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The Hysterical Personality

Before proceeding to discuss some of the difficulties which the psychotherapist may encounter in treating different types of person, I should like to outline what has been said in the previous chapters about the nature of the therapist's task.

His first duty is to provide a secure, reliable background of personal concern against which the patient can develop. Just as a child may be assumed to develop toward maturity in the best way if he is fortunate enough to live in a stable home in which continuing care is taken for granted, so it is assumed that neurotic patients are more likely to learn to understand themselves and to cope better with their personal problems if they are provided with a secure base in the shape of a therapist to whom they can turn as a caring, concerned person.

His second duty is to get to know his patient sufficiently intimately to make sense both of the patient's symptoms and also of his personality as a whole. This involves having a clear picture of how the patient developed from early childhood onwards. Although the acquisition of such understanding does not necessarily abolish all his symptoms nor bring about radical or sudden changes in character structure, it does enable the person to stand back from himself; to look at himself in much the same way as the therapist does, with an eye both critical and sympathetic. The capacity to regard oneself as one is, seems to me to be a prerequisite for change. Neurotic patients who seek psychotherapy do so not because their psychopathology is very

different from that of so-called normal people, but because they are overwhelmed or demoralised by their psychopathology. When they can stand back from their own personalities and problems, and apply critical understanding to them, they are on the way to achieving some degree of mastery.

The psychotherapist's third duty is to provide the patient with an opportunity to improve his interpersonal relationships by being a person with whom the patient can interact. He does this first, by providing himself as a more or less unknown quantity upon whom the patient will project the images of those persons who have been emotionally significant to him in the past; and second, by making the patient aware in the here-and-now of how those images and the assumptions which accompany them are interfering with his making positive relationships on equal terms with people he encounters in ordinary life. As the patient's capacity to relate to the therapist without negative assumptions derived from the past increases, so, in most cases, does his capacity to relate to other people outside the therapeutic situation.

I turn now to the consideration of some of the difficulties which the psychotherapist may encounter in applying these principles to the treatment of different types of personality.

The next four chapters are concerned more with types of personality than with discussion of particular neurotic symptoms. This is because I believe that psychotherapy today is more concerned with understanding patients as whole persons than with the abolition of particular symptoms direct. This topic will be more thoroughly explored in a later chapter. In considering different types of personality, I have adopted the conventional psychiatric classification of hysterical, depressive, obsessional and schizoid. These terms are far from satisfactory, and do scant justice to the extraordinary range and complexity of human character; but they do at least provide a rough categorisation which is better than nothing as a start.

The terms 'hysteria' and 'hysterical personality' are so misused as terms of abuse that the heart of the psychotherapist is apt to sink when he hears that a patient with such a label attached is being referred to him. Moreover, he may imagine that he will be unable to understand such a patient, because of his lack of capacity to identify himself with this type of person-

ality. Whilst most psychiatrists are ready enough to admit that they themselves can become depressed, suffer from various forms of anxiety, exhibit some obsessional traits or symptoms, or are capable of the detachment we label schizoid, they are usually very reluctant to recognise or admit the existence of any 'hysterical' components within themselves. Hysterical personalities are therefore apt to seem more alien than the other kinds of people whom the therapist comes across in his work. And yet, hysterical patients were not only those upon whose psychopathology the early structure of psychoanalysis was built, but were also those who seem best to have responded to treatment.

Today the psychotherapist is unlikely to see the dramatic cases of hysteria so vividly described by nineteenth-century psychiatrists. Gross hysterical paralyses, blindness, deafness, 'glove and stocking anaesthesia', fits, tremors and faints have become rare manifestations of neurosis. And, although we may all have patches of amnesia for upsetting happenings which we should rather not recall, fugues, in which the subject experiences massive amnesia for large areas of the past and finds himself in a strange place without knowing how he got there are not phenomena which the psychotherapist practising in out-patient clinics or private consulting-rooms is likely often to encounter. But 'hysterical personalities' who are prone to develop hysterical symptoms of a less dramatic kind are common enough. The best definition of the hysterical personality which I have come across is that given by Slavney and McHeigh (quoted in *The Harvard Guide to Modern Psychiatry*[1]): 'The hysterical personality is dominated by the urgent need to please others in order to master the fear of being unable to do so. This results in restless activity, dramatisation and exaggeration, seductiveness, either social or overtly sexual in manner (often creating disappointment in the other person), and immature and unrealistic dependence upon others.'

