THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS

PSYCHOTHERAPY WITH PATIENTS WITH HYSTERICAL DISORDERS

IRVINE SCHIFFER

Psychotherapy with Patients with Hysterical Disorders

IRVINE SCHIFFER

e-Book 2015 International Psychotherapy Institute

From *THE THEORY AND PRACTICE OF PSYCHOTHERAPY WITH SPECIFIC DISORDERS* MAX HAMMER, Ph.D.

Table of Contents

Psychotherapy with Patients with Hysterical Disorders

The subject of hysteria is historically important in the field of psychiatry because of the role it originally played in the development of psychoanalysis. The technical procedures employed by Freud and Breuer in studying and treating hysterical patients paved the way for Freud's invention of his instrument for examining the human mind, wherein a succession of obstacles to treatment was discovered, including the amnesia that is characteristic of the hysterical patient as well as other "resistances" to the uncovering of infantile sexuality and the Oedipus complex. Freud was able to discover the important role that sexuality played in the pathogenesis of hysteria and in the motive for "repression." Earlier the two men had felt that the splitting of consciousness, so striking a finding in their well-known classical cases, was a rudimentary dynamism in every hysteria and that this tendency to dissociation, along with the emergence of abnormal states of consciousness which they termed "hypnoid," was the basic phenomenon of the hysterical neurosis. Their early thinking on the etiology of hysteria included Breuer's concept of the habitual coexistence of two heterogeneous trains of ideas operative in the human psyche. "We are also capable of what is undoubtedly psychical functioning while our thoughts are busy elsewhere—as for instance when we read aloud correctly and with the appropriate intonation, but afterwards have not the slightest idea of what we have been reading." Breuer felt that the capacity to acquire hysteria was linked with some idiosyncrasy of

the person concerned, some peculiarity of his nervous system and his mind. The inability to tolerate boredom, the craving for sensations which drove the hysteric to interrupt the monotony of his life by all kinds of "incidents," these features he felt led the patient further and further along a road that required that he be ill, a trait which Breuer felt was pathognomic for hysteria. He postulated that hysterical emotional excitations invariably had a sexual content. He considered other characteristics of such individuals to be their high degree of suggestibility and their tendency to autohypnosis. He felt that the psychic content of these "hypnoid" states consisted in those ideas which were fended off in waking life and repressed from consciousness; the mental state of the hysterical patient Breuer likened to that of a hypnotized subject. The splitting of the mind then was the consummation of hysteria, a splitting that for Breuer explained the principal character of the disorder; one part of the patient's mind he saw as being in a "hypnoid" state—always prepared for a lapse in waking thought and ever prepared to assume control over the whole person. This "hypnoid" mind he felt was in the highest degree susceptible to suggestion.

Freud, with his attention on symptom formation itself, observed that the sexual function of the human was liable to a great number of disturbances, most of which exhibited the characteristics of simple inhibitions. He classed these together as "psychical impotence." He also underlined disturbances in the function of nutrition, locomotion and work, as inhibitions in the

expression of "restriction of an ego function." He further recognized that physical organs could become too strongly eroticized and that an ego function of an organ would become impaired if its erotogenicity (sexual significance) was increased. "It behaves, if I may be allowed a rather absurd analogy, like a maid servant who refuses to go on cooking because her master has started a love affair with her." He saw that the ego renounced organ functions so as not to be obliged to undertake fresh measures of repression—in effect, to avoid a conflict with the instinctual impulses (id). He also observed that there were certain inhibitions that served the purpose of self-punishment, such as those placed on professional activities. The ego was not allowed to carry on these activities because they would bring success or personal gain that the severe conscience (superego) forbade. He contrasted these renunciations to more generalized inhibitions of the ego brought about as the result of an impoverishment of energy, such as in states of depression. Basically he viewed the hysterical symptom as a sign of and a substitute for an instinctual satisfaction held in a state of abeyance. It was the consequence of a process of *repression,* a repression specifically created to remove the ego from a situation of danger. A generating of anxiety setting the symptom formation in motion was seen as a prerequisite to hysteria, in that if the ego did not arouse the pleasure-unpleasure agency by generating such anxiety, it could not obtain the power to arrest the process which was preparing in the id and posing a danger to the ego. Thus such symptom formation put an end to a

threatening situation that had two aspects, one hidden from view—the operation in the id; the other presented openly—a demonstrable creation in the place of the instinctual process—the symptom itself. Repression then was seen as serving the same purpose as flight; the ego was perceived as withdrawing its energy charge (cathexis) from the instinctual representation to be repressed and using that cathexis for the purpose of releasing unpleasure (anxiety). Freud recognized the ego then as the actual seat of anxiety. By making use of this signal of unpleasure, it could attain the complete repression of the instinctual impulse which of necessity was obliged to find a substitutive channel of expression, very much reduced, displaced and inhibited and no longer recognizable as a satisfaction—a substitute impulse which on overt expression no longer afforded any sensation of pleasure, but instead had taken on the quality of a compulsion. Freud saw that in repression, the ego exercised its power in two directions, acting in one manner upon the instinctual impulse itself and in the other upon the psychic representative of that impulse (the symptom).

