

It is in Marion Milner's (1969) subtle account of her clinical encounter with her patient, Susan, that a person's struggle to gather something vital from the dreaming experience that has been lost, is most poignantly described.

Who can communicate the whole of his self-experience through verbalization, to himself or the other? An essential part remains inaccessible. Freud, I believe, covered this by his concept of the primal repression. What is entailed, however, is a certain type of psychic experience that never becomes available for ordinary mental articulation. I advisedly use the word 'ordinary' because it seems that poets, painters and writers have access to it through their imaginative functions. Hence William Blake's claim: 'The imagination is not a state: it is the Human Existence itself.'

To my earlier hypotheses of 'the good dream' and 'the dream space', I am adding a third: *the dreaming experience*. My argument is that a person in his dreaming experience can actualize aspects of the self that perhaps never become overtly available to his introspection or his dreams. And yet it enriches his life, and its lack can impoverish his experience of others, himself and his sleep.

Grudge and the Hysteric

(1975)

In human cultures the hysteric has worn the mask that reflects the overt morality and the hidden sexual aspirations of the contemporary ethos. Hence if the hysteric has been at times identified as a witch and burnt, he or she has also been sanctified and celebrated as a saint. It was only toward the end of the nineteenth century that Charcot established the status of the hysteric's predicament as a specific clinical syndrome worthy of attention. But even with Charcot the understanding of the hysteric's predicament went little further than treating it as a prestigious psychiatric exhibit. It was left to the genius of Freud to define the nature and character of the hysteric's ailment. And Freud arrived at his insights through respecting the hysteric's 'resistance' to being known and his refusal as well as unwillingness to cooperate in his own cure. Freud (1895d) had argued that the hysterical patient's *not-knowing* was in fact a *not wanting to know* and he had concluded that this was 'a not wanting which might be to a greater or less extent conscious'. It is well known that Freud had at first ascribed this *not-knowing* to episodes of actual sexual seduction in childhood and later corrected it to fantasies of seduction that had been repressed and which the patient now expressed through a somatic language but refused to become aware of psychically.

Throughout history the bizarre sexuality of the hysterics had been castigated as the characteristic feature of their personality. What distinguished Freud's approach to the hysteric was that, in determining the aetiology of the hysterical symptoms, he had emphasized the predominant, and almost exclusive, role of infantile sexuality. This changed the whole approach to the hysteric's predicament. The hysteric was no longer to be maltreated as a psychopathic liar or a depraved sensualist but to be seen as a person trying to cope with experiences in early development that were vastly beyond the means of the emergent personality and for which there was little understanding available in the child's care-taking human environment.

In some seven decades since Freud's earliest writings on hysteria, psychoanalytic researches have added little to our further understanding of the hysteric. Instead, the clinical status of the hysteric has become confused with more severe personality disorders. In this

essay, my argument is that the hysteric in early childhood deals with the failures of good-enough mothering and care by precocious sexual development. The primitive anxieties and affects generated by the failure of a phase-adequate holding-environment, and the resultant threat to the coherence of the emergent ego, are coped with by intensification, as well as exploitation, of the sexual apparatuses of the body-ego. Hence, from the beginning, a dissociation is established between sexual experience and a creative use of ego-capacities. It is this dissociation and specific technique of coping with excitement and anxiety that gives the hysteric's personality in adult life its peculiar and bizarre sexual character, both in behaviour and symptomatology. If in adult life the hysteric deals with anxiety by sexualization, in object-relations the hysteric employs sexual apparatuses of the body-ego in lieu of affective relating and ego-functions. Both the promiscuity and the inhibitions in the hysteric's sexual experiences result from this. The hysteric tries to achieve through use of sexual apparatuses what, otherwise, a person achieves through ego-functioning. This accounts for the craving for sexual experience in the hysteric, which is matched only by the hysteric's inability to sustain or be nurtured by any loving relationship. Hence, in their self-experience, the hysterics live in a perpetual psychic state of *grudge*. They feel that something is either being withheld from them or their wishes are not being recognized for what they are. What in the childhood experience was an incapacity of the emergent ego that failed to receive adequate coverage from the care-taking human environment, in the adult life is projected and experienced as a refusal by others to recognize their wishes (largely sexual) and to gratify them. Every hysteric, male or female, devoutly believes that gratification of his sexual wishes and desires would cure his illness. They attribute their inability to achieve this gratification through any partner to a lack in their partner's total acceptance and love of them.

If the hypothesis that the hysteric in his early psychosexual development has substituted sexual exploitation of body-ego for development of ego-functions is true, then one can understand why the hysteric is not only fundamentally ambivalent and hostile towards his own innate ego-capacities, but is also maliciously hostile and envious of any ego-functioning in the loved-object in adult life. The *promise* of the hysteric's ego-potential is a large component of his charm as a person, both as a patient and in society. But this ego-potential in the hysteric is continuously sabotaged, unconsciously,

for the sexual solution. Hence the hysteric is at root pitted against his own ego assets.

