recorded, an incidence of 13 percent. These findings of Somers and of Proctor indicate that the observations of some others, that hysteriform conditions in childhood are uncommon, must be modified, at least in terms of the area in which the observations are made.

In the study of Proctor, only the frank conversion and dissociative reactions were counted and studied, inasmuch as these were phenomenologically consonant with the descriptions of hysteria of Charcot, Babinski, Janet, and Kretschmer; in that of Somers, the diagnostic criteria generally applied were those incorporated in the definition of conversion reaction in Strecker's *Fundamentals of Psychiatry*,<sup>2</sup> this also being descriptively and

LaBarre has pointed out that ethnographic and psychiatric records reveal that *Tobacco Road* is no artistic caricature but a faithful portrait of some regions of the South. He writes of the intricate interplay, including the discrepancies, between the rigidly compulsive cultural background of the Bible Belt and the individual's actual adaptation. The picayune fanaticism of some of the rural folk operates within the context of a fundamentalist rural religion which frowns on smoking, drinking, and sex, although these are all in fact heavily indulged in. In the mountains of North Carolina, as in other Appalachian areas, there is widespread belief in hex doctors and in faith healing. Side by side with widespread overt belief in magic and punitively repressive anti-sexual attitudes are the further factors of early stimulation of the child by discussion of original sin and by disapproval of the body, both of which at the same time hint at, and emphasize, the temptations and the desirability, of gross sensual pleasures. Such inconsistencies are often acted out. Thus, the familial style of life, including the sleeping arrangements associated with the poor housing, results in the frequent early observation by the children of sexual scenes between the adults. In addition to repeated exposures to the "primal scene," which is in any case associated with heightened difficulty in surmounting the oedipus complex and with later vulnerability to frustration, so that major hysterical attacks readily occur in adult life, sons sometimes sleep with their mothers and daughters with their fathers throughout a large part of childhood. This involves enormous

stimulation with concomitant denial of verbal expression, so that regression to primitive modes of somatic discharge readily occurs in childhood itself.

Winnicott showed the close relationship of convulsive phenomena in the first year of life to frustrated orality. He demonstrated with case material that infantile convulsions can at times be precipitated and perpetuated by an adverse mother-child relationship, especially when associated with clumsy and abrupt attempts at weaning. As early as 1882, Gillette carefully documented a functional paralysis of an arm in an eighteen-month-old child, and there is a similar case report by Anna Freud of a twenty-seven-month-old child. Proctor comments that a primitive discharge mechanism in the somatic sphere in the earliest infantile period (under a year), although descriptively similar to convulsive hysteria, is not structurally and dynamically the same, since at this time there is less distinction between id and ego and between the mental and bodily ego. Moreover there is no word representation to be repressed as a prelude to somatic regression and disguised expression.

Somatic dissociation in the slightly older child, such as the cases reported by Gillette or Anna Freud, raises many questions regarding faulty ego development, especially relating to the adequate construction of the boundaries of the image of the body, the core of the mental ego, which may be disturbed in the continuous interaction between the child and the mother. Indeed, Schilder emphasized that hysterical phenomena in all children show

with marked clarity the continuous interaction of the attitudes of the particular child with his parents. However, it would seem that a hysterical psychoneurosis does not properly form before latency with the consolidation of the superego following the Oedipus conflicts.

Kaufman gives an especially vivid account of conversion hysteria in the latency period in psychoanalytic treatment. At the age of eight and a half years, a patient, a girl, was referred for psychoanalysis because of hysterical blindness. The mother described the events preceding the referral: Catherine had been caught by two old ladies investigating a six-year-old boy to see if he was built the same way as her baby brother. In brief, the patient was caught peeping and made to feel guilty about forbidden activity shortly before the onset of blindness. During the course of her two years of analysis, she elaborated and worked upon the classical dynamic features of a conversion hysteria. She had an unresolved wish for the penis from her father expressed symbolically in terms of a gift from Santa

Claus. She portrayed herself as damaged and castrated. In her transference reaction, she wanted to take the analyst's finger from him, expressing her desire to be a boy. Later, she was able to elaborate a feminine identification and convey her wish for a baby. Additional material illustrated her blocked hostility against her mother and her fear of retaliation. The unconscious oedipal complex had been activated and then repressed

following the trauma, and had become associated with being caught and punished for her sexual curiosity about the differences between boys and girls.

