

Fugitives From Guilt:

Postmodern De-Moralization and the New Hysterias*

by

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One of the many important lessons Freud learned from Charcot during his period of study at the Salpêtrière (Oct. 1885–Feb. 1886), was that male hysteria exists. “What impressed me most of all while I was with Charcot,” Freud (1935) writes in his *Autobiographical Study*, “were his latest investigations of hysteria, some of which were carried out under my own eyes. He had proved, for instance, ... the frequent occurrence of hysteria in men” (p.13). But when Freud brought the news of male hysteria back to Vienna he got a cold reception. He writes: “One of them, an old surgeon, actually broke out with the exclamation: ‘But, my dear sir, how can you talk such nonsense? *Hysteron (sic)* means the uterus. So how can a man be hysterical?’” (p.15). But the fact is that men certainly can be hysterical, as Freud knew from the case with which he was most familiar: himself (his famous hysterical fainting episodes provide merely one example). Although he often tried to conceptualize his persistent symptoms as arising from what he called an *actual* as distinct from a *psychoneurosis*, a condition of an essentially somatic order supposedly without psychological meaning--the concept of the actual neurosis was dropped by subsequent psychoanalysts because no cases of it were found. At other times, Freud was able to acknowledge both to himself and others the hysterical and

psychoneurotic nature of certain of his symptoms.

But the resistance to recognition of male hysteria persisted. The concept received little attention in Freud's own later work, or in that of his colleagues and, as Elaine Showalter has pointed out, despite its early recognition of the fact of male hysteria, psychoanalysis came essentially to collude with the wider cultural feminization of hysteria in which a man might be said to be hysterical if he was homosexual, but otherwise his hysteria would be redefined as "shell shock," "battle neurosis," "post-traumatic stress disorder," or some other more "manly" condition. In speaking of hysteria, we reject such feminization and seek to reinforce Freud's and Charcot's original discovery. While its feminization is a significant aspect of our culture of interest to sociologists and feminist theorists, hysteria itself is not a gender-specific disorder. We see rampant evidence of male hysteria in our practices. It is because we ourselves, like most people we know, have suffered and at times still do suffer from hysterical symptoms, that we choose to speak of "we" rather than "them" when we refer to hysterics (and sufferers from psychosomatic conditions as well).

What then is hysteria? Without ignoring anxiety hysteria (phobia, panic attacks, etc.), we are concerned primarily with conversion hysteria, a condition in which we present symptoms that mimic those of organically-based medical illnesses, but that have no organic basis. The classic example of this is the so-called "glove anesthesia" in which the paralysis of the hand does not follow known nerve pathways but corresponds instead to our mental concept of the hand (as distinct from the wrist or the rest of the arm). Hysterics are not malingerers: we do not consciously fake organic illness, we unconsciously mimic it. Hysteria is not to be confused with

psychosomatic disease in which we suffer from a genuine medical illness or dysfunction, but one believed to be caused to a significant extent by psycho-emotional factors. Psychosomatic illness is not “only in one’s head”; it is clearly in one’s body as evidenced, for example, in the bleeding ulcers thought, in some cases by some analysts, to arise from chronic, internalized anger and rage. But whatever their causes, the ulcers themselves are real, not mimicked. By contrast, hysterical symptoms, although psychologically real and painful enough, have no organic basis: they are products of mimesis. Because their symptoms are not consciously faked, but unconsciously mimicked, hysterics are not malingerers, but neurotic sufferers.

The symptoms of both conversion hysteria and psychosomatic disease are painful and tormenting to patients suffering from them (and, of course, there are cases reflecting a mixture of the two, as in the case of Mr. B., described below). Why, the psychoanalyst must ask, do we bring such suffering and torment upon ourselves? The answer, we believe, is that we (both hysterics and psychosomatics) have an unconscious need for punishment. But why do we unconsciously seek punishment? We do so because our unconscious superego (not our conscious conscience) judges us guilty of some real or imagined crime. The punishment we seek may take one of two forms: either the conscious suffering entailed in having to bear guilt; or the unconsciously self-inflicted suffering entailed in hysterical, psychosomatic and other neurotic symptoms. Those of us who consider the admission of sin and wrongdoing an intolerable insult to our narcissism and find conscious guilt unbearable, are forced to resort to symptom-formation. The suffering entailed in our symptoms gratifies the superego need for punishment and, at the same time, evades unbearable conscious guilt. However, the price of

this refusal to render superego judgment conscious is loss of the opportunity to subject it to rational assessment leading either to conscious acceptance and the bearing of conscious guilt, or to conscious rejection and superego modification.