Hysteria is essentially an illness that finds its character and shape at puberty, through adolescence. This corroborates my hypothesis because at puberty, once again, the struggle between sexuality and ego-functioning achieves a new, critical confrontation. And the hysteric's choice, preconditioned by childhood experiences, is inevitably for the sexual solution. Hence the intrusive omnipresence of infantile pregenital, as well as genital, sexual fantasies and their displacement to ego-functions in the identity formation of the hysteric. For this reason the hysteric seeks, omnipotently, to solve new life tasks with sexual reverie and complicity with the adult humans, and beseeches them to take over the necessary and required ego-functions. The overdependence of the hysteric on the adult loved-object is a technique for handing over personal ego-functions in order to live from the sexual solution. And even when a hysteric finds the sexual solution with someone, it never works for long. It inevitably, through its innate hidden logic, ends in grudge and complaints. Why?

The answer to this question is threefold. From my clinical experience I get the impression that the hysteric does not discover genital sexuality at puberty as a new and novel potential of the maturing body-ego. In the childhood psychosexual development of hysterics there has been a flight to premature 'genital' sexuality as a way of coping with ego immaturity. This 'genital' sexuality is by necessity overloaded with pregenital impulses and fantasies. Hence the emergent genital sexuality at puberty does not surprise and enrich the personality of the hysteric as a new experience, but revivifies all the earlier pregenital fantasy-systems, which now conflict acutely with the moral code and values that the person has imbibed en route. In this conflictual inner climate the hysteric experiences himself a 'victim' of instinctual forces and moral prejudices that are felt to be not of his creating and making. To act out seems the only feasible solution. But because of the dissociation between sexual fantasy and ego-functions, the hysterics stay passive and expectant, waiting for someone who will help them act out their bizarre amalgam of pregenital and genital sexuality. In treating perverts, I was struck by the fact that often their accomplices ('victims') were hysterical women. The hysteric needs the other's sexual facilitation, as it were, to act out the latent and repressed sexual fantasies. Hence hysterics always feel innocent in all that actualizes as sexual experience in their lives. They feel more done to than doing, more sinned against than

sinning. Furthermore, consciously and overtly the hysteric rarely seeks an object for explicit sexual experience. The sexual desire and intent are expressed more as a tease and a provocation than as a self-acknowledged need. The clamour for sexual gratifications often emerges when the object-relationship has already become soured and the loved-object has begun to despair about finding an emotional mutuality with the hysteric. At the end of their relationships the hysterics discover, in a most sad and ironic way, the true need that was denied by them at the beginning. What the hysteric seeks through the sexual solution is essentially the facilitation of inadequate ego-functioning. It is this fundamental dissociation between body-ego and ego-functions that creates another dire predicament for the hysteric. The success of the sexual solution unconsciously means castration of ego-capacities. Sexual surrender to the object entails the threat of annihilation to the ego. Hence the hysteric's basic refusal of the sought and desired object.

Here we come to the second factor that militates against the success of the sexual solution with an external object. In all object-relating between the hysteric and others there is a basic *méconnaissance*. The object reads the hysteric's gestures as expressing sexual wishes and desires, and meets them as such, whereas they are essentially a symbolic body language for expressing primitive needs for care and protection. Hence the sexual experience for hysterics constitutes often a betrayal of trust and a crude exploitation of their sexual body-potential. A female patient, at the end of her perfervid love-affair with a very worthy man, exclaimed her grudge: 'What I needed was to be loved and all I have got out of it is being whored.' This mistrust of the gratifying adult object is preconditioned in hysterics by the character of their early childhood experiences. Their body-needs had been met but their ego-needs had not received the recognition and facilitation that was necessary. Furthermore, the hysterics project their own betrayal of the ego-process through precocious sexual development onto the adult objects in the new life situation. The essence of the hysteric's grudge, in this context, is that the new love object has also failed to distinguish between id-wishes and ego-needs in them.

This brings me to the third reason why the sexual solution fails for the hysteric. One of Freud's unique contributions to the epistemology of human experience is that he established the fact that hysterical symptoms are a *communication*, and this mode of communicating has its own peculiar grammar in human psychic functioning. Freud had spelt out how the hysterical symptoms communicate repressed and

unconscious wish-systems, largely appertaining to infantile sexuality. Winnicott added to this hypothesis another dimension when he distinguished between unconscious (id) wish-systems and unconscious (ego) need-systems. His argument is that wish-systems can be dealt with by intrapsychic processes, for example, displacement, projection and repression, whereas need-systems demand actual external facilitation and support from the care-taking environment for the emergent ego-capacities in the child to become gradually capable of autonomously coping with them in time. In trying to understand the nature of affective and psychic functioning in delinquent children, Winnicott (1956) introduced the concept of the antisocial tendency.