In summary, it is to be noted that primitive identification, dissociation, and discharge phenomena may occur in early childhood and resemble hysterical phenomena of later life. However, these phenomena occur in response to separation anxiety in the relatively undifferentiated psyche in a dyadic context; in the differentiated psyche of later childhood, formed defenses of repression, displacement, and conversion (with cryptophoric bodily and metaphoric bodily symbolization in a regression from word symbolism) are deployed in response to castration anxiety in a triadic context. There are many cases in later childhood in which both oral and phallic-oedipal aspects of psychopathology are evident. In the repetitive promiscuous patterns of many adolescent girls, the sexual acting out is less an expression of a genital need than an oral acquisitive process associated with the wish to receive care and attention from a mothering figure.

### **Incidence and Prevalence of Hysteria**

Hollingshead and Redlich, in their study of the relationship of social class to the prevalence of mental disorder, found more psychotics and fewer neurotics in the lower classes of this country than in the upper classes. Srole



and his co-workers found a similar difference in the prevalence of neurosis and psychosis in the lower and upper socioeconomic classes. However, according to Hollingshead and Redlich, hysterical reactions, unlike the other neurotic disorders, show an inverse relationship with class position. Although cases occur in all socioeconomic classes of the population, they are more frequently found in the lower classes, predominantly in classes IV and V in their designations, which are based on areas of residence, occupations, and levels of educational achievement.

There has been considerable discussion concerning the incidence of classic hysteria in Western society. Chodoff has maintained that an actual diminution in the incidence of conversion hysteria has occurred, because of changes in the cultural climate, including a wider dissemination of education and a less authoritarian social structure. However, Stephens and Kamp show that the admission rates for hysteria at the Henry Phipps Psychiatric Clinic during the periods 1913-20 and 1945-60 are not appreciably different. It may be that though dramatic conversion reactions are less frequent than formerly in the upper classes, hysterical character disorder, with identity diffusion and borderline qualities, is more common than earlier in the twentieth century. Anyway, the bulk of the disorders of a hysterical nature is not seen by psychiatrists. This segment of the population, perhaps at least 10 percent of those seeking medical help, applies to other medical practitioners and is often referred to neurologists. Further, injuries sustained in road accidents which

often, if to an undetermined extent, occur following transient hypnoid alterations of consciousness—alterations that interfere with accident-avoiding attention and intention—obviate the psychic need for conflict reduction in classical hysterical symptom formation. These patients are usually treated by the orthopedic surgeons, though some of them are later referred for psychiatric help.

Whether there is an actually decreased incidence of hysteria in urban Western society thus remains debatable. Certainly, classical forms of hysteria are common in the more outlying rural areas of this country, and are quite highly visible in clinics in such areas as Puerto Rico. Bart has shown that women who were admitted to the Neurology Service of the U.C.L.A. Neuropsychiatric Institute, and who emerged with psychiatric diagnoses, usually belonged to rural subcultures unlikely to have ambient “psychiatric vocabularies of discomfort,” and this was reflected in the way they presented themselves as physically ill. These women, with psychogenic physical complaints, were usually of lower social status, rural, and poorly educated, whereas members of another comparable group who on admission offered psychiatric reasons for their distress were usually of higher social status and of urban residence.

As already noted, hysterical symptoms appear in males, children, and elderly people, but they are most commonly seen in women who are in the

early period of adult life—except, of course, under military conditions in wartime.