It is precisely to avoid the question (why do we bring such suffering upon ourselves?), and the answer to which it leads (an unconscious need for punishment), and the further question to which this answer gives rise (what is our real or imagined crime?), that we resist so vociferously the very premise that grounds this unwanted series of questions and answers: the idea that we do in fact bring such suffering upon ourselves. If we are to evade the issue of “crime and punishment,” we must evade the fundamental idea that we are the agents, rather than victims, of our hysterical and psychosomatic misery. To represent ourselves essentially as passive victims of these afflictions rather than as agents inflicting them upon ourselves for understandable reasons is to “de-moralize” our understanding of such conditions and ourselves. But however much we seek such demoralization, both as suffering individuals and as a cultural community increasingly committed to a de-moralizing postmodern discourse, the fact remains that, like it or not, there is a moralist alive and well in each of us, and an often harsh and sadistic one at that: our unconscious superego. De-moralize as much as we like consciously; deny agency, responsibility and guilt as much as we will. All that applies only to consciousness. Unless it is analyzed, confronted, rendered conscious and modified, the unconscious superego will continue to accuse and to demand its pound of flesh. The demoralizing cultural and personal discourses that repress or otherwise evade agency, responsibility and guilt, end up producing the demoralizing conditions (depression, masochism, hysteria, paranoia, psychosomatic disease) that result from the activity of the

unconscious superego that these discourses deny: de-moralizing leads to demoralization.

In our experience, most of us, to one degree or another, are fugitives from guilt—whether our guilt evasion takes an hysterical, a psychosomatic, or some other psychopathological form. We cling to the de-moralizing discourses that we fabricate for ourselves, sometimes with the help of de-moralizing therapists, and the de-moralizing discourses offered by our postmodern culture, in a desperate attempt to believe we are victims of mysterious afflictions rather than moral agents afflicting ourselves with suffering for our real or imagined crimes. And we do this because we refuse the burden of moral agency: the need either to consciously bear guilt or consciously confront and modify the accusing superego. It matters little whether our hysteria takes the old-fashioned form of the paralyses, tics and fainting episodes, etc., that characterized the hysterias of the late nineteenth and early twentieth centuries, or such more contemporary forms as so-called “environmental illness,” “multiple chemical sensitivity,” “chronic fatigue syndrome,” “fibromyalgia syndrome,” etc. (readers of the *New Yorker* will be kept up to date regarding the newest hystero-paranoid manifestations), the dynamics remain essentially the same. However much what Edward Shorter calls “the legitimate symptom pool” may vary from time to time and place to place—for example, a legitimate symptom in one cultural situation is the Koro complaint that someone has stolen or reduced the size of one’s penis—the underlying dynamics remain constant: unconscious superego accusation for real or imagined crimes, leading to a need for punishment, that takes the form of hysterical, psychosomatic, paranoid and other forms of psychological and/or physical suffering.

What does characterize the new, as distinct from the old hysterias, is their more obvious reliance upon defensive externalization and, hence, the paranoid element in their structure. It is for this reason that we employ the term hystero-paranoid to describe states of feeling persecuted by supposed environmental agents (toxins, molds, parasites, etc.) or molestation by satanic cults or by aliens. The role of hostility, its projection, and its return in the form of delusions of external or internal persecution is emphasized in our paper precisely because these factors have been underemphasized in most previous discussions of hysteria.

