Hysteria: the Elusive Neurosis

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I would like to organize my presentation on hysteria around two interrelated questions. Does hysteria still exist and, if so, how can we define it and describe it? In my view these questions require an investigation that draws on psychoanalytic, historical, and cross-cultural perspectives.

It was with patients suffering from hysteria that Freud first explored the unconscious, repression, and intrapsychic conflict. (Breuer and Freud, 1893-1895) First with hypnosis and then with his directive, abreactive technique, an early form of free association, he found that patients' symptoms could be understood as expressions of unacceptable desires and defenses against conscious recognition of those desires. As work with these early patients was done during the topographic phase of Freud's theory making, conflict was conceptualized as drives that were repressed both for being unacceptable to a globally defined socialized self and for being too strong for immediate dissipation and ventilation by the psychic system. Both led to repression, a concept used by Freud during this period interchangeably with defense. Strangulated drives found derivative expression in conversion symptoms, and in some patients, anxiety as well. Unconscious defense, unconscious guilt, and signal anxiety would not be part of psychoanalytic theory until the advent of the structural theory about 25 years later (Freud, 1923). These early patients were considered hysterics really because of the presence of conversion symptoms: psychological conflict, as conceptualized within the topographic model, expressed through a symbolic use of the soma. Hysteria and conversion symptom formation were synonymous.

With the diminishing appearance of conversion symptoms from psychoanalysts' practices during the first half of the 20th century, some have contended that hysteria has disappeared. The argument goes: people became more sophisticated, the culture grew more accepting of sexuality, so hysteria no longer could exist or needed to exist. (I should mention here as more than a footnote that conversion symptoms still appear fairly regularly in neurologists' and internists' practices. This will become understandable later). Putting that aside for a moment, if classic conversion symptoms (hysterical fits, psychogenic paralyses, hysterical blindness) have largely

disappeared from psychoanalysts' offices, why should analysts even consider hysteria to be a useful diagnostic reference point?

Hysteria, in my view, does continue to be a very useful concept theoretically and clinically if we broaden our understanding of it to include a truly psychoanalytic view of its underlying dynamics. In a basic sense Freud's definition of hysteria (as distinct from conversion symptoms) was strikingly unpsychoanalytic. It was based on the prevailing definitions of Janet and Charcot that an hysteric was someone who presented conversion reactions along with some other surface behavioral traits such as passivity, emotional lability, childishness, and flirtatiousness. Through much of the 20th century, the definition of hysteria in the psychoanalytic literature continued to be based on, paradoxically, not underlying dynamics (the core of a psychoanalytic diagnostic point of view), but on surface behavior traits! With a few exceptions, notably Kernberg's work (Kernberg, 1967) on borderline personality and Nagera's on obsessive-compulsive neurosis (Nagera, 1976), this has been unfortunately typical of psychoanalytic nosology. It may help explain why psychoanalysis has, in effect, given up on diagnosis and focused increasingly on technique and the study of psychoanalytic process. In many papers in these areas, the underlying dynamics of a particular patient's psychopathology, from a psychoanalytic point of view, are underemphasized or completely ignored. I think psychoanalysis' abandonment of the study of diagnosis has facilitated the regression in psychiatry to neo 19th century Kraepelinian diagnosis in the form of the DSM diagnostic schemes.

So we come to a choice point. If hysteria is just a label that refers to a person with certain surface behavioral traits and conversion symptoms, and if conversion symptoms have disappeared, why not just scrap the concept? This is an option which many clinicians have tacitly taken. A second option is to determine if there are some regularly occurring underlying dynamics that are found with some degree of consistency in certain people. Put another way, is there a type of character that we could usefully call hysterical character or hysterical personality? Considering that something called hysteria is among the oldest recorded medical conditions, it seemed to me when I began my study of this personality type to be presumptuous to write the epitaph of this disorder. In her history of hysteria Veith (1965) described the ancient Greeks' theory that hysteria was a condition in which the uterus wanders through the body, putting pressure on various organs that

then produce symptoms. Treatment involved trying to lure the uterus back into its natural place.

My position (Krohn, 1978), which I will now present, is that the concept of hysteria, if approached from a comprehensively psychoanalytic point of view has enduring value. So how to build a definition of this personality type. Hysterical personalities manifest traits and conflicts with origins during the oedipal phase of development without significant regression to anal or oral phases. They use as their major defense the developmentally advanced defense of repression. Preoedipal defenses such as projection, splitting, and the usual anal phase defenses of reaction formation, doing and undoing, isolation, and isolation of affect all occur but are infrequently employed defenses, seen under conditions of unusually great environmental stress. Though dissociation may be present, true psychotic withdrawal from reality does not occur.

The hysterical personality has traversed the preoedipal stages of libidinal and aggressive development generally successfully. The unconscious wishes that produce neurotic conflict within this type of personality involve triangular oedipal rivalries. The conflicts revolve around forbidden or frightening wishes toward incestuous objects (more specifically desires directed toward the mental representations of parents, often with associated childhood attitudes included in them). Although the specific nature of the intrapsychic conflict varies widely among individual cases of hysterical personality, the unconscious wishes in the male hysterical personality involve to a significant extent sexual longings for the mother and the fear of retaliation and castration from the father for such desires. In the male hysterical personality there is also often an emphasis, as well, on the negative oedipal conflict, involving an unconscious wish to replace mother and have an exclusive bond with father. In female hysterical personalities the unconscious wish involves a phallic-oedipal fantasy of replacing mother and being phallicly penetrated by father and obtaining a penis-child from him. In both sexes these wishes generate fears of losing the love of, being punished by, or killed by the rival parent. Unconscious guilt over competitive and parricidal wishes leads to neurotic conflict.