An elemental passionateness with an excessive love-craving forms part of one type of hysterical personality, as will be discussed, and hysterical neurosis is often encountered in women of this type. In regard to this liability to hysteria, certain problems in feminine development may be briefly adumbrated here. The girl, like the boy, passes through a phallic phase. Later, she attains a feminine position and this entails a change of libidinal object, from the mother to the father, and another erotogenic zone, the vagina. As Freud elucidates, there is a difference between the sexes in the relation of the Oedipus complex and the castration complex. The boy's oedipal strivings develop out of the phase of phallic sexuality. The threat of castration results in a decisive repression of these strivings, and a severe superego in regard to the incest taboo is inwardly established as the legacy of the rivalrous relationship with the father. In contrast, in the case of the girl, the castration complex, including penis envy and increased hostility towards the mother, prepares the way from the preoedipal attachment to her mother to an intensified positive relationship with her father; in this "Oedipus" or, as is more accurate parabolically, Electra situation, she remains more indefinitely than does the boy. These complications which beset woman's development are responsible for greater liability to hysteria, which not infrequently remains on the plane of specifically sexual disability, including all degrees of

frigidity. On the other hand, under the stress of military conditions in wartime, especially in battle, the stage is set for the increased incidence of male hysteria.

### **Hysterical Personality**

Charcot emphasized the role of heredoconstitutional factors in the pathogenesis of hysterical neurosis and might thus have proceeded to a detailed investigation of the inborn characteristics of the personality of those suffering hysterical symptoms. However, he directed his interest to the classification of symptoms and the differentiation of hysteria from organic neurological disease, so that apart from drawing attention to the unstable nervous system and the exaggerated suggestibility of those suffering hysterical symptoms he did not offer a more detailed analysis of the behavioral or anamnestic characteristics of his hysterical patients. At this time, the known etiological field consisted of constitutional factors and of environmental factors which were not especially related to early emotional transactions in childhood. The important role of the early personal environment was largely hidden from the view of clinicians before Freud's investigations. Freud was in fact also impressed with the importance of heredoconstitutional factors in the etiology of the neuroses, but in unraveling the meaning of symptoms in terms of the patient's experience, he penetrated the amnesia for events in early life, and recognized also the crucial formative

importance in personality development of these early happenings. More attention thus came to be paid to the personality characteristics of patients suffering from symptom neuroses.

The first psychoanalytic contribution to characterology was Freud's paper in 1908<sup>3</sup> on the anal character. As it became apparent that the optimal goal of therapy went beyond the relief of symptoms to resolving the need for symptom formation, psychoanalytic characterology increasingly assumed clinical importance. Reich, in his book on character analysis, attempted to depict the character structures in symptom neuroses, including hysteria. He described the behavior of the hysterical character as obviously sexualized, including coquetry in women and softness and effeminacy in men. Even locomotion, he considered, was sexualized so that movements are soft, graceful, and sensually provocative. As the sexual behavior came closer to attaining its apparent goal, apprehensiveness became evident. Reich also described unpredictability, strong suggestibility, sharp disappointment reactions, imaginativeness, lack of conviction, compliance readily giving way to depreciation and disparagement, compulsive need to be loved, over-dependency on others for approval, powerful capacity for dramatization, and somatic compliance. He attempted to explain these features as being determined by fixation in the early genital phase of infantile development with incestuous attachment, but as we have noted, Marmor and others have with more cogency related some of these features to pronounced orality in

the hysterical personality.

Chodoff and Lyons challenge the close relationship adduced by others between conversion phenomena and the hysterical personality. Of 17 patients with unequivocal conversion reactions, only 5 satisfied criteria (similar to those of Reich's description above) they laid down for the diagnosis of the hysterical personality. They therefore concur with Kretschmer and Bowlby in the opinion that conversion reactions do not occur solely, by any means, in patients who present the characteristics of the designated hysterical personality. They suggested that instead of conversion hysteria there may be substituted one of the three more precisely defined diagnoses: conversion reaction, hysterical personality, or hysterical personality with conversion reaction, whichever may be appropriate. In the 1968 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II), authorized by the Council of the American Psychiatric Association, "Hysterical Neurosis, Conversion-Type," "Hysterical Neurosis, Dissociative-Type," and "Hysterical Personality (Histrionic Personality Disorder)," are separately listed—a maneuver which enables adequate classification without separating conversion reaction from its venerable association with hysteria at any time, but with the option of either separating conversion-type hysteria from the hysterical personality, or citing them together.