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In *Hystories: Hysterical Epidemics and Modern Media*, Elaine Showalter (1997) explores a range of conditions—chronic fatigue syndrome; multiple personality disorder; recovered memory; satanic ritual abuse; alien abduction; Gulf War syndrome—that she views as modern forms of hysteria as distinct from the old conversion and anxiety hysterias characteristic of the last *fin-de-siecle* and explored by Charcot, Janet, Breuer and Freud. Against the widespread claim that hysteria is a thing of the past, having disappeared due to the rise of feminism or a level of psychological sophistication incompatible with the formation of hysterical symptoms (except perhaps among culturally “backward” populations), Showalter argues that, on the contrary, far from having died, hysteria is alive and well in the form of the psychological plagues or epidemics of “imaginary illnesses” and “hypnotically induced pseudomemories” that characterize today’s cultural narratives of hysteria (pp.4-5).

Although she provides a rich description of the new hysterias—the “hystories” or hysterical stories of chronic fatigue, alien abduction, etc.—Showalter does not pretend to offer a depth psychological account of the psychodynamics underlying these conditions beyond identifying the role of suggestion on the part of physicians and the media in their creation and dissemination. Her definition of hysteria as “a form of expression, a body language for people who otherwise might not be able to speak or even to admit what they feel” (p.7) and as “a cultural symptom of anxiety and stress” arising from conflicts that are “genuine and universal” (p.9) is accurate enough as far as it goes. From a psychoanalytic point of view, however, it does not go far enough.

While she does not appear to share Mitchell’s (2000) insight into the fact that “there is violence as well as sexuality in the seductions and rages of the hysteric” (p.x), Showalter does call attention to the centrality of externalization (i.e., projection) in these conditions. She writes: “Contemporary hysterical patients blame external sources—a virus, sexual molestation, chemical warfare, satanic conspiracy, alien infiltration—for psychic problems” (p.4). In so calling our attention to the paranoid element in hysteria, albeit without explicitly theorizing the connections between hysteria and paranoia, Showalter contributes to the evolution of a deeper, psychoanalytic understanding. In the following, we will fasten upon this externalizing feature and offer a psychoanalytic, more particularly a modern Kleinian, understanding of hysteria—including so-called multiple chemical sensitivity, environmental illness, and fibromyalgia syndrome—as sub-types of what we view as a more general *hystero-paranoid syndrome*.

Whereas traditional psychoanalytic accounts have emphasized the role of oedipal and preoedipal sexual wishes and conflicts in hysteria, seldom associating it with aggression and paranoia, we will argue that such overlooked psychological factors as unconscious aggression, envy, hostility, malice, destructiveness and the resulting persecutory “guilt” and need for punishment occupy a central place in both the old and the new hysterias.^[1] Following Carveth’s (2001) conception of the unconscious need for punishment as a defensive evasion of unbearable *conscious* guilt, rather than a guilt-equivalent (as in Freud’s view), we view hysterical, psychosomatic, depressive, masochistic and other self-tormenting conditions as defensive alternatives to facing and bearing conscious guilt.

While our analysis has much in common with both Showalter’s (1997) *Hystories* and Shorter’s (1992) *From Paralysis to Fatigue*, we at the same time seek to correct their occasional blurring of the important distinction between hysteria and psychosomatic conditions and their use of the term “somatization” in the description of both. Showalter, for example, even while correctly noting that “On the whole, Freudians make strict distinctions between hysterical symptoms and psychosomatic symptoms” (p.44), refers to “psychosomatic conversion symptoms” (p.36). She muddies the waters further by describing the conversion symptom as a particular form of “symbolic somatization” (p. 44). But psychosomatic symptoms result from a process of somatization in which psychological and emotional forces contribute to the development of genuine organic disease and in which symbolization, if it is operative at all (and we believe it often is), takes a somewhat different form than it does in conversion. Showalter makes no secret of her

difficulty with these concepts: “How psychiatrists tell the difference between hysterical and psychosomatic symptoms is hard for a layman to figure out” (p. 44). But in many instances it isn’t hard at all: psychosomatic symptoms are symptoms of objective medical disease: organic tissue pathology is evident. Such disease is thought to result from the somatization of psychological and emotional forces affecting the immune system and operating in conjunction with various organic and constitutional predispositions. By contrast, hysterical symptoms involve no objective organic pathology but entail *mimesis*: the unconscious mimicry of organic disease and dysfunction, as distinct from their conscious imitation as in malingering.