Freud became aware that the mental process which had been turned into a symptom owing to repression could maintain its existence outside the organization of the ego and independently of it. This process and all its derivatives could enjoy a privilege of extraterritoriality; and when such derivatives came into associated contact with the ego organization, they were in a position to draw a part of it over to themselves and thus enlarge

themselves at the expense of the ego. Freud likened this to the reaction of tissue to a foreign body which keeps up a constant succession of reactions in the tissue in which it is embedded. He saw it as only natural that the ego should try to prevent symptoms from remaining isolated and alien by using every possible method to bind them to itself in one way or another and to incorporate them into the ego organization by means of these bonds. A classic instance of this he saw in those hysterical symptoms which were a compromise between the need for satisfaction and the need for punishment. Such thinking led to his understanding of "secondary gain" from illness. This gain was seen as coming to the assistance of the ego in its endeavor to incorporate the symptom and increase the symptom's fixation; treatment then aiming at helping the ego in its struggle against the symptom would be met by the opposing conciliatory bonds between ego and symptom—bonds operative on the side of *resistance.* The symptom being the true substitute for and the derivative of the repressed impulse would carry on the role of the impulse, continually renewing its demands for satisfaction, and thus oblige the ego in turn to give a signal of unpleasure and put itself in a posture of defense. This secondary *defensive struggle against* the symptom, a struggle that takes on many different shapes, is in fact the *clinical picture* of the *hysterical patient* who presents himself for treatment.

With this brief historical background, we are now in a position to take a look at those varied clinical shapes and entities that are encompassed by the

term “hysteria,” and we might well begin with *phobic disturbances.* Here the motive force of the repression is a fear of castration. The signal of anxiety, which is the essence of the phobia, comes not from the process of repression nor from the libidinal energy of the repressed impulses, but as I have indicated from the repressing agency itself, the ego. Phobias then are related to an anxiety felt by the ego in regard to the demands of libido. They do not arise from repressed libido. Freud grouped together all phobias under the term *“anxiety hysteria.”* The substitute formation in phobia—namely, a castration anxiety displaced toward a substitute object and in a distorted form—has two obvious advantages: it avoids the conflict due to the ambivalence relative to the original object and it enables the ego to cease generating anxiety, because the anxiety belonging to the phobia is conditional, only emerging when the object of it is perceived. What happens in phobia then is that one external danger is replaced by another. The anxiety of phobia differs in no respect from the realistic anxieties which the ego normally feels in situations of danger except that its content remains unconscious and only becomes conscious in the form of a distortion. For example, a boy may develop a castration anxiety relative to his father as a result of the Oedipus complex and by means of repression, in substitution for the terror of his father, evolve a phobia for an animal such as a dog, wherein the youngster’s anxiety is only felt in the presence of the animal, the boy having now become oblivious of his original fear of his father. An additional

element in phobia relates to the existence of "anti-cathexis," a mechanism more characteristically operative in the obsessional neuroses, where an alteration in the ego called reaction formation serves to reinforce an attitude which is the direct opposite of the instinctual trend that is to be repressed. Such anti-cathexis also occurs in phobia, where reaction formations unmistakably serve to further disguise the object of ambivalence and in some circumstances represent the principal symptom of the patient; a hatred of a loved one for example may be submerged by an exaggerated amount of tenderness. In phobics, such reaction formations do not have the universality of character traits as they do in obsessionals but rather are confined to particular relationships. Reaction formations in hysterics tenaciously cling to particular objects and never spread throughout the ego as they do in obsessional neurosis. There is yet another form of anti-cathexis peculiar to hysteria in the nature of a special vigilance which, by means of restrictions of the ego, allows external situations to be avoided. Such restrictions are especially noticeable in the phobias.