Let me address in this context the argument that hysteria lost its need to exist because the society became more accepting of sexuality. This argument ignores the simple fact that the conflicts in hysterical personalities (along with other neuroses) has less to do with sexual feelings permitted or

prohibited by the culture and much more to do with specifically incestuous sexual feelings and imagined acts, that is sexual desires toward parents. These are just as conflictual as they ever were and are taboo in all cultures.

What I have so far described begins our understanding of hysterical personality, but does not yet fully differentiate it from other types of personality organizations. So we go on to other distinguishing features.

Conflict in hysterical personalities is limited to certain areas of functioning, leaving others intact. Conflict often shows itself in close, intimate, sexual relationships, while work functioning may remain intact. At times when an unconscious fantasy is invoked in a work situation, that area may be more affected and personal, romantic, and sexual life less so. The hysterical personality does not show the pervasive dysfunction of ego and superego pathology seen in borderline, psychotic, and character disordered patients in whom virtually no area of life is unaffected by psychopathology.

The ego of the hysterical personality is crucial to our understanding of it. The ego has undergone substantial, successful development in early life. Though certain ego capacities are inhibited and others hypertrophied, the ego structure is not seriously distorted. Ego structure, indeed the whole personality, in the hysterical personality is close to what is considered normal or healthy.

The hysterical personality is capable of solid secondary process thinking and operates under its principles most of the time. Under the pressure of affect-laden situations or when an unconscious fantasy is provoked, there is a tendency to turn away from logical, cause and effect thinking and toward global, impressionistic, and vague thinking.

These aspects of cognition are part of a repressive style, a style that centers on not knowing. The hysterical personality is inclined toward defenses of "not knowing", "not seeing" and "not recognizing": repression, sudden blocking of thoughts, dissociation (and more subtle dissociative trends), and hysterical denial. Hysterical denial involves not seeing some aspect of a situation or person, such as those traits in a potential partner that do not accord with an oedipal fantasy of the ideal father or mother. Or not seeing some problematic aspect of an object in order to play out some self-punitive need under the auspices of the superego. Another dominant defense is displacement. As the hysterical personality is commonly struggling to

establish a fantasy tie to an incestuous object while avoiding taboos and imagined retaliations, displacement is a suitable defense. An object is sought that has some qualities of the tabooed object or is in some way associated with that object so that childhood desires are played out more safely with that person.

To avoid loss of love, the hysterical personality employs another defense variously described as living vicariously, having a pseudo self, or enlarging self boundaries to include a libidinal object. These are the many sides to the hysterical tendency toward identification. The underlying need in doing so can be guilt over wishes to displace a rival parent or a desire to be more attractive by assuming qualities perceived in the desired object or for some other intrapsychic purpose.

A few more aspects of the ego that are character expressions of repression: pseudo-stupidity and naiveté are character defenses that serve to avoid thinking unacceptable thoughts. Being dramatic, melodramatic, and flamboyant are commonly seen character traits that are in the service of the defensive proclamation: what I feel, and which you observe in me, is not me, it is a role. Being dramatic also contains the defensive use of an exaggerated form of an emotion to defend against the direct, much more heartfelt, non-dramatized experience of that same emotion. A big show of sadness may defend against a very painful experience of sadness of normal proportions.

Though embedded in what I've been saying, let me turn more directly to the nature of relationships in hysterical personalities. The hysterical person expects relationships to conform to unconscious infantile, fairy-tale images of love and romance and grows depressed, angry, or disengaged when an object fails to measure up to these fantasies. There is often a phase in forming relationships during which the hysterical personality, through hysterical denial, dissociation, or narrowed, wish-fulfilling cognition, manages not to see aspects of the object that do not correspond to the fantasy. With time the object's reality becomes undeniable and its lack of congruence with the infantile images causes serious disappointment. (This is all in contrast to more disturbed people, such as borderlines, who never have the capacity for accurate perceptions of other people).

Hysterical personalities' perceptions of others are anchored by basically stable, relatively differentiated and multifaceted object representations. Object images are not fluid or preambivalently split as in borderline

personalities. They are not subject to the intense, love-hate ambivalence seen in anal characters and obsessive-compulsive personalities. While objects may be idealized as part of an attempt to sustain the illusion that an infantile object has been found, there is fundamentally a rich spectrum of object representations available to the ego. Consistent with relatively advanced development, there is a capacity for basic trust. There is also object constant, as distinct from, need-satisfying, object relations as described by Fraiberg (1969)

To fully understand the nature of internalized object relations and actual relationships formed by hysterical personalities you must have a thorough understanding of the Oedipus complex. Here I'll be able only briefly to explore this, as a thorough understanding of this core complex is, of course, a vast subject in itself. The hysterical personality pursues a relationship patterned on unconscious wishes toward parents that have characteristics of a child's experience of them during the oedipal phase. The object and the relationship in adult life to the object must conform to an often complex and specific set of unconscious requirements. The hysterical personality is in pursuit of a relationship with certain qualities patterned on unconsciously remembered oedipal phase constructions of the parents' relationship with each other. These constructions are much more specific than constructions of relationships with origins in earlier development. The unconscious oedipal fantasy involves, of course, competition (and death wishes) with one parent for the prize of an exclusive relationship with the other. The fantasies include images of a powerful prince or king attaining the exclusive love of an idealized princess or queen. There are also images of the competitor as bad as in the wicked queen or stepmother. From a clinical point of view, this fairy tale quality of internalized object representations and actual relationships is often one of the first signs that one is dealing with an hysterical personality.