Whereas many writers on psychosomatic disease see it as entailing the failure or foreclosure of symbolization, we believe a symbolization process may yet be at work in it, as the following case vignette suggests:

CASE 1: Mr. A.

Mr. A had been suffering for some years from an objectively observable, painfully tormenting rash covering much of his body surface. It had proved resistant to a myriad of medical treatments. Recently, in addition, he had been experiencing frequent “accidents,” a few of which had been life-threatening. It turned out that for years, as the eldest son

of a large family, he had been saddled with the sole responsibility for looking after his aging parents, his chronically depressed mother and his bitter, manipulative, narcissistic father. His own business was suffering due to his need to make frequent trips to another country to attend their real and imagined needs. His siblings, in the meantime, were leading their own lives and quite content to have the patient free them from their own responsibilities vis-à-vis the parents. When asked in the first session whether he ever felt angry over this state of affairs, Mr. A. looked curious and reported that his friends had sometimes asked him that. Over the next few sessions Mr. A. proceeded to become angrier and angrier and as he did so his rash began to diminish. He had been raised within a particularly concrete and magical version of Orthodox Christianity. The rash, it turned out, had made him feel he was “burning in hell” in punishment for his hitherto unconscious death wishes toward his parents and the siblings who saddled him with the responsibility for looking after them. As his rage and death wishes became conscious and began to subside as he started to take constructive action to end his masochistic submission to exploitation, the rash gradually disappeared. But because Mr. A was unable to experience and bear conscious guilt, his rash was quickly replaced by other forms of self-sabotage and self-punishment.

As a result of clinical experiences of this sort, we are not at all convinced that the difference between conversion and somatization boils down to the presence of symbolism in the former and its

absence in the latter, though it is possible that different types or levels of symbolization may be involved in the two conditions. Showalter quotes Mark Micale who writes that “hysteria is ‘not a disease; rather it is an alternative, physical, verbal, and gestural language, an iconic social communication’” (p. 7). Psychosomatic illness *is* disease—but it, too, appears, at least sometimes, to involve interpretable unconscious meaning.

According to Mitchell (2000), “hysteria’s many manifestations have shown some striking similarities throughout the ages—sensations of suffocation, choking, breathing and eating difficulties, mimetic imitations, deceitfulness, shock, fits, death states, wanting (craving, longing)” (p.13). Under the category of mimetic imitations falls the hysterical utilization of the body in the simulation of organically-based disease and somatic dysfunction. In the theatrics of “conversion” physical illness is dramatically mimicked—once again, unconsciously, not consciously as in malingering—and somatic dysfunction (difficulty swallowing, paralysis, contracture, non-organic limp, paraplegia, etc.) lacking any discoverable organic basis is displayed. The type of hysteria known as hypochondria involves subjective suffering and the conviction that one is medically ill in the absence of objective evidence of disease or injury.

Psychosomatic illness involves somatization as distinct from conversion or mimetic imitation. In somatization, manifest psychological distress of various sorts (such as Mr. A’s rage, death wishes, and consequent need for punishment) is found by the subject to be unbearable and consequently is foreclosed and somehow channelled into the body, resulting in real organic disease (such as

his objectively observable burning rash) which functions as a self-punitive and persecutory alternative to unbearable conscious guilt. The foreclosure of conscious distress does not always, we would argue, entail a foreclosure of symbolization. The pain arising from his organic rash symbolized to Mr. A. that he was “burning in hell” for his sins, his failure to “honour” mother and father and his Cain-like murderous rage toward his siblings. Although all disease involves psychological factors to some degree, what distinguishes psychosomatic disease is precisely the prominence of psychological factors in its aetiology.