In regard to Chodoff and Lyons' divorce of conversion reactions from

“hysterical personality,” the following comments are appropriate. Freud noted that instances of neurotic illness fall into a “complemental series,” within which the two factors of type of personality and adverse experience (discussed as the fixations of the libido and frustration) are represented in such a manner that if there is more of the one, there is less of the other. As stated above, some of the features of the hysterical personality belong to derivatives of pregenital points of fixations, and where these are absent it might be expected that the etiological role of the actual conflict would be more emphatic. Secondly, while the predisposition to acquire hysterical illness is built up very largely from undue emotional attachment to one or both parents, with difficulty of later displacement of this attachment, the dependent and other correlative patterns of personality are often not so simple and obvious. To understand deviations from such a pattern it is necessary to study the total repertoire of unconscious defenses and to take into account that the evident achievements in external adjustments and independence may show the marks of overcompensation. Basically, such patients remain unconsciously dependently fixated on the infantile object (in fact or in fantasy), and are vigorously defending themselves against this fixation. An example from military psychiatric experience is briefly outlined below.

Following enlistment in the army, the patient, aged thirty, developed pains in the stomach. Later, he began to suffer trouble with his eyes,

especially when riding his motorcycle. He could not keep them open and complained they kept “screwing up,” which, indeed, they did. He was of a very aggressive character-type. Prior to enlistment, he often performed in fairgrounds on the “wall of death,” demonstrating his skill and daring on a motorcycle, and was proud to be earning much more money than his father. He had always been a daredevil, amateur motorcycling being his hobby from an early age. His usual employment was that of a butcher, and he was the mainstay of the home. He had never taken up a sustained relationship with any woman other than his mother, to whom he remained very attached. In discussions he made it clear that he was ready for anything in the army and could perform wonders on his motorcycle—were it not for the spasms of his eyes.

In this case, both the unconscious underlying over-dependency and passive homosexual strivings were vigorously countermanded by character defenses. These gave an appearance of remarkable and heroic virility and independence, with others depending upon him, prior to his separation from his mother and the onset of symptoms, including conversion reaction.

Brody and Sata suggest that a semantic solution may be achieved by using the term “histrionic personality” to describe that type of hysterical personality background identified by Reich and by Chodoff and Lyons. They give the following useful clinical description:



The people described in this manner are vain, egocentric individuals displaying labile, and excitable, but shallow affectivity. Their dramatic, attention-seeking, and histrionic behavior may encompass lying and pseudologia phantastica. They are conscious of sex and appear provocative, but they may be frigid and are dependently demanding in interpersonal situations. They have a lifelong history of seriously disturbed relationships with others. The loss of a parent through divorce, desertion, or death is often reported.

Histrionic personalities under stress may exhibit impaired reality testing, intensive fantasy production, and convictions about the motives of others bordering on delusion. In moments of repose, they are characteristically vague and imprecise about emotionally significant matters. They cannot express their inner feelings with accuracy and often utilize bodily action for communicative purposes.

Although histrionic personalities may exhibit conversion reactions, the latter can occur in association with almost any type of character structure. Histrionic character features occur more frequently in Western society among women. They are, indeed, considered feminine by our societal standards, and male histrionic characters are frequently described in this way.

In a transcultural survey of 21 female patients, 7 from San Francisco, 7 from London, and 7 from Copenhagen, Blinder found that they all exhibited the characteristics of hysterical personality adumbrated above. A picture emerged of a group of women, often the youngest children in their families, born of mothers who seem to have had scant time or talent for serving as models for identification and of fathers even less able to interact favorably with their growing daughters. These women exhibited a significant number of persistent childhood neurotic traits, and their medical histories revealed an

uncommonly high incidence of abdominal surgical procedures. Particularly in the sexual sphere, they were strikingly underdeveloped or inhibited.