Many relationships are viewed as competitions (if not battles) with someone for "possession" of the love object. The competition is to be the most phallicly superior or admired – to be looked upon as the strongest, smartest or most beautiful. The object sought is often viewed as a prize or trophy. It is often experienced as taboo, off-limits, or forbidden. A pattern of repeated relationships with "unavailable" objects, such as married men or women, is common. The unavailability represents the unconscious incestuous significance of the object. Once the object is attained, there is commonly a loss of interest in him or her. The object is no longer unattainable and

therefore ceases to be experienced as the desired oedipal object. In some hysterical personalities to defend against awareness of oedipal desires, objects are sought that are either "madonnas" or "whores," but not both, as Freud (1910) described. For women the comparable syndrome is to have sexual feelings for the "bad boys" while affectionate and loving, but non-sexual feelings are directed toward the responsible, less flashy men.

As well, the experience of objects and wishes directed toward others have the imprint of the outlook of a 3-6 year old child. While I have emphasized the relatively developmentally advanced nature of hysterical personalities, we must keep in mind that the fixations they evidence are still from ages 3-6, much before true genitality and the more mature, differentiated understanding of relationships associated with latency, adolescence, no less adulthood.

I want to stress that to fully understand an individual patient with hysterical personality demands a thorough understanding of the Oedipus complex as it plays itself out in a particular patient. Such dimensions as the active or passive nature of phallic phase strivings or the relative importance of positive versus negative oedipal dynamics will determine object choice, the nature of the desires toward the object, desired sexual practices, self image, among many other things. Understanding hysterical personality means understanding the Oedipus complex in all its variations. In my book I spell out the ways these specific variations manifest themselves in constellations of behavior, object choice, and neurotic conflict, but unfortunately I cannot cover all of this here.

All along I've been alluding to how the hysterical personality is different from the borderline or more disturbed personalities. It is also useful briefly to comment on the differences between the hysterical personality and the other major neurotic constellation, the obsessive compulsive personality. The whole stance of the hysterical personality is to use defenses that take the self out of the locus of control of thoughts and feelings. The character style revolves around feeling oneself the victim of something that has overtaken and directed the self. This is possible because developmentally the anal phase needs for hypercontrol of the self and willful domination over others have been fairly well left behind. In the obsessive compulsive personality there are, in contrast, powerful needs to feel in control of much that is not inherently controllable: emotions (especially anal sadistic ones), the dangers of the world, and the actions of others. So the obsessive compulsive is

seeking through magical thinking, ritualistic behavior and other defensive means to play out a desire on the level of the self to feel all is somehow under the control of the self. The hysterical personality is very willing to consciously feel submissive to forces outside his or her control (though unconsciously may be enacting very active desires), while the obsessive compulsive personality is seeking to feel in control of that which is not controllable such as danger, injury, loss, death, or the surging of his or her own aggressive, sadistic feelings.

There are also struggles around narcissism in the hysterical personality. When problems around narcissism are discussed within psychoanalysis, there is, unfortunately, an inclination to assume we are discussing difficulties reflective of basic, severe pathology of object relations and self-structure development dating to the first two years of life. Of course, severe forms of narcissistic pathology do have these early origins. But narcissism, like libidinal development, has its own line of development in Anna Freud's sense. There are aspects of phallic narcissism described by Annie Reich that bare on our understanding of hysterical personality. In hysterical personalities there is often an unconscious knowledge dating to the oedipal phase that even if the oedipal battle is won, the self is still a 3-6 year old child, smaller, weaker, less physically and sexually endowed than adults. Many female hysterical personalities feel they are not pretty enough or smart enough to be with an adult man. They often feel unconsciously to be little girls. Male hysterical personalities feel they are not strong enough, with big enough penises, to satisfy adult women. There are often compensatory efforts arising from these narcissistic dynamics; in men needing to show off by flaunting power, money, sexual desirability or sexual exploits, in women becoming preoccupied with looks, clothes, and collecting signs of being attractive to men. The diminished, narcissistically injured sense of the self can, of course, sit side by side with compensatory inflations of the self's power and sexual attributes,

The superego in the hysterical personality has a basic integrity, neither rigid nor uncompromising. It lacks the moral masochism and self-directed sadism seen in obsessive compulsive personalities. As the content of the superego can be amended and altered in accord with what is pleasing to certain important objects, it can appear to be weak. At its core, however, such peoples' attitudes and behavior are governed by a fairly high adherence to the dictates of their conscience. Part of the reason for basically high moral

functioning is that their generally advanced level of object representations brings with it empathy for others which in turn brings with it moral imperatives. A decided weakness in the superego of the hysterical personality arises from the need to sustain the illusion that responsibility and accountability are in the hands of another person or some force outside the self. It is to this quality of the hysterical ego to which I will now turn.

What I have described so far takes us quite a way to defining hysterical personality and understanding its underlying dynamics. But to fully understand a key aspect of ego functioning and overall personality organization in this type of personality we must return to where we started -- to the problem of the relationship between hysterical personality and conversion symptoms and why conversion symptoms are rarely seen these days in analysts' offices. To address this problem we must step back and approach hysterical personality historically and cross culturally. We must understand the way the ego in the hysterical personality uses the forms of his or her own culture.