Any meaningful treatment of phobia (or anxiety hysteria) would of course require an uncovering, not only of the original object of fear but of the castration complex revolving around that particular object (commonly the Oedipus complex). For this reason, depth analysis is the treatment of choice and other more superficial therapies such as conditioning, supportive and others can at best be only temporary and afford but symptomatic relief

without dealing with the underlying conflict and its resolution. Yet supporting a patient's fixated infantile sexual solution by superficial therapeutic techniques is still the practice of many therapists even in this day. It can only be justified when extenuating circumstances contraindicate depth exploration.

Abraham described *hysterical dream states* wherein the dynamic power of the repressed wishes was so strong that the patient's available means of repression was unable to cope with such instinctual trends. In such cases, the neurosis itself sub-served the instinctual tendencies exclusively. Abraham observed the hysterical dream state as one of a variety of phenomena by means of which the multitude of repressed wishes found expression. He saw in such states a domination of sexual fantasies, on the surface appearing nonsexual, yet arising from sexual wishes through the process of sublimation. Such fantasies, by their admission to consciousness through the censorship, were seen to serve as a medium for the representation of repressed sexual wishes and derived their energy from the latter source. Here again, treatment should desirably aim at dealing with the unresolved sexual conflict underlying such dream states, otherwise the therapist can be led down the garden path by such dramatic, colorful and seemingly endless chain of sublimations emanating from early sexual conflicts. A student of physics, "obsessed" with florid fantasies ostensibly dealing with the refraction of fight rays through different sized apertures, revealed in analysis the underlying

sexual impasse he had never surmounted in his earlier years relative to certain penetration fantasies of his phallic period of sexual development.

Helene Deutsch, in her observations on hysterical states, wrote on *"fate neurosis."* She saw this type of neurosis as a form of suffering imposed on the ego by the outer world with a recurrent regularity. The diagnosis of fate neuroses can be ascribed to people for example who in their early infantile sexual development have become libidinously enmeshed with a parent to such a degree as to be doomed in later life (ostensibly by fate) to a repetitive substitution of love objects carrying ingredients of personality identical to the original parental object. Oftentimes such parental objects may be untrustworthy, unfaithful, sadistic or psychopathic and so the patient embarks (unconsciously) on a lifelong quest for untrustworthy, unfaithful, sadistic or psychopathic love objects. To illustrate, one of my female patients could only allow herself a sexual involvement with men who eventually abandoned her in the manner that her father had abandoned her mother (and her) for a mistress. Deutsch saw such fate neuroses as hysterical when they could be traced back to repressions which arose in that period of childhood in which infantile sexuality had reached the stage which corresponds most nearly to the genital sexual life of the adult. In such cases, the libido did not regress to earlier stages of development; the unsuccessful repression affected the choice of object and the conflicts which resulted from the fixation in the infantile genital phase of the libidinal development. Like hysterical symptoms,

the hysterical fate neurosis acts as an alien body organized against the ego in its entirety. Fortunately, the fate neurotics are quite adaptable to treatment because the blows of "fate" are conditioned by the same inner motives as neurotic symptoms. Hysterical fate neurotics can be described as having a disorder wherein clinical conditions are lacking; "healthy" patients so to speak, healthy in the sense of being free from symptoms, yet pathological in their perpetual conflict with the outer world. Such patients do not come for therapy because of symptoms, but because of unhappiness and a search for a helping hand. They commonly resist depth analysis of their "loser" complex until through the transference of their therapy, they begin to recognize the repetitious bondage of their sexual life and likewise begin to discover a capacity for exercising an option that their sexual choices never permitted as long as the original conflict remained buried from conscious volition and appeared under the duress of "fate."

Freud never ceased to search for the "mysterious leap from the mind to the body," from a mental process to a somatic enervation; and in this respect Felix Deutsch continued in Freud's footsteps. For his cornerstone of psychosomatic theory, he used Freud's concept of the sense of reality—namely, something that originates from the projection of sensory perceptions of one's own body onto objects outside of it, the external objects being perceived as if severed from the body and lost. Deutsch became impressed with the importance of the process of symbolization stemming from the