The most characteristic feature of an hysterical symptom is that it serves a purpose of which the patient is unaware, or only partially aware. This purpose is, therefore, at first denied by the patient. Hysterical symptoms tend to serve three main purposes. First, they may enable the patient to evade situations which are distasteful, frightening, or potentially humiliating.

'Convenient' headaches are typical hysterical symptoms. Psychotherapists who believe themselves free of hysterical potentialities should search through their memories of childhood. They are likely to find at least one example from their own experience of a physical symptom which conveniently appeared to let them off some boring or alarming occasion, and as conveniently disappeared again when the occasion was safely past.

Second, the symptom may serve the purpose of revenge or punishment of people toward whom the patient feels resentful, whether or not this resentment is objectively justified. Frigidity, for example, is as often a stick with which to beat the patient's husband as it is an expression of distaste for the sexual act.

Third, the symptom may serve the purpose of attracting sympathy or at least attention. Patients of this kind are frightened of making direct demands on people, and therefore draw attention to their distress and need for help by developing symptoms which require that others should pay attention to them.

Patients presenting hysterical symptoms are, therefore, divided selves in that, to the observer, there is an obvious discrepancy between what the patients say they want and feel and what their symptoms make clear that they actually want and feel.

'I wanted to go for a walk, but my legs wouldn't let me.' 'I love my husband, but I can't bear him to touch me.' 'I wanted to die when I took the tablets', but took obvious precautions to ensure that she would be found before there was any chance of dying.

This type of discrepancy arouses in the mind of the doctor the suspicion that the patient is play-acting; a suspicion which may be reinforced when the patient displays emotions of an exaggerated, 'histrionic' kind whether of distress, gratitude, love, or anger. Indeed, to the layman, 'hysterical' and 'histrionic' are almost interchangeable adjectives. In spite of Freud's description of repression, the suspicion remains that the patient is somehow playing false, simulating emotions which she does not feel, denying others which she does feel, and generally making herself out to be someone quite other than she truly is.

It is this characteristic of hysterical patients which doctors

find so irritating. It is easy to feel sympathy with the despair of the depressed patient, with the isolation of the schizoid, or with the compulsions of the obsessional. Such patients are obviously 'genuine', however unconscious they may be of their less admirable aspects. But with hysterics, the doubt remains. The discrepancies are too close to the surface to be convincing. If the hysterical patient tries to please, she overdoes it in such a way that the doctor feels that he is being 'manipulated', another pejorative phrase which is constantly applied to such patients. Many hysterical patients try to please by being 'charming'; but the charm is that of an Oriental who is trying to sell one a carpet. One is all the time aware of an ulterior motive.

Doctors rely on the honesty of their patients. Confronted by a patient of whose honesty they feel uncertain, they tend to be nonplussed and then angry, believing that they are being 'pushed around' instead of treated with the respect that, as authorities, they feel they deserve.

Their resentment is understandable, and not wholly unjustified, since it is in practice quite impossible to say how conscious or unconscious a patient may be when conflicting emotions are very near the surface, as in the kind of cases I have been attempting to describe.

At the time of writing, hysterical patients very often come to the notice of psychiatrists by using the device of the 'overdose'. This is an extremely tiresome and dangerous way of drawing attention to one's emotional problems, but a very effective one. Anyone who has attempted to estimate how far any particular patient was genuinely so distressed that she momentarily wished to die, or was primarily making an attack upon her nearest and dearest for neglecting her, or was really hoisting a distress signal, will know that accurate weighing of diverse and complex motives is often impossible.