McDougall (1989) employs the title *Theatres of the Body* for a book dealing primarily with psychosomatic disease rather than hysteria. But there is no doubt that theatrics are more obvious in the drama of hysterical conversion than in the often obscure somatization processes underlying psychosomatic disease. This is in no way to suggest the absence of symbolization in what McDougall views as the “archaic hysteria” of psychosomatic disease as distinct from the theatrical “neurotic hysteria” (p.54) in which it is so obvious. The point is only to suggest that the symbolization entailed in somatization (as distinct from conversion) may take the archaic form that Segal (1957) describes as “symbolic equation” as contrasted with the more elaborated symbolization processes entailed in what she calls “symbolic representation.” Far from seeing meaning in hysteria and only a foreclosure of meaning in psychosomatic disease, we believe that in both conditions, whatever additional factors may be in play, we see unconscious aggression and an unconscious need to suffer as an alternative to and defense against unbearable guilt. But whereas the mimicry and theatrics of hysteria embody an hysterio-paranoid defence against and substitute for the experience of

unbearable guilt, in psychosomatic conditions the need to suffer finds an all-too-real and concrete outlet in the development of organic disease and its attendant discomfort, pain and torment.

Both classical Freudian and post-Freudian psychoanalysis have emphasized the role of such factors as forbidden sexual wishes, unresolved oedipal conflicts, castration anxiety, the need for attachment and the compulsion to preserve needed object ties or the need to preserve a threatened sense of self in hysteria. In so doing they have tended to lose sight of the role of aggression and guilt—just as in various branches of contemporary psychoanalytic thought the dynamics of the superego have been lost sight of. [2] It is not our intent in the following to deny the role of sexuality, attachment, object relations or issues of identity and the self, but merely to re-focus attention upon factors we regard as central but which, for a variety of reasons, have succumbed in certain branches of contemporary psychoanalysis to what Jacoby (1975) has referred to as the “social amnesia” in which “society remembers less and less faster and faster” and in which “the sign of the times is thought that has succumbed to fashion” (p.1).

Even while “listening with the third ear” (Reik, 1948) to the latent meanings, messages, motives and dynamics underlying manifest symptoms and experience, Freud was so centered upon sexuality at the time when he was most concerned with hysteria that he tended to overlook or downplay the role of aggression in this condition. Although in his dual instinct theory Freud (1920) eventually made aggression as fundamental as sexuality in his metapsychology, he never reworked his psychology of hysteria in this light.

Mitchell (2000) has recently argued that another reason for the neglect of the role of aggression (and, hence, of guilt) in hysteria has to do with Freud's and subsequent psychoanalysts' relative retreat (it was never complete) from Charcot's and Freud's own earlier recognition of the fact of male hysteria. Despite this recognition, Freud and his followers came to collude with the wider cultural equation of hysteria with femininity. While hysteria could be acknowledged in the "effeminate" male homosexual, instances of hysteria in heterosexual men were redefined as "shell shock," "battle fatigue," etc., while the everyday instances of male hysteria—dizzy spells; fainting (such as Freud's famous faints in Jung's presence); organically ungrounded orthopaedic dysfunctions; and such psychosomatic phenomena as sensitive breasts and swollen tummies in men whose wives are pregnant, etc.—are somehow overlooked or discounted.

But while listening with the third ear does not guarantee recognition of the aggression underlying manifest suffering, without this distinctively psychoanalytic listening capacity there is simply no way it will be detected. As a consequence of this failure, the objects of such suffering, like Carol White in the film *Safe* (see next section), remain unempowered by the discovery of their unconscious subjectivity. For far from being simple victims of mysterious afflictions, in reality they are unconscious agents—sadomasochistic agents in fact—inflicting such suffering upon themselves for understandable reasons. This is the liberating discovery made by the members of Carol's group, but not by Carol herself.