When considered within a particular culture, the definition of hysteria remains elusive because the definition rests largely on the way in which this personality type uses cultural forms, regardless of the culture-specific content of these forms. The hysterical personality uses the dominant forms of his or her culture in a particular way to resolve conflict. Hysterical personality, therefore, assumes as wide a variety of overt forms as there are variations among cultures. Only when hysterical personality is viewed in its many specific manifestations across cultures do its common, basic structural features emerge. Hysterical personality can be defined as a personality type that plays out dominant, current cultural identities often to a marginal but never to a socially alienating extreme, in an attempt to promote an illusion of passivity. Though its overt forms have changed, its essential structural properties and unconscious conflicts have endured.

The illusion of passivity refers to an attempt to disown, both internally and interpersonally, responsibility in the broadest sense for thoughts, acts, and impulses. The hysterical personality promotes a sense within himself that he did not actively choose to have certain feelings, to make certain choices, or to entertain certain thoughts. So in some cultures, spiritual forces, not the personal will, are considered responsible for personal acts, choices, or desires. In other cultures the play of physical, biological, or even

psychological forces are used by the hysterical person to explain and disown a wish or act.

Let us turn now to some historical and cross-cultural examples of hysterical personality. First the "victims" of witchcraft, mostly women. The victims of witchcraft in both New England and earlier in Europe participated in prevailing myths of their cultures, myths that the Devil or witch could wrest control of the body and mind and use it for their own purposes. The bewitched was not to be held accountable for her behavior, for she was the unwilling victim of the will of another. The fits, anesthesias, and spells suffered by the victims were not the victim's, but the devil's, doing. The victim could also disown her wishes to gain support, sympathy and attention. In Salem many of these "victims" were adolescent girls who claimed older women were witches. We can speculate about the oedipal strivings at work in these girls, strivings that could be disowned through the illusion of passivity fostered by their culture's sacred beliefs.

The Apache shaman is another example: the Apache shaman demonstrates how adaptive the hysterical resolution can be. The duties of the shaman include making contact with ghosts and spirits for others in the culture. The Apache belief is that shamans are recruited during adolescence by homeless spirits. The shaman sees himself as an emissary to the spirit world, capable of calling upon and mediating between sources of awesome and frightening power and people in his culture, while paradoxically being himself a relatively powerless usher or channeler of such wonders. Similar to the witchcraft victim, the shaman is not himself responsible for the powers that work through him. Though he may command awe and respect for being the vessel that can hold these forces (and rid someone suffering from some evil spirit by absorbing these toxic demons into himself), the forces themselves are not his. He feels himself to be passive to forces that work through him.

Now to Freud's hysterics, the Victorian ones. To fully understand Victorian hysteria in the United States or Europe, especially in females, demands an analysis of the cultural and social strains on women during that era. I discuss this in my book, but time will limit the extent of my discussion of the full topic here. I will deal here then with only a few of the roots of Victorian hysteria. The Victorian hysterical personalities used conversion symptoms. As is typical of hysterical personalities, she expressed her conflicts using a set of ideas that were coming into their own in her culture -- in this case the culture's new view of the body. With the ascendance of the

germ theory in the second half of the 19th century, the culture was taken with the notion that something could invade the body and make it sick. As well, drawing on social expectations that a woman should seem passive and weak, it was considered natural that a woman would get sick and "take to bed" instead of acknowledging that she had some unwelcome wishes or desires. To love or hate strongly and overtly were close to impossible for the Victorian woman. To be weak and sick, however, were considered basic to feminine nature. To fall ill became one of the few ways within the limits of Victorian convention through which a woman could express inner passions and conflicts. (Of course, outside the limits of convention, a psychotic or schizoid personality, as in every culture, expressed his or her response to conflict by the standards of the culture much more deviantly.). Due probably to the advances in the study of disease and to the growing secularization of the culture, concern with vulnerability to disease replaced earlier fears of divine vengeance. "These are not my hatreds, loves, or ambivalences, but owing to the disease that has overtaken me" was the ego attitude of the Victorian hysterical personality. It was a solution which in characteristic hysterical fashion remained solidly within the limits of propriety and conventionality and at the same time aroused enough concern, concern merited by one who is ill, to enlist the attention of people from whom to receive and toward whom to express, in disguised forms, the loves and hatreds unacceptable in the Victorian woman. Illness, in the form of conversion reactions, became a symptomatic way by which tabooed thoughts, feelings, and wishes could be disowned and, through the body, symbolically expressed. Unraveling these symbols and tracing their roots in the hysteric's history was, of course, one of Freud's first psychoanalytic accomplishments.

Modern psychiatry and psychoanalysis were misled by Victorian hysterical personalities' use of somatization. Both fields generalized from the Victorian hysterical personality's use of conversion, considering hysteria to be virtually the same as conversion. The Victorian hysteric, with her conversion reactions, was modern psychiatry's first exposure to hysteria, an historical accident that had some unfortunate consequences for later thinking about the disorder. Because hysteria expressed itself as mock disease during that period, the disorder came to be considered, implicitly or explicitly, as a disease of physical symptoms of psychological origin. So as the 20th century began, hysteria was known as the imitator of disease. Hysteria was conversion and conversion was hysteria. Unfortunately as hysteria came to assume new forms with changes in the culture, as is its very essence, the

theory of hysteria, lagging behind, persisted in trying to conceptualize it as a disease of psychogenically produced physical symptoms. As conversion symptoms showed themselves with less frequency in clinical practice, some contended that hysteria was disappearing. Within psychoanalysis Fenichel (1945) made a respectable attempt to define and describe hysteria based on underlying dynamics, but his description was very abstract and overly focused on unconscious fantasy. Horowitz (1977) did an extensive review of the literature on hysterical personality and provided interesting case illustrations, but never really distilled, in my opinion, a clear definition of the personality organization.