continual wish of the infant to restore this loss of the body wholeness; by observing how the physiological functions of those body parts which had taken on the representation of such symbolized objects came to be modified because of such symbolizations, he developed his concept of the somatic symptoms characteristic of *conversion hysteria.* Deutsch considered symbolization the most important factor in conversion and recognized how it fused together the body parts so that the unconscious became infiltrated by such symbolizations, which formed a bridge to consciousness; though they faded into the unconscious, nonetheless when re-evoked, they became the precursors of the conversion symptom. Deutsch saw the beginning of symbolization as a happening at the earliest period of one's life and identified a rudimentary body ego, using nonsexual energy and in fact an antecedent to the process of identification. "Only when the fantasy and dream world is imbedded in the reality of the body does the process of symbolization begin. Previous to that, however, the body or body parts of the lost object are searched for in one's own body." Deutsch perceived that sense perceptions evoked by this search were forerunners of dream symbolization. Just as Freud postulated a knowledge of dream symbolism as unconscious in the dreamer's mind, so Deutsch saw organ symbolism as unconscious in the waking state. He recognized the development of a body ego as contingent upon the incorporation of others into itself. The process of symbolization was seen in this respect to be similar to identification, but nonetheless differing in that it

originated in one's need to make good for the earliest loss of the body's integrity by a reintegration into the body ego of adequate substitutes. Further, Freud had observed that we become aware of the living objects around us by perception complexes which came forth from them but which are fused with memories of similar perceptions of our own body; Deutsch clinically confirmed how patients used such sensory perceptions to become reunited with the lost objects in the process of symbolization. He recognized how certain sensory stimuli emanating from different objects—a voice of a father for example, or the aroma of a mother's bath powder—could serve as a trigger signal to revive the mechanism of retrieval of such lost objects into one's body ego via the reactivation of one's earlier network of symbolizations. Thus, for example, the bronchial contractures of an asthmatically disposed individual could become triggered by an olfactory stimulus linked with a parental object.

Conversion hysteria differs from conversion in more "average" individuals insofar as its development seems to be based on a constitutional or pre-dispositional inability to ward off emotional tensions which the healthy individual masters without apparent disability and which in the hysterical individual leads to an inevitable transformation of great amounts of libido into organic manifestations. Yet conversions can be viewed as necessary forms of a continuing psychodynamic process in all individuals, playing a part in any normal or neurotic condition as they attempt to adjust

the individual's instinctual drives to the demands of his culture; the most suitable targets for conversion seem to be those body parts with an organic pathology. In the absence of such, the organ systems selected for transitory conversion are those most appropriate for their symbolic suitability. The individual, by choosing this conversion means of defense against certain stimuli, renounces the adequate discharge of his emotions via the proper channels, and the continual repetition often leads to psychologically induced organic disturbances in ever widening and less related body parts. The residues of incompletely discharged emotions then continuously keep alive this process in conversion hysteria. Such emotions, though prompted to a significant degree by the aggressive instincts and though strongly linked with early identifications, are nonetheless predominantly initiated by conflicts in the area of sexuality.

Analysts following Deutsch's lead such as Ludwig, Mann, Mushatt and Silverman have given particular attention to the nonverbal communication of their patients—their gait, their posture, their body movements and their sensory experiences. Their work has offered considerable data corroborating Deutsch's views. I reported clinical findings of a woman in analysis with conversion hysteria; her body parts strongly reflected the early environmental objects that had become symbolically incorporated into her body imagery. In her mid-thirties at the time when she sought treatment for a problem of frigidity, she presented herself as a not unattractive, well-built

woman with an embarrassed blush, restless agitated hands and constant picking of her fingers. Her anamnesis revealed her to be a strongly controlling, envious woman, the “ugly duckling” and oldest of four daughters of an unhappily married middle-class couple. She had assumed the role of family “hostess” from the time she was thirteen until her mother’s death and her own marriage at twenty-two. She maintained a stranglehold on her husband and five children throughout her marriage. She recalled intruding herself between her parents in the parental bed at the age of three and this power to “divide and conquer” stayed with her throughout her later adolescence and adult life. She was convinced that it was because of her that her mother and father separated for a period of time when she was a child. In the course of her analysis, this woman was able to bring into view an extensive pattern of her body representation. Her legs symbolized her parents, her left leg her father, her right leg her mother. When threatened with loss of these figures or their surrogates, she developed symptoms in her lower extremities, the laterality depending on the particular figure involved in loss. A threat to her control over one of her sons achieving a shift from adolescence into early manhood (a threat of loss) was met with somatic symptoms in one of her thumbs—her body symbolization of this particular object. Her analytic associations to her frigidity in sexual relations revolved around early pregenital experiences which were noteworthy by the repression of erotic elements. Through the investigation of her conversion