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In Todd Haynes (1995) film, *Safe*, Carol White (Julianne Moore) is an affluent but bored suburban housewife who appears, at the outset, to be suffering from a personality disorder of a schizoid type characterized by identity diffusion, anhedonia, diffuse anxiety and emptiness depression. Obsessively preoccupied with maintaining and enhancing her spacious, tastefully furnished and decorated home, she seems otherwise unoccupied and lost. She seems curiously detached from both sexuality and aggression. Her stepson's vivid (albeit politically incorrect) essay on gang violence offends her; she asks "Why does it have to be so 'gory'?" In another scene the camera plays over Carol's curiously blank and emotionally detached face as her husband performs intercourse (one cannot call this making love); she pats his back distractedly as he reaches orgasm.

Gradually, in addition to her vague anxiety, joylessness and detachment, Carol begins to develop a range of mysterious physical symptoms (nose bleeds, coughing fits, difficulty breathing, etc.) for which, after extensive investigation, her doctor is unable to find any physical basis. He refers her for psychiatric treatment, despite her suppressed but yet evident hostility toward and bland resistance to the idea that psychological factors might be at the root of "symptoms" that by now have led her to withdraw entirely from sexual involvement with her husband. As frustrating as he finds this situation, he struggles, not entirely successfully, to suppress his irritation. But, despite his father's strictures, Carol's stepson still

manifests his anger toward her; socialization into the family culture of politeness and non-aggression has not yet fully “taken” here it seems.

Encouraged by the suggestions of a friend and a flier found in a health food store from an “alternative health care” organization that she later contacts, Carol herself comes increasingly to attribute her problems to an environment that she believes contains toxins to which she is chemically sensitive. We witness the worsening of her “environmental illness” (EI) or “multiple chemical sensitivity” (MCS) as she retreats from her home and family to a supposedly chemically “safe” environment provided by this group in the rural southwest and then, when this proves insufficient, to a specially engineered, igloo-like habitation designed to provide even more effective protection against a world to which she seems increasingly allergic.

Throughout most of this film the director maintains a neutral attitude regarding the status of Carol’s affliction, as chemically based as she insists, or as hysterical or psychosomatic, as her physicians seem to think. But towards the end there is a group encounter session at the retreat led by its resident guru in which, one by one, her fellow patients painfully acknowledge that their EI had arisen as a kind of unconsciously self-punitive alternative to consciously facing, bearing guilt and making reparation for their hitherto unacknowledged hatred, bitterness, longings for revenge and inability to forgive others and themselves. Carol listens distractedly but appears unmoved by these revelations. Her “illness” intensifies. At the end of the film we see her recoil anxiously from her visiting husband’s parting embrace,

apparently a “reaction” to the cologne he was wearing, as he and her son prepare to fly home. With what appears to be an oddly contented look on her face, she heads back to her isolated and hermetically sealed capsule.

One of the aspects of the film most interesting to the clinician concerns the way Peter Dunning, the resident guru/therapist, is depicted. Initially at least, he and his organization appear to advocate the idea that “environmental illness” is a genuine medical condition caused by toxins that official medicine has so far failed to identify. But over time we detect a subtle shift in the messages he communicates to his “patients”: he increasingly suggests that their suffering is a consequence less of toxic chemicals than of toxic emotions.

Although Dunning’s directions to “think positive” and replace hatred with love have a distinctly “New Age” flavor and strike the psychoanalytically sophisticated viewer as naïve, the overall therapeutic strategy of his retreat could be viewed as ingenious. Instead of directly confronting the patient with the hysterical and paranoid nature of his or her disorder, he adopts what followers of Hyman Spotnitz’s (1969; 1976) “modern psychoanalysis” refer to as the techniques of “mirroring” and “joining.” He “mirrors” their condition himself: he too suffers from an immune deficiency disease. And instead of attacking the resistance to awareness of the emotional causes of their suffering, he “joins” this resistance and gives the appearance, initially at least, of sharing their understanding of it as caused by a toxic environment. (Much later he will insist that sufferers from EI have made themselves sick by attacking their own

immune systems, thus making themselves vulnerable to environmental factors.)