Over the past 100 years hysteria has changed in accordance with changing cultural trends. In Western culture especially women, but men as well, have been accorded greater freedom to use alloplastic, active alternatives. This allowed hysteria to express itself as a pattern of life choices. With this expanded range of interpersonal action hysterical solutions were no longer limited to the autoplastic alternative of falling ill. Hysteria ceased to express itself exclusively as a mimicry of physical disease and mapped itself out as a general pattern of personal action. Where the Victorian hysteric expressed feelings and thoughts unacceptable in consciousness by symbolization of body parts, the modern hysterical personality, making use of new social options, came to use the avenue of object choice and identification to express unconscious strivings and to maintain the ubiquitous hysterical illusion of passivity. For example, a female hysterical personality might unconsciously identify with qualities of her mother as seen during the oedipal phase and choose a man with qualities associated with her picture of her father from the same phase. She might do this even if she is very different from her mother and is seeking men who are not fundamentally to her liking.

During the 20th century, consistent with the essence of hysterical personality to draw upon current, in vogue, cultural modes, to play out an illusion of passivity, it has continued to change its overt form. Briefly here are few of the incarnations of the hysterical personality: With the new social prerogatives afforded women, combined with remnants of Victorian myths of women as weak, innocent, and intellectually inferior, the first half of the twentieth century witnessed the popular stereotype of the "dumb blonde" who is unwittingly seductive yet psychologically, if not physically, virginal. Parts played by Marilyn Monroe epitomized this twentieth century myth of the naïve, childish woman. It is this American myth of feminine passivity

that many twentieth century hysterical personalities made part of their character style. The catalogue of hysterical character traits put together by Easser and Lesser (1965) culled from the literature on hysterical character – labile emotionality, suggestibility, excitability, acting like a flighty child-woman essentially describe this stereotype.

The popularization of psychology and psychoanalysis in the United States during the middle of the 20th century led to another version of hysteria. Just as the scientific study of physical disease in the 19th century supplied metaphors which led to the experience within the hysterical personality that her body was overtaking her with physical symptoms, so with the discoveries of Freud that thoughts, feelings, and motivations can influence us, the hysterical personality came to feel: I am the passive victim of my feelings, a victim of a popularized idea of the unconscious. Just as she had been prey to a wandering uterus in ancient Egypt, or the power of the Devil or a witch in the middle ages, or physical disease during the Victorian era, now she could experience herself as passive in relation to psychological forces outside her control. Rather than resorting to illness (such as conversion) or invalidism to disown, and at the same time express, for example, her resentment, she could now express and disavow such feelings by claiming to herself and others that "the feelings just came over me. I don't know what happened, all of a sudden I was overtaken by my emotions." In short, she was now the victim of her psyche as in other times she had been at the mercy of spirits or disease. In all these cases, we need to keep in mind that this all functions to play out underlying struggles of a mostly oedipal nature.

Some even more current expressions of the hysterical ego attitude: During the 1960's the hysterical ego attitude was that feelings, actions, and thoughts were the sole result of social and political forces. Other myths of passivity of that decade were passivity to one's diet, "you are what you eat." In the last 10 or so years there has been a tendency for hysterical personalities to feel passive to one of many syndromes, some medical, some psychological. Feeling oneself to be the passive victim of complexes described in self-help books such as the Cinderella complex. Or being the victim of an "addiction" such as a sex addiction (or any of a vast variety of other so-called addictions). Chronic fatigue and fibromyalgia may be genuine medical conditions. In hysterical personalities they can be unconsciously mimicked. While some people with eating disorders have very severe oral phase struggles with separation anxiety at the core, others are hysterical

personalities who are unconsciously mimicking this syndrome, using it to play out oedipal level dynamics. Or just as some people have genuine multiple personality disorders, when that diagnosis became widely discussed and written about, there emerged a small army of people with this problem. Real multiple personality disorders do exist, but they are, as they have always been, rare. So here again the hysterical personality adopts this syndrome to play out his or her intrapsychic conflicts, most of which are oedipal in nature. Another current form of the hysterical ego attitude of defensive passivity is to feel that everything one does or is is the result of one's genes. Because major new discoveries are being made about the role of genes in the formation of our physical and psychological selves, a current hysterical personality can toss off responsibility for some wish or action with "I guess it's just in my genes."

The popularization of the concept of "stress" has provided the raw material for another current hysterical character attitude. Instead of facing internal wishes or desires the hysterical personality can feel upset by "stressors." An hysterical personality I treat spoke of his mother-in-law's constant phone calling to his wife as being "a stressor in my life." He was feeling himself to be the passive victim of her behavior rather than facing his impulses toward her, connected in many ways with his hostile feelings, including death wishes, toward his own emotionally eruptive, intrusive mother. By not facing these feelings he was inclined unconsciously to act out an identification with his mother by being loud and intrusive with his wife and children. Related to this is the character defensive position that what the self feels or does is the result of trauma and abuse. Again there are many people who have been traumatized and abused, but the hysterical personality unconsciously enacts this as a character defense.