symptoms, the analysis afforded not only an understanding of her body symbolization but also of her mechanism of splitting phallic sexual strivings from deeper pregenital cravings of an especially oral nature. It was possible to forecast which family figures were to appear in her verbal content by the conversion signals given somatically. Trends initiated in her childhood were faithfully repeated in the transference, dictating the manifest content of her dreams and the associations to her symptoms. The symbolizations of hands and legs as representations of parental and sibling objects demonstrated a clear splitting of laterality (left representing male objects, right female) and was heavily determined by the patient's early handling of the primal scene. With her parents as accomplices, she had managed a "divide and conquer" dynamism from her earliest years that was destined to account for a strong bisexual dissociation, a markedly dissociated right and left body image and a concomitant splitting of phallic sexuality from deeper maternal oral cravings. Further observations reported by me on the mechanism of conversion symptoms included the hypothesis that the lost object in the conversion process was symbolically taken back into one's body in a "defective" state in order to fulfill and perpetuate the symbiotic needs basically motivating the process. My particular addition to Deutsch's concept of the conversion process has been further elaborated in more recent papers yet to appear in print, but for now, I will only mention clinical cases I have already published. One involves a 32-year-old man whose laryngeal function was strongly

eroticized. His profession involved public speaking. He used his voice to demonstrate his aggressiveness and his masculinity as well as to seduce audiences to his ideas. He undertook treatment for a symptom, an almost total loss of his voice. Physical investigation by a specialist had failed to reveal other than slight inflammation of the vocal cords. Features shedding light on this man's problem included his constant reference to his symptoms as "loss of control." Once in treatment, it was soon clear that he was a very manipulating and controlling homosexual. An early homosexual object was his brother whom he envied earlier for his larger penis and later for his stronger speaking voice and his greater success in his profession. Analysis of my patient's psychopathology revealed that shortly following his renunciation of a guilt-laden homosexual relationship wherein he resisted performing fellatio on his partner, he psychologically and symbolically incorporated this man's phallus (a substitute phallic brother) in a defective state, the patient abruptly developing a damaged voice (vocal phallus). His laryngeal conversion symptom not only represented a "'borrowing" of his brother's envied phallus but further served to elicit secondary gain—sympathy from his professional associates as well as his therapist, all of whom became objects for exploitation in this man's acting-out of his oral-phallic conflict.

Another patient, a lawyer in his mid-thirties, consulted me for incapacitating twitching, pain and stiffness in his buttocks and legs of such

severity as to make standing and protracted sitting while at work almost impossible. Extensive medical work-up over a period of months for brain or spinal cord disorder failed to reveal organic pathology. His history included a voyeuristic preoccupation at puberty with young girls' legs, beginning with his 8-year-old sister who aspired to the ballet. Earlier, he had idolized a famous track athlete who had overcome polio involving both legs. He recalls how at that time, he developed a transient limp in one leg in order to appear heroic to his classmates. A later idol was Franklin D. Roosevelt. At age eighteen he developed a perverse interest in young women's buttocks and began indulging in what he called "frottage." This involved unobtrusively brushing his flaccid penis against the buttocks of women in streetcars or in other crowded situations. On one such occasion in a department store, he was apprehended by the store detective. At age six or seven, there was a history of sadistic sexual excitement while impaling imprisoned butterflies on a sharp pin or needle and gleefully watching the twitching of the antennae and the slow oozing of brownish fluid. He recalls embalming the butterflies in formaldehyde to "preserve" them. A character trait of fickleness this man described as his "butterfly tendency." His father was a passive, ineffectual man dominated by a phallic, compulsive woman who was to be the model for this man's marital choice. It was following the near-loss of his son through infantile diarrhea that this patient developed his hysterical conversion symptoms. Coincident with their appearance, he once again impregnated his

wife as insurance against the death of his only son.

This man demonstrated how the anal-sadistic content of his repressed sexual fantasies also played a vital part in the quality of his conversion symptoms where in his early symbolizations were re-evoked, his legs becoming eroticized to complement the twitching “butterfly” buttocks that were the symbolic representations of his young sister. His “frottage” was the acting-out of his incestuous anal fantasies surrounding his sister. The conversion symptom was also an expression of the need to guard against his fickle “butterfly” identification with his “impaled and embalmed” sister who remained permanently symbolized in his petrified buttocks and spastic legs, an unconscious imprint always in readiness for reactivation. The treatment of these cases of conversion hysteria rested on the detailed exploration of the body symbolizations involved and a reconstruction of the sexual conflicts surrounding the early objects represented in these symbolizations. The aim of such analytic work was to permit the patient to belatedly free the libido tied up on these infantile sexual attachments, allowing a discharge of emotions to take place along more appropriately adult channels no longer linked with organ systems such as vocal cords, legs and buttocks. This effort at belated genitalization is by no means an easy task, but one thing is certain, any treatment of conversion hysteria that fails to take into account the symbolization of the body and the reconstruction of a patient’s dealings with early lost objects and the struggle for reunification is only palliative at best

and on a par with the temporary results of hypno-therapies or other transference "cures."