Like many psychoanalysts who work with highly resistant, personality disordered and psychotic patients, Dunning has the clinical wisdom not to attempt, at the outset and perhaps for a very long time, to differ with or challenge the preferred self-understanding (the illusions and delusions if you will) of his patients. But unlike those therapists who never move beyond empathy and the validation of experience and who therefore collude with the very pathology they should be treating, Dunning, like Spotnitz and his followers, eventually comes out of the therapeutic closet, as it were, and invites his patients to face the much resisted emotional basis of their afflictions, which he regards (as we do) as rooted in the dynamics of unconscious self-attack.

We don't know what becomes of Carol. Perhaps she eventually becomes willing to set aside her paranoid evasion of responsibility and begins to call herself into question. But we doubt it, for we think she is more than "half in love with easeful death." But what are the sins, real or imagined, for which she seems to have judged herself deserving of self-execution? Whereas the hatred poisoning the psyche of Nell, one of the other patients in the group, is hot and therefore unmistakable, Carol's is cool and easily masked by her apparent meekness and suffering. Being only eleven and, in the great tradition of eleven-year-olds, as yet uncivilized, her stepson Rory sees it—and hates her back.

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Central to Showalter's (1997) argument is the observation that the hysteria investigated by Breuer and Freud was not the isolated product of a certain historical period. Rather, the same "illness" has mutated into contemporary forms corresponding to changes in cultural context. Thus, the late-twentieth-century syndromes she describes (chronic fatigue syndrome; multiple personality disorder; satanic ritual abuse; alien abduction; Gulf War syndrome) are modern forms of the hysteria once diagnosed in upper-class Victorian women; and they are "psychological epidemics" (p.1). To Showalter's list of new hysterias, we would add: Carol White's multiple chemical sensitivity or environmental illness; fibromyalgia syndrome; as well as current popular concerns with intestinal toxins, parasitic infestation and colonic cleansing (Gold, 2000) and with molds (Belkin, 2001). We believe it makes sense to classify all of the above as subtypes of a more general *hystero-paranoid syndrome*.[\[3\]](#)

Showalter defines hysterics as "the cultural narratives of hysteria" (p.5). In no way is she accusing patients of merely fabricating, pretending, seeking attention, or malingering. Nor is she stating categorically that there is absolutely no organic basis for the perceived symptoms, although, as she points out, none of the hundreds of studies investigating this claim have produced any conclusive evidence. Despite this absence of evidence, sufferers aggressively maintain an unyielding conviction that their symptoms are organically based.[\[4\]](#)

In *Hysteria: The Elusive Neurosis*, Krohn (1978) writes: “It should be stressed that hysterics are not faking, playing games, or simply seeking attention...The hysteric is neither a malingerer nor a psychopath in that the sorts of parts he plays, feelings he experiences, and actions he undertakes have predominantly unconscious roots—he is usually not aware of trying to fool or deceive” (p.162). Yet, as Krohn observed, such illusions may display certain standards of conventionality and reality-testing: “The facility with which the hysteric can utilize roles considered acceptable by his culture attests to his sensitivity to the norms of the culture, the limits of acceptability, interpersonal resourcefulness—in short, his capacity for good reality testing, impulse control, and interpersonal sensitivity” (pp.161-62).

It is a hallmark of those suffering from the newer forms of hysteria to insist on the existence of objective (as distinct from subjective or psychological and emotional) causes of their perceived symptoms: viruses (as yet neither isolated nor identified by medical researchers); toxin-producing fecal matter impacted in the bowels; radiation emitted by video display terminals; molds growing on or in the walls of houses; long-repressed memories of satanic ritual abuse; abduction by aliens; etc. Indeed, thousands of people in North America and Western Europe are presenting with long lists of seemingly inexplicable and unrelated symptoms: extreme fatigue, sore muscles, swollen glands, headaches, stomach troubles, rashes, memory dysfunction, depression. So vehement are the convictions of many of these patients that their conditions have objective rather than subjective origins that Showalter has been roundly attacked for

suggesting that psychological and sociocultural factors might be involved.