The sense of being the victim of trauma is connected with another modern form of hysteria, the "recovered memory" craze. The patient submits to and joins with a therapist's notion that a traumatic experience is making her/him sick. Again, this is actually true of some, probably small group of, patients, but in hysterical personalities, as "recovered memory" treatment has been written about in magazines and discussed on TV, it becomes a cultural form that can be unconsciously fashioned into a myth of passivity. A variant of this is the fantasy of being victimized by people performing satanic rituals. Some people who claim this are, of course, much more disturbed, even psychotic, but there are hysterical personalities who play this fantasy out. Another current version of this hysterical ego attitude views brain biology as

the source of all of a person's behavior and feelings. As important discoveries are made in the area of neurobiology and psychopharmacology, hysterical personalities can use these culturally current discoveries to play out his or her neurotic attitudes. What I do and feel is not really motivated by my wishes or desires, it is the result of what my brain physiology is making me do or feel. In each of these cases these cultural currents are recruited to play out conflicts that are predominantly oedipal, in the context of an ego that uses higher level defenses, fairly developmentally advanced object relations, and the other ego and superego structural features described earlier.

I said at the beginning of this presentation that it will become understandable why hysterical personalities who use conversion symptoms still appear, but now in neurologists' and internists' offices. This is because in those medical contexts, a physical symptom of supposedly physiological origin still has great currency. Just as a "recovered memory" therapist provides an interpersonal framework for the idea that all of a patient's problems are due to some unremembered event, so a physician provides the context where symptoms may be viewed as caused by something being wrong with the brain or body. Psychoanalysts certainly and many psychiatrists these days as well are less likely to assume such symptoms to be physical and wonder about the motives and feelings behind them. This context threatens to unveil the underlying motivations which is exactly what hysterical personalities in all forms are trying to avoid.

Understanding the hysterical personality's use of cultural forms to play out an illusion of passivity is significant in two ways: First, it is crucial to seeing through the era and culture specific manifestations of the hysterical personality toward the goal of defining hysterical personality universally. Second, the hysterical personality's sensitivity to new, just in vogue, cultural forms reflects a quality, one might call it a strength, of the hysterical personality's ego and object relations: that is an ability to be sensitive to what is happening in people and in the culture, an intuneness with the people and the environment, a social sense. This can be characterized as an intuitiveness about people, an awareness of style and custom, and an ability to pick up beliefs and attitudes of others. The hysterical personality's ego then goes on to craft what is picked up from the environment to make a character style including adaptive and defensive modes of functioning.

I'll now present another current example of the way the hysterical personality operates through a brief case illustration. The subtle, but powerful effects of cultural stereotypes and prejudices of people based on their race, ethnicity, and religion are being now very appropriately recognized and highlighted in our society. Cultural sensitivity to these issues has been long overdue. But here again this current focus can be recruited by hysterical personalities. A single 27 year old female hysterical personality, a resident in pediatrics, born and raised in New York City of Indian-American parents, considered virtually everything she felt, thought, or wished to be the result of others' pressures on her to behave in a particular way based on her race, ethnicity and religion. She could avoid recognizing wishes as her own and guilt for her actions as her own. This character attitude that she could be magically taken over by or transformed by others showed itself, too, in feeling that if she were in the presence of people, typically men, whom she viewed as strong, their strength would somehow pass into her and make her strong. Conversely when she had social contact with people whom she viewed as weak and passive, she couldn't stand to be in the same room with them. As we analyzed this feeling in connection with a friend whom she saw as an accommodator, a peacemaker, a timid woman, the preconscious thought rushed into her awareness and she said, "that woman will infect me with her wussiness." This patient was continually working to repair feelings of defectiveness arising from a major castration complex by continually looking for people, mostly men, from whom she could get coaching, mentoring, and guidance, even though this collided with her sense of independence and her belief in the equality of women. Her oedipal struggles had major active phallic elements inflamed by wishes to be her father or older brother who had a very close relationship with each other, a tie from which she felt painfully excluded. She struggled with an unconscious belief that she was like her passive, weak, ineffective, periodically substance abusing mother and a wish to be like her phallic phase experience of her father as strong in his rigid, authoritarian attitudes. She often acted like this image of the father with her fiancé whom she viewed as weak and whom she needed to be weak. Later in this patient's analysis she used a similar character defense to disown positive oedipal, competitive impulses. She talked about the competitive atmosphere of medicine "making me feel" competitive with a fellow female resident for the attention of several attending doctors. As the defense was analyzed, she could "remember" her "mean-spirited" comparisons of sexual attractiveness, especially her pleasurable feelings, her shadenfreud, about the friend's acne

scars. This in turn brought to mind adolescent memories of pleasure at her mother's overweight.

Feeling passive to a fantasy of an idealized, imagined, fairy tale relationship can be another manifestation of an hysterical ego style. This tendency, along with other features of the hysterical personality, will be illustrated in the following, more extensive, case example of a male hysterical personality.

The patient is a man in his late 30's of medium height, muscular build, strong voice, intelligent, articulate. Originally from Toronto, he has lived in Michigan for the past 15 years. He has never married and has no children. He dresses with a studied casualness, gestures largely as he talks, seems to be striking actorly poses and has in general a dramatic quality, illustrated by his making lying down on the couch look like a gymnastic move, with an outstretched arm, locked at the elbow, that he rotates around as he lies down.