Blinder was impressed with their superficially cheerful childlike manner, their emotional lability, their dramatic use of overstatement, or of stoic understatement when this could be used for dramatic effect, the incongruence of their verbal communication with their actual behavior, their emphasis on feminine characteristics to the point of caricature, and their widespread use of denial.

It is clear that in the West there exists transculturally a histrionic female character (to be observed in fact also in the East) liable to hysterical neurosis. However, there are other character structures not so well or so frequently discussed in the literature, and the soldier described briefly above is an example. Such men do not exhibit “softness and effeminacy” as described by Reich. On the contrary, character traits of persistent insistence on being the strong man, of exaggerated exhibition of sadistic masculinity, are anamnesticly revealed prior to hysterical symptom formation. It is indeed remarkable that Reich omitted a discussion of the consolidated reactive defense (including identification with the male aggressor) against unconscious feminine identification of these men who are liable to hysterical attacks and symptoms. Some of them, though by no means the majority, pursue women vigorously, are hyperactive, even athletic, sexually, thus

feverishly countermanding castration anxiety and remaining busy a large part of their time constructing and reconstructing a “he-man” image for themselves, and to purvey to others.

Many women liable to hysterical attacks and symptoms are quite overtly inhibited sexually; on account of deep-seated guilt and anxiety related to incestuous fantasies which continue to saturate their sexual strivings unconsciously, they strenuously avoid sexual provocation and sexual contact, dress drably, and far from being aggressively exhibitionistic, are excessively modest and masochistic in their style of life. When symptom formation occurs, the sexual symbolic references are ample.

It will be recalled that the same Oedipus who eventually killed his father and married his mother began life by being exposed on a mountain, deprived of maternal care. While the final stages of the Oedipus drama are more representative of one broad category of hysterical character disorder and neurosis, one generally accessible to psychoanalysis of relatively limited duration, there is a second broad category for which the beginnings of the legend are more pertinently parabolic. This second broad category contains those with pronounced oral character traits, sometimes also undergirded by severe narcissistic ego disorder. These latter cases may often be better considered as hysteriform borderline personalities. In the course of treatment psychotic problems may become apparent. It has been noted by

Reichard that 2 of the 5 patients reported in the *Studies on Hysteria* showed schizophrenic features. Easser and Lesser differentiate “hysteroid” from hysterical characters and especially remark on the painful masochistic elements in the fantasies of these more pregenitally oriented patients.

## Diagnosis

Glover sums up the pathogenesis of symptom formation in hysteria by citing roughly in sequence the major factors usually involved. These are: (1) somatic compliance; (2) frustration; (3) introversion; (4) regression; (5) reactivation of Oedipus strivings; (6) failure of repression; (7) displacement, symbolization, and/or identification with the incestuous object; (8) breakthrough of innervations; (9) inhibition or exaggeration of somatic function, giving rise to crippling or painful symptoms; and (10) somatic dramatization of unconscious fantasy formations, including repetition of some elements actually associated with Oedipus-phase development.

Examples of somatic compliance are the localization of symptoms in accordance with fixation of body libido (erotogenic zones) and localization due to libido disturbance, the result of organic disease. Thus, conversion symptoms of an oral kind may readily occur in a patient of constitutionally strong oral libido with oral fixation. On the other hand, an organ affected by organic disorder is readily chosen to express symbolically a reactivated

oedipal conflict. This last is an important warning to the clinician not to adopt an “either-or” frame of reference in the differential diagnosis of hysteria from organic disease.

Conflict induced by frustration results in the reactivation of an Oedipus complex which has been held in faulty repression and of which the negative (homosexual) aspects are strongly emphasized.