It is understandable that, in such cases, the doctor should be suspicious and prone to resentment. However, he will never be able to help his patient if he continues to feel such emotions. What he has to do is to control his immediate response sufficiently for him to penetrate a short way beneath the façade presented by the patient. When he is able to do this, he will find a deeply unhappy human being with whom he will be able to sympathise and whom he may be able to help.

Hysterical patients are defeated persons. They do not consider themselves capable of competing with others on equal terms. More especially, they feel themselves to be disregarded, and, as children, often were disregarded in reality. If a child finds that grown-ups do not appreciate his needs or try to meet them when they are made manifest, how does he behave? He becomes demanding, and attention-seeking, exaggerates his needs dramatically, or adopts subterfuges in order to get what he wants indirectly. In trying to understand hysterics, I have found it useful to picture a child who has repeatedly attempted to get his parents to treat him as a person in his own right, but who has repeatedly failed in this endeavour. Many parents pay very little attention to their children's needs, or treat them simply as extensions of their own personalities rather than as individuals with separate identities and requirements.

The deafer parents are, the more the child has to shout to gain their attention. A child who is desperately frightened of going to school, but who knows that, if he were to admit such a fear openly, his parents would dismiss it as 'silly', may shout, scream, or threaten to run away or commit suicide in order to have his feelings taken seriously. Or, if direct appeals prove ineffective, he may find that indirect ones will work. Physical illness is generally accepted as a valid reason for not attending school, and also has the advantage of ensuring at least some additional attention from adults. No wonder that children in desperate straits develop illnesses which serve this double purpose.

Patterns of behaviour of this kind are adopted by children because, at the time, they were the only ones which worked; the only way in which they could persuade adults to pay attention to their needs. When such patterns persist inappropriately into adult life, we label them 'hysterical'. Since hysterics commonly feel unlovable as well as ineffective, they often try to make themselves appear sexually irresistible. Since women are allowed more exhibitionistic licence than men in our culture, these efforts are more obvious in their case. Psychotherapists become accustomed to the phenomenon of the girl who dresses and makes up like a model, but who complains that she is actually frigid. Such girls often learn all the tricks of seduction, but habitually prove disappointing to the males whom they

persuade into bed. Some remain as 'cock-teasers', holding out promises which they never in fact fulfil. It is easy to criticise the excessive attention which such girls pay to their appearance as 'narcissistic' (another psychiatric term which has come to be used abusively), and to forget that such attention is a symptom of neglect. It is those who have never received enough attention who lavish attention upon themselves.

The stage as a profession has a particular appeal for hysterics, and some of the most successful actors and actresses belong to this personality type. There are a number of reasons why this should be. First, the stage provides an opportunity for the dramatic display of emotion; something at which hysterical personalities are often expert, since they learned the techniques in childhood. Second, actors and actresses, if at all successful, are approved and applauded by the crowd. This collective adoration is extremely gratifying to someone who has not felt appreciated by his own family and who consequently has no inner conviction of being personally acceptable. To be a public figure is rewarding even though the rewards are superficial and the fidelity of the public less reliable than that of a spouse or parent. Third, actors are, by definition, playing parts; pretending to be someone other than themselves. As we have seen, hysterics, because they have failed to gain what they want by being themselves, are prone to adopt all kinds of masks and roles which they hope will be more acceptable to those around them. In doing so, they tend to lose touch with any sense of continuity in their own personalities; to lose any sense of an inner core which constitutes the 'real I'. People of this type feel that they do not exist as individuals in their own right, and dread being alone because they are then confronted with an inner emptiness. Such individuals, paradoxically, feel more real when they are acting. They only come alive when acting a part.

Successful psychotherapy with patients of this type is almost wholly dependent upon the establishment of a positive transference. Although such patients are sometimes highly intelligent, they are seldom intellectuals. Consequently, insight plays less part in their improvement than does the emotional conviction that, in the therapist, they have found one person who understands and appreciates them.