His day job is driving a shuttle for the University. More important to him is his evening and weekend work as a personal trainer and owner of a small gym. He has aspired to do much more with his physical training interest such as becoming a physical education teacher, organizing exercise-diet workshops, or becoming a martial arts instructor, but he has never felt he could do any of this. Though he is intelligent, articulate, and writes well, he never attended college. Though he has thought often about going to college, something he can't describe holds him back. He remembers even as young as eight feeling that when other kids were thinking about driving ahead in life, he was puzzled and confused as to how to do this. His life has been limited by inhibitions of ambition, achievement, and competition. Paradoxically and tellingly, he is often caught up with gauging other men's intelligence, attractiveness, and success with women and comparing these men with himself. His body language is that of power and strength which are, of course, very much part of his work as a personal trainer. His voice tone and behavior can be very confronting, but when I commented on this to him, he was surprised and very apologetic. He sees himself as nice, quiet and meek. On one occasion when a personal training client of his described him as physically formidable, he was pleased, but very surprised. So, he unconsciously is very phallic in his behavior and pursuits, but at the same time inhibits these and in larger areas of his life has been self-castrating. In the sports area, he was very good at basketball as a kid when playing with other kids, but at tryouts where competition was involved and adults were evaluating him, he clutched and didn't make the team.

He came for analysis after a succession of relationships with women he knew were intelligent, attractive, warm, good people. Unlike some neurotic men, he makes good choices in women. The problem is that after about three months he grows disappointed with each woman. He becomes aware of and preoccupied with their flaws. He then idealizes past women or possible future ones and then gets distant and decreasingly sexual with the woman he is currently with. They end up leaving him. I'll sketch out the overdetermined meanings of this pattern as we've pieced them together in the analysis: no woman will ever live up to his fantasy of his mother who felt he could do no wrong. If he remains uncommitted to any woman, a place is left open for his mother. He externalizes his own phallic phase sense of having flaws, caused in part by comparisons with his harsh, crude, degrading father who was loud, combative with neighbors, and from time to time physically abusive to the patient. He continually seeks new relationships because during the courting phase there is praise of him and excitement about him, which serves to shore up phallic-narcissistic vulnerabilities. He also wants the perfectly attractive woman for the imagined admiration it would bring to him in the eyes of other men. The patient is often very caught up with concerns about how he looks to others, with his experience of himself ranging from very strong and sexy to dumb and awkward (essentially castrated). In typical male hysterical fashion the experience of the self as small and weak is, at times, defended against with an overinflation of the sense of self, a phallic grandiosity, along with accompanying body language. Yet when castration anxiety is ascendant within him, he will use the feeling of being small and weak to defend against competitive urges that are associated with his father's arrogant, superior, often bellicose behavior. The oedipal wish to be like the father or to surpass him on the father's own terms, such as fantasies of defeating him in a physical fight, is fended off by feeling weak. Succeeding and excelling are unconsciously equated with physically defeating and killing his father and therefore must be undermined. The image of the perfect woman in typical hysterical fashion is very much that of a princess, including an excessive involvement with her appearance and a fantasy that they will be continuously sexually aroused by each other. Finally, his critical attitude toward each current woman keeps him in a removed, judging position to avoid what he feels to be a feminine, babyish surrender to strong emotions. So all this is condensed and played out in his pattern of object disappointments.

And what is so characteristically hysterical is his stance toward his problem of questing after the next or last perfect woman. He feels himself to be the passive victim of his problem, under the sway of it, a helpless victim of it, In the transference he maintains an overtly submissive position with me that fends off oedipal competitive strivings. He hopes that I as his analyst will rid him of his problem, while he passively submits to the treatment. There is little real ownership of the wishes, desires, fantasies, and irrationalities contained in this quest.

Another way this ego style shows itself: In one session he spoke of his mind being so fucked up. I just can't stop this selective memory thing (remembering only positive things about past, failed relationships), my unconscious is just so messed up, I have no control over any of this. For brief moments he can step back and see that it is *his* selective memory that makes him forget the dull or disappointing aspects of a previous woman and also to exaggerate the good things. For brief moments he can see that it is he that is doing this. But he then returns to feeling he's powerless to control it. Regularly he'll ask me to tell him what his problems are, to go over what we have many times discovered, and what I can do to change him. I work with him on how this question expresses a problem: he needs to disown what he is doing, feeling the problems are outside himself. I will tell him what they are, while he passively listens. He doesn't own the problem, doesn't put himself behind the wheel of his own car, his own mind, his own wishes. In essence what he does is to see things as he wishes them to be. He refuses to see that an ideal, fairy tale woman and relationship is not possible, because then he would have to recognize that it's a fantasy, his fantasy, an unrealizable fantasy, and he would have to give it up. In one session after I made this interpretation he talked about how he keeps himself confused about what he really feels, unlike the clarity he thinks he'd have about his feelings if, say, his mother died. I pointed out to him that to own what he's wishing for and to realize the impossibility of these wishes is to let his larger than life desire for the mother he remembers as a four year old die.

In typical hysterical fashion he sees himself as a little boy. As a boy passes through the phallic phase, his narcissism is assaulted by the recognition that he is not an adult man with adult man's body and an adult's rights and prerogatives. During sex he felt from time to time that the woman was too large for him, that her body was big and his was small. The defenses against that self experience are also typical phallic oedipal ones: he carried his body with a four year old boastfulness, a kind swagger, like a little boy trying to

look like a cartoon or comic book superhero. There was, too, a phallic phase exhibitionism that showed itself in his preoccupation with how people would see and evaluate his looks, strength and, via displacement upward, his intelligence. Wanting to be seen with a beautiful woman was also, of course, both an expression of a phallic phase desire to be a strong manly man with the princess/queen/mother and a defense against his little boy experience of himself as small and weak. The underlying feeling of smallness and weakness would, however, show through in a painful self-consciousness in social situations about being seen as awkward and stupid.