With these major points in mind, it can be stated that the positive grounds upon which a diagnosis of hysteria is established consist in the distinctive marks of its etiology and psychopathology which psychiatric investigation of the patient and his symptoms affords. The disorder is the result of mental conflict, and there are connections between the conflict and the symptoms. Hysteria is manifest in so many forms, some of which closely imitate organic disease of the nervous and other systems, that without the distinctive marks of its etiology and psychopathology symptoms may be misleading. It often happens that the symptoms themselves are no more characteristic of hysteria than of other diseases. In some cases, however, where there are characteristic symptoms such as *astasia-abasia*, *anesthesia en manchon*, *clavus*, *globus hystericus*, or the changing of one to another symptom, it is necessary to consider the extent to which hysteria is responsible for the illness of the patient. The stigmata only occasionally accompany other symptoms of hysteria. Rarely, pharyngeal anesthesia may

be discovered, and cutaneous anesthesia is sometimes demonstrable, for example, in case of hysterical convulsive attacks.

The occurrence of mental conflict prior to the manifestations of the disease, or of its exacerbation, may be revealed by a painstaking history of the present illness. Such conflict is provoked by changes in the life situation of the patient. It is necessary to determine the temporal connections of periods of stress with the conflicts and symptoms. Following this chronological correlation, which is positive in cases of hysteria, the nature of the conflict and its possible symbolic relation to the symptoms needs to be more closely studied. In hysteria, the meaning of the symptoms thus becomes evident, for they express regressively (and often in a body language) both the repressing forces and the repressed Oedipus strivings in the field of conflict. Next, the personality characteristics of the patient need to be evaluated. Dependence aspects may disclose attitudes derived from the persisting, albeit unconscious, strong emotional attachments to the parents or their surrogates. The repressed Oedipus complex of early childhood may express itself in the record of events of later life which the patient is able to recall. Overdependence in the spheres of occupational, social, and sexual adjustment is often clear. In some cases, this is masked by a reactive insistence upon independence, which, however, betrays the character of overcompensation and shows the marks of unresolved aggression toward the parent (or parent figures).

It is also possible in diagnostic interviews to increase understanding of the patient and his illness by a consideration of the neurotic traits that he has evinced during the process of growth and development. These are prominent and, in cases of hysteria, often persist into adult life. In some instances, too, there is a history of previous frank neurosis which can be correlated with the life situation and the conflicts evoked at that time. No interview schema should be rigidly followed, but the data are all required. It may be necessary to have more than one distributive discussion, in which the patient is helped to talk freely in his own way and at his own pace, in order to elicit the information.

As repeatedly stated above, hysteria and organic disease may be contemporaneously present. Organic disease may follow hysteria, as for example when refusal of food proceeds to anorexia nervosa and subsequent physiological derangement. In other cases, physical disease is primary, with disturbances of the body image and an induced regressive ego orientation—a state of affairs conducive to conflict in many people with symptoms comprising, perhaps, an overlay of hysteria.

It is sometimes difficult to differentiate hysteria from organic nervous disorder. In general, an organic lesion of lower-motor-neuron type is one of individual muscle elements, whereas hysterical paralysis is usually a paralysis *en masse*.<sup>42</sup> An upper-motor-neuron lesion, however, often results in a

paralysis which superficially resembles that which occurs in conversion reaction, but there usually are important symptomatic differences. Thus, lower-face paresis, hemianopsia, and circumduction of the leg at the hip, are common in an upper-motor-neuron lesion. Pronounced changes in the tendon reflexes, sustained ankle clonus, and the sign of Babinski, usually point toward organic involvement of the nervous system. Hysteria has to be diagnosed, however, on its own characteristics and not merely by the exclusion of organic disease, which, at times, it may accompany. The following schema summarizes the requirements in history-taking for the diagnosis of hysteria.

#### *Directive Scheme for History-Taking in Diagnostic Interview*<sup>4</sup>

##### 1. Present Illness:

- a. Consideration of chronological correlations of onset and exacerbation of symptoms with changes in life situation (or traumatic experiences ).
- b. Consideration of conflicts evoked by such changes in life situation. The connections of these conflicts with particular symptoms as far as can be consciously disclosed in discussions by the patient when his attention is directed thereto.