Briefly stated, Winnicott's hypothesis is that an antisocial tendency can be found in all personality disturbances. The presence of an antisocial tendency indicates that 'there has been a true deprivation' in the person's early childhood, relating to good experiences in the ongoing life of the child, which were then disrupted or lost over a length of time during which the child was not capable of sustaining a memory of what had been good and positive. In later life the person acts out these traumatic experiences through an antisocial tendency. What characterizes the antisocial tendency is 'an element in it which compels the environment to be important'. Furthermore, the antisocial tendency implies 'hope' and represents 'a tendency towards self-cure'.

I find Winnicott's concept of the antisocial tendency extremely valuable for an understanding of the hysteric's predicament. It seems to me that the hysteric expresses the antisocial tendency through exclusively sexual experiences. In the developmental process the hysteric has dealt with what Winnicott calls mother's failure 'in catering for ego needs' by precocious sexual development. This makes the adult sexuality in the hysteric not so much the vehicle of instinctual gratification and nourishment as an idiom to communicate deprivation, and a technique for expressing hope that the object will heal the dissociation through reading the ego-needs that are unconsciously expressed through overt sexual compliance and instinctual seeking. Hysterics are notoriously gifted in finding suitable objects, only to defeat and dismay them. The 'promise' of the hysterical personality carries more of a hope in it than a wish or capacity.

Lastly, I would revert to Freud's original hypothesis of the role of *actual* trauma (seduction) in the aetiology of hysteria. There *is* an *actual* trauma in the aetiology of hysteria but it is not of a sexual

nature. It relates more to the failure of the mother to cater to the ego-needs of the child. The child's 'self-cure' of this trauma by premature sexual exploitation of body-ego experiences sets the hysteric's basic model for all future situations of stress and conflict. It also conditions his use of objects as well as his own ego-capacities, and accounts for the fact that the hysteric is such a promising and recalcitrant patient. Analytic therapy works through provision of a highly specialized object-relationship. It is precisely in the area of object-relating that the hysteric has suffered his earliest traumata and learnt to be mistrustful. Hence the hysteric oversexualizes the transference, that is, tries to compel the sexual solution on the analytic process. What looks like the hysteric's acute intolerance of sexual frustration is in fact his basic mistrust that the external object will meet his ego-needs. Just as in life, so in the transference, the hysteric establishes that peculiar psychic reality – *the grudge* – through which he or she can relate without mutuality and communicate without the risk of being known and helped.

If the hysteric has been the initiator of the analytic therapeutic process, the hysteric also pushes it to its limits. In the past decade many analysts have questioned the analysability of the hysteric. Zetzel (1968) pertinently sums up the contemporary status of the hysteric in analytic psychotherapeutics when she states that the hysteric 'may have developed an intense, highly sexualized transference neurosis, but with little evidence of a stable analytic situation. None of them appeared to have made any genuine progress towards analytic resolution of their presenting problems.' I consider that the reason for this is our misunderstanding of the hysteric's mode of communication. The hysteric communicates with himself and others through symptom formation. The ability of the hysteric to create, manifest and exploit symptoms screens his basic incapacity to use psychic mental functioning, as well as affectivity, in relating to the self and the object. Anna Freud (1952) has postulated that in the pervert the central dread is that of emotional surrender to the object. In the hysteric the basic dread is that of psychic surrender to the object. The passivity and suggestibility of the hysteric misguide us clinically in truly evaluating his negativity toward psychic functioning. The grudge in the hysteric further defends him against being helped to face this incapacity. The hysteric compels the environment to act upon him, or for him, but does not become accessible to mutuality of psychic dialogue and sharing.

If my argument that in the developmental process in childhood the

hysteric has substituted precocious sexual development for ego-integration is true, then it is possible to postulate that the dread of psychic surrender for the hysteric entails discovering that there is little true creative psychic functioning or affectivity in him. This blankness constitutes the hysteric's essential predicament and militates most against a positive use of the analytic process towards self-knowing and personalization. Hysteria is not so much an illness as a technique of staying blank and absent from oneself, with symptoms as a substitute to screen this absence.

The question arises: what has necessitated this need for blankness and caused this dread of psychic surrender through the early mother-child relationship in the hysteric? Or to put it differently: why does the hysteric's inner life become a cemetery of refusals? I shall report on current work in the analysis of a young married woman to throw some light on the nature of the mother-child disturbance that underlies the hysteric's refusal of object-relating in favour of oversexualization of part-object gratifications.