The establishment of a stable conviction of this kind does not, of course, come overnight; and there are often many ups and downs and tests of the therapist's patience on the way. Because these patients are passionately anxious to find someone who understands and cares for them, and, at the same time have almost lost hope of ever finding such a person, they are apt to behave 'badly' in order to find out whether the therapist will be able to tolerate this. Thus, appointments may be missed without good reason; or, if the therapist is in private practice, accounts may be overlooked and their payment postponed. During the sessions themselves, patients often accuse the therapist of lack of sincerity. 'You don't really care about me, it's just a job to you, a way of making a living.' If the psychotherapist is young and relatively inexperienced, the patient may pick this up and use it as a weapon against him. Any psychotherapist who is a doctor will be listed in the Medical Directory, where the patient may easily find his date of qualification, the degrees he has obtained and what medical posts he has held. If one is young and vulnerable, it is difficult not to react to such a patient's accusations either by angrily refusing to go on treating him, or else by becoming depressed at one's own inadequacy as a therapist. However, if one can hold on to the realisation that the patient's accusations spring from a deep unhappiness, and that unless the patient had some hope that the therapist was not really as black as he was painting him, he would not be coming to ask for his help, it will generally be possible to work through this negative stage.

Some patients alternate between idealisation of the therapist and vicious attacks upon him. I have had patients who, during one session, would extol me as uniquely kind, understanding, perceptive and sympathetic and at the very next would abuse me as useless, cruel, insensitive and altogether hateful. One such patient, terrified that I would dismiss her, would write me deeply apologetic letters after every 'negative' session.

Such patients are profoundly deprived and unhappy people who are generally suffering from the effects of maternal neglect throughout their early childhood. When they do form attachments to people, they repeat over and over again the disappointments of their childhood, because they make impossible demands upon their chosen objects, and then become furiously

angry with them when those demands are not met. One woman attached herself to a series of mother-substitutes whom she worshipfully adored during the honeymoon stages of the relationship. As, however, she demanded absolutely exclusive attention, and became intensely jealous if she thought that her beloved paid any attention whatever to anyone else, her relationships always went wrong. Her rage did not confine itself to verbal expression, and she received at least one prison sentence for inflicting 'grievous bodily harm' upon a woman who had taken pity on her. It is unlikely that the inexperienced therapist will have referred to him hysterical patients who 'act out' to this extent. Such people are likely to have attached to them another psychiatric label of a pejorative kind – the term 'psychopath' – and to be adjudged unsuitable for psychotherapy. However, even if his patients are sufficiently controlled to verbalise their emotions rather than act upon them, the emotions are likely to be of much the same kind. What I am trying to convey is that, in dealing with some of the more deeply disturbed hysterics, psychotherapists may find themselves confronted with emotions of an extremely violent and primitive kind which they themselves may find disturbing. Provided that the therapist remains calm in the face of abuse, he will usually find it possible to understand and sympathise with the patient's feelings, and to interpret them in terms of the patient's actual experience in childhood. Thus, if the patient accuses the therapist of neglect or rejection, the therapist might say: 'I'm sure that you have felt rejected in this way by other people before me. In fact, it always seems to happen, doesn't it? Can you remember when you first felt as you are feeling now?' In this way, it is often possible to disclose a long history of repeated patterns of hope followed by disappointment, and to show the patient that it is because her hopes are so exaggerated that they are always doomed to failure.

Or the therapist can attempt to delineate what aspects of his own behaviour in the here-and-now have given rise to the patient's misinterpretation that he is rejecting, especially when there has been a sudden switch in the patient's attitude in the way indicated above. Very often, some quite trivial alteration in his behaviour may trigger off feelings of rejection. For example, a patient may say: 'You didn't smile when you opened the door for me'; or, 'Your voice sounded different. I was sure that you

were fed up with me'; or 'You yawned whilst I was talking'.

Although psychotherapists must try to remain calmly and reliably the same, their demeanour is bound to vary from day to day to a minor degree. Perhaps the therapist is tired or worried or has a hang-over. Patients who are hyper-sensitive to rejection pick on changes in the therapist's behaviour which may be trivial, but which, nonetheless, are really there. It is therefore unwise to dismiss the patient's complaints as having no basis at all in reality. Although, as I have explained, there are very good reasons why the therapist should not talk about his own feelings, there is no reason why he should not admit to being human without going into details. Thus, in response to the patient's accusation that he is 'different', he might say: 'Yes, I expect I do vary from time to time just as you do. One has to allow for that in other people. I wonder why you find it so difficult to tolerate.'