##### 2. Personality Background:



Dependence Aspects:

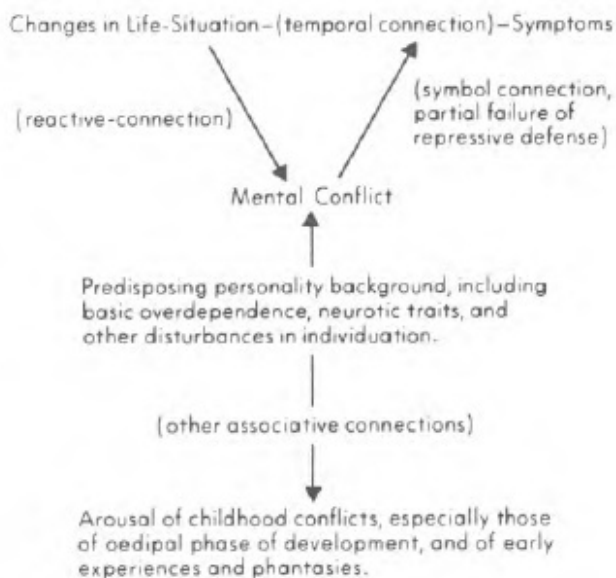
- i. Nature of current interpersonal relationships, especially family and affianced.
- ii. Current occupational, social, and sexual adjustment, including recreational and cultural interests.
- iii. Employment and school record and achievement.

b. Neurotic Traits:

Predominant type, time of appearance, disappearance, or persistence.

- c. Previous Nervous Breakdown: type, correlation with life situation at that time.

3. Family and Hereditary History, and the patient's view of it.



**Figure 8-1.**  
Associative anamnesis in hysteria.

In certain forms and phases of schizophrenia, with delusions, hallucinations, disfigurements of speech, and the generalization of automatization, the disease is readily distinguished from hysteria. Incipient schizophrenia may occasion difficulty in differentiation, especially because the resemblances depend upon an initial similarity of psychological mechanism. The difficulty is enhanced by the fact that, occasionally, hysteria ushers in a schizophrenic psychosis, that hysterical phenomena may cover, or occur with, schizophrenic disease, and by certain forms of hysteria, including dissociative reactions, such as fugue, Ganser's syndrome, pseudodementia,

puerilism, and stupor. These last are sometimes part of a transient psychotic disturbance, but there is usually no regression to fixed schizophrenic disorganization. Hypochondriasis in schizophrenia is usually of a bizarre nature, which may be accompanied by a subjective experience of a change or duality of sex, perplexity, and a peculiar overideation. If any of these symptoms accompany somatic conversion symptoms, schizophrenia should be suspected.

Ganser's syndrome is not infrequently observed in people charged with crime, of which they may or may not be actually guilty. The patient is unable to answer simple questions with accuracy, although he is not altogether incoherent, as in hysterical pseudodementia, which, however, may ensue. He compulsively answers all questions approximately, including ones of no relevance to the circumstances of his arrest. Thus, if at 3 p.m. the patient is shown the examining doctor's watch, which is accurate, asked the time of day he may say 4 p.m. In such instances, there is a hypnoid alteration of consciousness which is clouded and suffused with anxiety. The patient may become panic-stricken and excited if questioned very much. Usually he is unfit to plead and requires sedation and supportive psychotherapy before he can focus his thoughts at all adequately. The example offered above in regard to an approximate answer as to the time of day demonstrates, as other such answers do, an overwhelming motivation against organizing events in time and space. This, of course, would be required of the patient in the course of

investigation of the events at the time of the alleged offense. In regard to the latter, a particular patient may be caught up in it in his fantasy or associated with it in actuality; the syndrome is a sequel of accusation.

Depressive or paranoid episodes may punctuate the course of a predominantly hysterical illness. In such cases the diagnosis may more properly be designated as “borderline state,” and the treatment may require appropriate modification.