After a year of very productive analysis, which had helped this patient to understand a great deal of her difficulties, having to do both with sexual frigidity and intellectual inhibitions, suddenly the whole clinical process came to a standstill. For six weeks she was unable even to speak in the analytic situation. Alongside this, her symptoms of frigidity returned in her marital life and she could not even open a book to read. Inertia pervaded all her behaviour inside and outside analysis. The first thing that became clear was that she had moved from an overexcited idealization of me to a passive denigration of me. I had become as useless as everyone else had been before in her life experience. She also became unable to eat anything. All this led me to interpret to her that the regression was now to a very archaic oral mode of desiring me, where my function as a person providing understanding and insight was experienced as a threat to her well-being. Little of this had any effect on her and she continued to punish me by turning up regularly and staying begrudgingly mute in the sessions. Eventually in one session she dozed off and was startled by a hypnogogic image that she had. It was not a dream. The image was that she was sucking my phallus. But as she became aware of it, she also perceived that I as a whole person was not there at all. There was only the phallus. From this it was possible for me to interpret to her that regressive part-object sexual incorporation of me through fellatio was her way of sustaining herself while rejecting me as a threatening

person. From this point she was able to recall vividly how, from her very early childhood, she was aware of her mother's indulgent care of her person, particularly in terms of feeding her, but also acutely aware of a certain emotional mood in her mother from which she felt she must protect herself.

One could postulate from all this material, the complexity of which I cannot report here, that in the hysteric's childhood there is a precocious awareness of the mother's subjective mood as a person intruding upon the mother's care-taking function. The child in these circumstances regressively sexualizes a part-object relationship (gratification by the breast or its substitutes) in order to refuse that intrusion by the mother's emotionality and intimacy of mood with which a child's nascent ego-capacities cannot cope. It is this threat from mutuality that sets up in the hysteric a lifelong battle between seeking an exciting object and refusing it through the very act of gratification. Hence my statement that the inner world of the hysteric is a cemetery of refusals. Furthermore, as Freud himself stressed, the hysteric remembers par excellence through repetition. The hysteric remembers from early childhood largely somatic memories deriving from maternal care, which do not lend themselves to psychic elaboration and verbalization. Hence comes the hysteric's demand in the clinical situation for sensual gratification; because this demand cannot be met, his proclivity is to act out. It is this bias of the hysteric's sensibility to remember by repetition that pushes the analytic process to its limits. The ego-coverage that maternal care provided to the infant and young child's id-needs had in it, in the hysteric's case, an excess of intrusive personal needfulness of the mother, so that its satisfactions became idealized as a safe experience where there is a beginning and an end. By contrast, the ego-needs in the child become hidden or are expressed only through id-wishes. This sets up a perpetual confusion in the hysteric's subjective experience between true id-wishes and ego-needs. In adult life, and particularly in the analytic situation, what starts off as a demand for object-relating towards understanding of the self very soon changes to a confused clamouring for id satisfactions. In this context the interpretative function of the analyst is experienced by the hysteric as a phallic attack or seduction. Hence the hysteric has to refuse the whole relationship and return to the safety of that blankness which is a negation of both the self and the object.

None Can Speak His/Her Folly

This narrative of my clinical encounter with a young girl and the vicissitudes of madness, psychotic states, being in health, etcetera, is not a 'case-history' in the accepted analytic sense of that word, in so far as it eschews the use of metapsychological concepts. I have chosen to present the 'case history' first, followed by my theoretical discussion, because I do not wish to pre-empt the reader's freedom to experience and evaluate the clinical narrative.

Judy, age fifteen

This young patient had been compelled upon me by her physician, with whom I had worked for years, for urgent consultation, because she had attempted suicide a few days earlier. She was a plain but wholesome looking, buxom, puppy-fat girl. She was wearing the tightest jeans she could possibly have squeezed herself into. Her blouse was unbuttoned to an indecent point. She sat down and was very silent and sullen at the start. She had evidently tried committing suicide by cutting both her wrists, which were heavily bandaged, and which she flaunted by constantly shifting her arms. I concluded that at this visit she was certainly not going to 'speak' to me, but merely establish her presence by exhibiting herself. I decided to go along with her antics.

After some twenty minutes of mutually provocative silence, she asked in an aggressive way: 'You know what has led to all this?' I replied: 'No!' 'Don't you read the papers?' I replied: 'No.' 'Then what do you read?' 'Books,' I said. 'Well I can tell you it was headline in all the evening papers four days ago: the scandal, and it will be on the nine o'clock TV news again tonight.' I simply said: 'I don't see TV either,' and that even if I did, I would not see it tonight. Instead, I would wait until she was less ashamed and could trust to tell me the whole scandal herself. She sank into a raging silence for another ten minutes or so. I waited. Then, with a strange authority in her voice, she demanded: 'If you really want to help me, then get me out of school. I cannot go back. I am too ashamed, and I shall really kill myself next time.' I asked her how I could get her out of the school.