As with any psychopathology a fully psychoanalytic diagnosis is made through discovery of what lines of interpretation lead to confirming data, deepening of material, or therapeutic change. A key line of interpretation with this man finally revolved around the ways his feelings of fear of being humiliated, looked down on, and injured in imagined fights were rectified and psychologically redressed by thinking of himself as a sexy man with an extremely attractive woman. Even more interesting was that the state of being sexually attracted and aroused (which he craved and which he would temporarily find with each new woman) quieted his fears of being small and scared. As we have pieced together the nature of his fantasy of the woman he seeks, it has become clear that she is like a "princess in a fairy tale." How this oedipal wish is handled by his hysterical ego is illustrated by his talking about how he is so under the sway of his "princess complex," a syndrome that causes him to feel what he does. He feels the imagined woman's attractiveness takes over, and he is powerless. So he uses this illusion of passivity to avoid conscious recognition that these wishes are his and further to avoid seeing the nature of these wishes: that they are unconscious desires for his oedipal phase mother. To illustrate this connection to his mother: he often thought about an incident with a particular woman from his past, retrospectively idealized of course, who on their first date intuited that he would like a particular novel that turned out to be his favorite. This was absolute magic for him. At several points in the treatment he reported a memory of coming home from first grade and his mother asking him to come upstairs to his bedroom where to his absolute delight she gave him a new Hardy Boys mystery which he loved. Before I pointed out the connection to him, he had no conscious recognition that the idealized woman's behavior was, in his mind, a duplicate of the memory of his mother. In the memory of the mother you can, of course, hear the fantasy of a seduction by her. This mother was not in any way inappropriate

with her son – his wishes gave the screen memory its seductive, sexual overtones.

I should mention here that the maternally based fantasy of the ideal woman had some significant bisexual elements. Following a dream of a unicorn there were a series of sessions in which he talked about one of the women from his past whom he longed for who could talk about sports and other things "like a guy." He said: she had breasts, a vagina, and a nice body, but she was otherwise just like a guy. This seemed to me not a preoedipal desire for a phallic mother but more a disguised desire for a passive submission to the father.

Another meaning of this patient's problematic relationship pattern was that as he came to know a particular woman as a person, as a "companion," he would feel a decreasing amount of sexual desire for her. This is part of a madonna/whore defensive position that Freud (1910) described. When a woman is loved affectionately "as a person" and is the object of sexual feelings, this comes too close to reviving childhood oedipal fantasies and with it castration anxiety and other fears. So as he gets closer to a woman, he has to shut down the sexual component of his feelings toward her and look toward the next woman who he thinks about in non-companion, strictly erotic ways.

This all happened in the context of a man whose ego structure and range of object representations reflected a great deal of solid development. He had, outside his romantic relationships, the capacity for three dimensional views of other people. He had achieved object constancy and with it empathy. He could delay and channel impulses and had good reality testing.

He also had an intact superego. He was a man of his word, played by the rules, and was true to commitments he made to others.

There was an absence of primitive splitting and the oscillation between rage and oceanic feelings of love seen in borderline patients. He did not have the intense active-passive, love-hate ambivalences seen in obsessive-compulsive people. There were no struggles with sadistic impulses toward others and the severe self-criticism when these are turned against the self. Though he had preoccupations about how he was viewed by others, these were not concerns that reflected a primitive fear of self-dissolution or self-disintegration. In fact, we were able to get some insight into his intense self-

consciousness; it had phallic exhibitionistic elements (that is behind the fear of being seen was the wish to be seen), but even more interesting this self-consciousness came to be understood as having a self-controlling function which, if it were absent, he feared would open him up to being "an aggressive son-on-a-bitch" like his father. It would also, "get me in trouble with other men, feeling I'd gone over some line in being way too confronting." So there was here a kind of counter-identification with father to fend off a more deeply repressed wish to be like him. To be like him brought up two intrapsychic problems: it risked unearthing memories of being the victim of his abuse and more importantly led him to fear retaliation from others for his aggressive wishes. This is classic Little Hans type projection of aggressive, murderous wishes and then fear of injury from the object onto whom the wishes have been projected. This patient presented continually the following resistance when I would point something out to him: "I can see that what you're saying is true, but what do I do with it?" The analytic work was being defensively processed as me saying things to him which he passively hears, but which he avoids actively engaging and embracing. He would say my mind or my unconscious are just so fucked up there's nothing I can do.

Leslie Farber (1961) wrote: "an hysteric makes sexuality of the therapist's science, while the therapist makes science out of sexuality. In this affair, the hysteric has the advantage, there being more sex to science than vice-versa." This is still true and has implications for what hysterical personalities, like the patient described, can do with the psychoanalytic situation. As psychoanalysts we work to help patients recognize that there are forces outside their awareness and conscious control that can have enormous effects on what they do and feel. This outlook is an important component of the working alliance. It is basic to Sterba's (1934) therapeutic ego split on which an analytic process depends. That process has as its ultimate aim to foster in the patient an ownership of, and to some degree control over, what is in his or her unconscious. But this notion of an unconscious that exerts control over the self can be drawn into the character defensive and ego-attitudinal proclivities of the hysterical personality and constitute a major resistance. In this way the analytic situation itself can become a kind of micro-environment in which the hysterical personality can play out yet another version of itself. This character style and the defenses and ego attitudes contained in it need to be well understood by psychoanalysts and psychotherapists treating these patients.

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