No clinical discussion on hysteria should exclude description of that character type whose personality ingredients are basically derived from and reflective of all the afore-mentioned hysterical mechanisms because such are secondarily defended, embellished and disguised by a superstructure of reaction formations. They take on a personality cast that can best be labeled the *hysterical character.* This clinical picture is of special significance in that it has become one of the commoner shapes in which the hysteric patient presents himself in the modern-day psychiatric setting for treatment. The days of the "grand hysteria" appear to be more or less numbered. Sociological factors presumably have played a role in their gradual disappearance from the clinical scene. Gross hysterical palsies and other similarly incapacitating bodily afflictions now play only a relatively minor part in most psychiatric practices. It is true that in the past, the interest in hysterical disorders was focused primarily on body symptomatology; now with the broadened knowledge of contemporary psychiatry, the focus of interest on both the physician's part as well as that of the patient has turned toward the deeper elements of the neurotic disturbance. Moreover, with many more people coming to therapy these days, the incidence of gross hysterical symptomatology may only appear to be reduced, since such cases are proportionately in much smaller numbers within the overall spectrum of the

diagnostic categories of neuroses. Nonetheless, hysteria—1970 style—appears to be significantly comprised of the hysterical character types. What exactly are such types? The essence in the hysterical character, true to Freud's dictum, is the systematic repression of genital and adult elements of sexuality. The cause of such is usually castration anxiety. Instead of an overt neurotic conflict, one finds a substitute personality development which has a qualitative stamp that ranges from acting and theatricals to outright imposturing. Such patients behave "as if' they had certain meaningful emotions—"as if" they were anxious to consummate a love affair, "as if' they were caught up in an involvement with people, community and global society. Yet because there is a wholesale repression or discarding of the genital elements of sexual expression and development, one discovers in these patients a wholesale rejection of genuine independent feelings, thoughts and impulses. Such people are often capable of dual or multiple personalities. As I have indicated, they give the impression of experiencing great depth of emotional commitment, yet closer scrutiny identifies their emotionality as a shallow and flimsy structure, which to be maintained must find constant corroboration in one form or another from the outside world. Lacking a basic sense of autonomy, hysterical characters commonly go out of their way to gain attention, recognition or notoriety. Their symbiotic need is in depth of immense proportions and the objects for their dependencies are usually selected from those considered strong or socially prominent. The fear of

losing their carefully nurtured substitute personality joins with a fear of losing the borrowing power afforded by their symbiotic attachments to prestigious objects and results in most possessive and parasitic liaisons which such patients frequently refer to as "love." Their over-dramatizations, including their "show" of super-sensuality are indicative of the impoverished substratum on which such superstructures have been built. Their imposturing, charlatanism and disturbed sense of identity provoke a chronic state of fear of being unmasked. This accounts for the extreme forms of secretiveness and vigilance that many such people harbor toward an outer world that for them is potentially humiliating; their fear is for the shame and ridicule, not for the experiencing of any guilt, an indication of their poorly defined ego ideal—yet another deficiency in such hysterical disorders. In hysterical characters there are often strong outer layers of a negative reactionary nature to their personality. Many behave as if constantly threatened with a loss of integrity, of being invaded by the very external influences they secretly admire and envy. Strongly resentful of authority or coercion, they defend heavily against such external forces that in depth they would absorb like a sponge if they were not in fear and conflict. In effect, their negative resistance is but a defense against their own suggestibility. Likewise, in the intellectual area, such people often show a peculiar mixture of extreme credulity and extreme skepticism. Hysterical characters often react against their tendencies toward excessive repression of mature adult drives by a

zealousness wherein it becomes impossible for them to postpone gratification of their hypertrophied infantile wishes and impulses. Actually they hold little hope for any meaningful gratification and their impatience of a "now or never" variety is based on their conviction that there are very few opportunities left for them. The objects in their stunted sexual fantasies are often real persons but ones who are most unlikely to reciprocate realistically in these compensatory infatuations and are, therefore, hardly in a position to challenge the impoverished and limited sexuality of these hysterical characters. The other common fantasy elements in such people relate to the omnipotence of their narcissism, which takes the form of protracted family romance complexes that further indicate the infantile scope of ego ideal structure. On the group level, the beatniks, the hippies and the yippies seem in many instances to be appropriate representations in our modern society of the hysterical character. Angyal has offered a fine descriptive outline of this personality type under the heading of "the pattern of vicarious living."