If the therapist has really been at fault; that is, if he has actually yawned, or missed something the patient was saying, or forgotten something which the patient told him previously, he must always admit it. Psychotherapy can only be conducted on the basis of honesty on both sides, and to pretend to be better than one is is to falsify the relationship.

Provided the therapist has the fortitude and tact to hold on through the times during which the patient accuses him of lack of understanding, the patient's 'good' image of him will predominate. However, depending upon the degree of disturbance shown by the patient, this image will tend to be idealised in the way already hinted at. That is, the therapist will be seen as impossibly good, understanding, loving; a paragon of all the virtues, an idealised parent who will solve all problems, heal all hurts, make up for past unhappiness. What the patient is seeking from the therapist is total devotion of a kind which only new-born babies are justified in expecting. It is extremely difficult to obtain objective evidence of what has actually been missing in the patient's early development to account for this infantile demand; but, in a few instances, I have been given evidence that the patient's mother was actually incapable of loving her children. It has often seemed to me that, if human beings have not been given what they need at the appropriate stage in their development, they are left with a compulsive

hunger which drives them to try and obtain what has been missing. Whether this is actually true or not, this explanation helps me to understand the kind of patient I have been attempting to describe. He or she is driven to demand from the therapist the total acceptance, protection, care and love which mothers give their new-born infants at the stage when nothing can be expected from the infant in return.

The therapist cannot, of course, fulfil such an unrealistic expectation. Even if he were to abandon all his other work, and take up residence with the patient, be available at any hour of the day, minister to the patient's slightest requirement, he still could not make up for the past nor wholly fill the aching void which the patient carries inside. Such patients have to come to terms with the fact that, although the therapist may have been able to help them to make a new and better kind of relationship with the people they encounter, he cannot wholly replace what has been missing in early childhood. To accept this is exactly like coming to terms with a physical disability. If one has lost a leg, one has to make do with an artificial substitute. If the patient can accept this, the compulsive demands cease, and the patient comes to look at other people in a new and more realistic light. It is, perhaps, a matter of being able to allow oneself to be depressed; to mourn for the ideal mother who never was, rather than continue to hope to find her in someone else.

In my view, hysteria is best regarded in the light of a defence against depression. In trying to avoid pain the patient makes things worse rather than better. It is only when the therapist has an appreciation of what lies behind the hysterical façade that he can help such patients.

Reference

1. Nicholi, Armand M. (ed.) (1978) *The Harvard Guide to Modern Psychiatry*, p. 287. Cambridge, Massachusetts: The Belknapp Press, Harvard University Press.

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The Depressive Personality

Depression is probably the commonest symptom which brings a patient to see a psychiatrist. It may range in severity from a temporary state of low morale which anyone is likely to experience in the face of commonplace setbacks, to a tormenting condition of melancholic hopelessness which may result in suicide. In the past, psychiatrists were wont to divide depression into 'neurotic' and 'psychotic' varieties. The former was often called 'reactive'; a term which implied that the patient's state was clearly a response, though perhaps an excessive response, to definable events like bereavement, a broken love affair, failure in an examination, loss of a job or a financial reverse. Cases of 'reactive' depression were sometimes treated with drugs or ECT; or might be referred to the psychotherapist, especially if other neurotic symptoms accompanied the depression. Psychotic varieties of depression, on the other hand, were referred to as 'endogenous'; that is, as taking origin from the patient's personality without reference to external events. Such cases of depression were more likely to be accompanied by insomnia, loss of appetite and consequent loss of weight, and other physiological manifestations of disorder. Faced with a patient of this kind, most psychiatrists were, and are, content to prescribe anti-depressant drugs or electrically-induced convulsions without feeling it their duty to investigate the patient's personal psychology or social circumstances in any detail.

Although it remains true that the more profound varieties of