### **Prognosis, Management, and Treatment**

Conversion hysteria, especially when associated with some mild manifest anxiety, is often best treated in individual psychoanalysis. In retrospect, it would seem that analyzable hysterical patients successfully brought to termination of their treatment were usually characterized by adequate ego strength and flexibility, by drive organization predominantly fixated at the phallic-oedipal rather than at pregenital levels, with a good measure of basic self-esteem, and they were well motivated for both treatment and recovery. Psychoanalysis usually succeeds in such cases in not only the deletion of symptoms but in minimizing the need for symptom formation in response to frustrational life situations. Various conditions, however, may indicate the suggestive methods of psychotherapy for relief of symptoms, and others may contraindicate classical psychoanalysis.

Immediate medical help may be mandatory as, for example, in acute conditions, such as anorexia with bodily emaciation, or when anxiety is intense and confusion prominent. In such cases of acute hysteria, tranquilizing medication by day and sedation at night may for a time be necessary. Consideration of these cases for psychoanalytic therapy must wait until symptoms have been relieved and the patient is calmer. Advanced age, exceptionally great secondary gain from the illness, or feeble-mindedness, are contraindications to analysis. In instances of conversion or dissociative reaction which follow a severely stressful precipitating situation, the simpler supportive methods of psychotherapy may suffice for recovery to the *status quo ante*. The question of psychoanalysis may in such cases be raised by the patient himself, and may be best left, for the most part, to his own consideration and decision to visit and discuss with a psychoanalyst his suitability for psychoanalysis.

In some cases complicated by the exhibition of psychotic mechanisms, psychoanalytically oriented psychotherapy with modification of the usual technique of psychoanalysis is beneficial. This is frequently the case in the more severe dissociative reactions.

In selected instances of conversion hysteria, especially at phases of a readiness for recovery, following adequate investigation, hypnotherapy, with direct suggestion of symptom relief under hypnosis, may be usefully

employed. Some therapists also utilize hypnosis in “uncovering” types of psychotherapy with remarkable success.’

Hysterical character disorder is often usefully treated in group analytic psychotherapy in a carefully composed therapy group. For some patients, weekly individual sessions are also desirable to prevent antitherapeutic acting-out episodes.

It frequently happens in families of lower socioeconomic class, and sometimes in others, that if an individual is to change sufficiently, so that he is not easily liable to recurrence of hysterical symptoms, the context in which he lives must also change. The patient cannot be brought forth from the family soup, so the soup also has to be doctored. There is insufficient basic individuation and socialization and over much deep collective family dependency, so that only temporary improvement may result from individual or even from group psychotherapy—when the group is not composed of the family. Family therapy is thus an important modality of treatment in community mental health clinics.

There are some cases of conversion reaction with an unfavorable prognosis, no matter what treatment is attempted. The conversion reaction may be the only possible emotional solution for the patient, because the real life situation excludes healthier possibilities of gratification. Even in these

cases, psychotherapy on a weekly or more infrequent basis may be considerably ameliorative. Other cases, formerly designated "chronic degenerative hysteria" and characterized by an intense and profoundly pervasive masochism, deteriorate into a massive form of emotional dependence, even parasitism, upon others. When the victim or victims separate or are separated, institutionalization may become necessary, sometimes because of a supervening psychotic disorder of depressive or paranoid type.

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## Notes

1 "Jedermann ist ein bisschen hysterisch," as quoted by Jones.

2 E. A. Strecker, *Fundamentals of Psychiatry*, 6th edition, M. M. Pearson, ed. Philadelphia: Lippincott, 1963 dynamically, so far as it goes, similar to those offered by the earlier investigators mentioned in connection with the Proctor study.

3 Freud, S. (1908) "Character and Anal Erotism," in *Standard Edition*, Vol. 9. London: Hogarth Press, 1959 Pp-169-175.

4 Reproduced by permission of the publishers, from D. W. Abse, *The Diagnosis of Hysteria*. Bristol: John Wright & Sons, Ltd., 1950.