Hysterical characters are more difficult to treat than hysterics with overt symptomatology because their motive in seeking psychiatric help is commonly as superficial and flimsy as their created personality superstructures. Status or "prestige analyses" is in the same category for such people as expensive limousines and mink coats. However, when in their treatment their "bubble bursts" as the initial resistances are overcome, such hysterical characters often become earnestly disgruntled neurotics,

desperately struggling to overcome their early repressions and impoverishments and capable in many instances of using their previously dissipated creative talents and energies towards the mobilization of more genuine and basic affects, impulses and ideas.

The *treatment of hysterical disorders* in general has improved consistently over the years through the increasing understanding of the psychology of the ego. Earlier, Freud observed: "we found, to our great surprise at first, that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect. ... It brings to an end the operative force of the idea which was not abreacted in the first instance, by allowing its strangulated affect to find a way through speech, and subjects it to associative correction by introducing it into normal consciousness (under light hypnosis) or by removing it through the physician's suggestion, as is done in somnambulism accompanied by amnesia." Many are of course familiar with Freud's changing techniques in the treatment of hysterical disorders, such as the cases of Emmy Von N., Elisabeth Von. R. and Dora, studies which remain classics to this day. Today it is still safe to state that difficult though the resistance in hysterics may be, what with the overdramatized, hyperemotional yet amazingly shallow transference features which such patients exhibit, psychoanalysis continues to provide the only situation in which the hysterical

defensive reaction against the early narcissistic injuries of childhood can be stripped away to expose the infantile conflict and allow it to be worked through and adequately resolved.

Very often, hysteria is only positively identified diagnostically through the treatment situation itself. Abraham's notations on hysteria are helpful in differentiating the more clouded and bizarre hysterical syndromes from schizophrenia. He observed that with neurotics in general, the sexual impulse is distinguishable from that of a normal person by its excessive strength and the fact that the component instincts are incompletely subjected to the heterosexual one which is repressed; with the outbreak of the neurosis, the repressed material emerging into consciousness becomes converted into hysterical symptoms, serving as a discharge for such impulses, often of a perverse nature. Unlike hysteria, he saw schizophrenia as destroying the person's capacity for sexual transference and for object love; a revulsion of the libido from an object upon which it was at one time cathected with particular intensity Abraham saw as an irrevocable vicissitude in schizophrenia. Although such patients were often very suggestible, he saw such suggestibility as of a different order from that of the hysteric; in the former, the patients failed to struggle against outside influence because they were too indifferent to oppose such influences; they suffered a disturbance in the capacity for attention. It seemed then to Abraham that such suggestibility was an absence of resistance, yet, nonetheless, very easily changed into

resistance. The negativism of schizophrenia was an antithesis to transference. In further contrast to hysteria, the patients were only to a slight degree susceptible to hypnosis. In the psychoanalysis of schizophrenics, he discerned an absence of transference. The strong presence of autoeroticism was yet an additional feature that for Abraham distinguished schizophrenia from hysteria; in the former, the libido was seen as withdrawn from objects, while in the latter, it cathected objects to an excessive degree. Further, he discerned a loss of capacity for sublimation in schizophrenics, whereas in hysteria there existed an increase in this capacity. Abraham's differential remains an invaluable yardstick in assessing the therapeutic prognosis of hysteroid conditions in depth therapy.

Easser and Lesser have described some of the difficulties in working with the transference of hysterical patients. They underline the zealousness with which the hysteric approaches the therapeutic situation, seemingly more than ready to absorb insights yet trying to obscure his vicarious posture of onlooker, observing and reacting to the analyst at work rather than working himself with his own problems. These authors have underscored the dangers confronting the analyst and his own countertransference problems. "The analyst finds his day enlivened by this patient's hour, courted and flattered . . . the analyst's expectations of his curative powers are mobilized by the apparent simplicity of the defenses." By far the major tactic through which the hysteric achieves his secondary gain is his ability to evoke in others strong

emotional reactions of responsiveness and pleasure; such undesirable countertransference reactions in a therapeutic situation invariably produce a repetitive neurotically gratifying experience rather than corrective analytic insight; thus the patient continues to sustain the very inhibitions and repressions that allow him his neurotic manipulations, his stock in trade from early childhood, wherein infantile sexuality can be exploited in an endless repetition of seductions; in hysterics, the infantile repression of their own genital sensations continued into their adult fives leaves them with limited outlets for sensual expression, forcing them to resort to an evoking of sensuality in others.

A middle-aged woman, married to a mathematics professor and the mother of an infant child, came to analysis because of a symptom of sexual disappointment in her marriage. Though she “loved” her husband, she found little satisfaction in intercourse, a sense of impoverishment also experienced in sporadic extramarital affairs. Her transference in therapy was keynoted by monotonous infantile efforts at arousal and seduction of the therapist, wherein she repeated all the games and tricks in her limited arsenal of hypertrophied genitalless sexuality. Only through detailed working through of the heavy superstructures of these compensatory offerings did this patient ultimately risk the revealing of her underlying conflict, including her strong envy of all men and her punishment of herself and them by an identification with a similarly envious and theatrically seductive mother.

The hysterical patient brings into her transference a faithful repetition of her way of relating to many figures, including the earliest ones. Such attitudes and posturings, laden with shallow hyper-emotionality, over-dramatization and game-playing—defenses and resistances against the primary narcissistic hurt in the patient's core—are the stereotyped patterns of the transference of the hysterical patient for better or for worse; as such, they require patient and thorough analysis until they are ultimately abandoned, so that the underlying infantile conflict of the patient can be exposed and the freeing of the genital strivings of the patient toward a pathway to maturation effected. This is the aim in the treatment of all forms of hysterical conditions, whether they be primarily problems of frigidity, impotence, conversion, character disturbance, fate neurosis, phobias or inhibitions in work or other aspects of normal living.

In conclusion, the treatment of choice in hysterical disorders is psychoanalytic intervention. Any modification of such a procedure by psychotherapists should be advisedly a therapy of an uncovering and reconstructive nature. Other therapies, whether basically drug oriented, hypnotic, behavioral or reconditioning, are at best palliative and offer only a temporary resolution of the more superficial manifestations of the hysterical problem.

REFERENCES

Abraham, Karl: The psychosexual differences between hysteria and dementia praecox. *Selected Papers on Psychoanalysis*. New York, Basic Books, 1953, pp. 64-79.

Abraham, Karl*: Hysterical Dream States*: Selected Papers. 1910, pp. 90-124.

Angyal, A.: *Neurosis and Treatment*. A Holistic Theory. New York, John Wiley & Sons, 1965, pp. 136-155.

Deutsch, F.: Zur Bildung der Konversionsymptoms. *Int Ztschr*. Psa., 10:380-392, 1934.

Deutsch, F.: *On the Mysterious Leap From the Mind to the Body*. New York, International Universities Press, 1959, pp. 75-79.

Deutsch, H.: *Hysterical Fate Neurosis*. Neurosis and Character Types. New York, New York International Universities Press, 1965, pp. 14-28.

Easser and Lesser: *Transference Resistance in Hysterical Character Neurosis—Technical Considerations: Developments in Psychoanalysis at Columbia University*. New York, Hafner, 1966, pp. 69-80.

Freud, S., and Breuer, J.: On the psychical mechanism of hysterical phenomenon. Preliminary communication. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 2, pp. 3-7.

Freud, S., and Breuer, J.: Theoretical. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 2, p. 185-251.

Freud, Sigmund: The psychotherapy of hysteria. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 2, p. 255.

Freud, Sigmund: Case histories. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 2, p. 48-181.

Freud, Sigmund: The interpretation of dreams. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 2, p. 550-577.

Freud, Sigmund: A case of hysteria. *The Standard Edition of the Complete Psychological Works of Freud.* London, Hogarth Press, 1962, vol. 7, pp. 7-122.

Freud, Sigmund: Inhibitions, symptoms and anxiety. *The Standard Edition of the Complete Psychological Works of Freud*. London, Hogarth Press, 1962, vol. 20, p. 77-174.

Ludwig, Mann, Mushatt and Silverman: In *On the Mysterious Leap from the Mind to the Body: A Workshop Study on the Theory of Conversion*, edited by Felix Deutsch. New York, International Universities Press, 1959.

Schiffer, I.: The psychoanalytic study of the development of a conversion symptom. *Int J Psychoanal*, 63 (Parts 2-3).T69-174, 1962.

Schiffer, I.: Psychoanalytic observations of the mechanism of conversion symptoms. *Psychoanal Rev*, 5 (No. 2): 33-42, Summer edition 1964.