Similarly, with respect to so-called “fibromyalgia syndrome” (widespread body pain of unknown origin, often accompanied by other symptoms, such as, for example, irritable bowel or chronic fatigue), neurologist Thomas Bohr who with psychiatrist Arthur Barsky “contends that even honouring this bundle of symptoms with a medical label may be doing more to make people sick than to cure them” (Groopman, 2000, p. 86), “has received more than two hundred pieces of hate mail, and has been lambasted by fibromyalgia advocates on the Internet and in newsletters” (p.91)—despite the fact that “these doctors don’t claim that the symptoms of fibromyalgia are not real, only that their origin lies in the mind and not in the peripheral nerves of the body” (p. 86). Showalter remarks that the ferocity of these reactions “has only confirmed my analysis of hysterical epidemics of denial, projection, accusation, and blame” (p.x).

Nevertheless, challenging American Medical Association position papers, some physicians lend support to the objectifying claims of these patients, maintaining that they are suffering from genuine illnesses to which names such as “chronic fatigue syndrome,” “fibromyalgia syndrome,” and “multiple chemical sensitivity” have been appended. It is for this reason, Showalter asserts, that the proliferation of these conditions depends both on the media “narratives” that do so much to generate them (hence the “stories” of “hystories”), and on the collusion of physicians, researchers and psychotherapists, who either take at face value the patient claims

with which they are presented or, in some cases, operating from their own therapeutic agendas, actually help manufacture the maladies in question through processes of subtle and not so subtle suggestion and interpersonal influence (pp.17-18, 122). In this connection it is significant that the rheumatologist who first codified the so-called fibromyalgia syndrome, Frederick Wolfe, now wishes he could make this diagnosis disappear:

“For a moment in time, we thought we had discovered a new physical disease,” he said. “But it was the emperor’s new clothes. When we started out, in the eighties, we saw patients going from doctor to doctor with pain. We believed that by telling them they had fibromyalgia we reduced stress and reduced medical utilization. This idea, a great, humane idea that we can interpret their distress as fibromyalgia and help them—it didn’t turn out that way. My view now is that we are creating an illness rather than curing one” (Groopman, 2000, p. 87).

The fact that hysterical symptoms as they are presented “have internal similarities or evolve in similar directions as they’re retold” (Showalter, 1997, p.6) does not necessitate the conclusion that an objective event or organic disorder underlies them: “Patients learn about diseases from the media, unconsciously develop the symptoms, and then attract media attention in an endless cycle. The human imagination is not infinite, and we are all bombarded by these plot lines every day. Inevitably, we all live out the social stories of our time” (p.6). Showalter’s literary training also serves her well in

her critical analysis of the similarities that believers find so compelling:

Literary critics...realize that similarities between two stories do not mean that they mirror a common reality or even that the writers have read each other's texts. Like all narratives, histories have their own conventions, stereotypes, and structures. Writers inherit common themes, structures, characters, and images...We need not assume that patients are either describing an organic disorder or else lying when they present similar narratives of symptoms (p.6).

As Showalter observes: "A century after Freud, many people still reject psychological explanations for symptoms; they believe psychosomatic [and hysterical or somatoform] disorders are illegitimate and search for physical evidence that firmly places cause and cure outside the self" (p.4). The validity of Showalter's observation is born out by the vociferous insistence of hysteric patients themselves, who demand that their symptoms, however indefinite and variable, be acknowledged as genuine, organically-based conditions. For example, rejecting any suggestion that psychological factors might be involved in her suffering and insisting on the medical objectivity of so-called fibromyalgia syndrome, one patient told Groopman (2000): "I won't see any doctor who questions the legitimacy of what I have" (p. 87). Showalter observes that such patients "live in a culture that still looks down on psychogenic illness, that does not recognize or respect its reality. The self-esteem of the patient depends on having the physiological nature of the illness accepted" (p.117). It would seem that this disrespect for

psychogenic illness is shared by those physicians, including some psychiatrists who, despite the lack of supporting scientific evidence, nevertheless seek to validate such externalizing claims. Insofar as large segments of psychiatry itself foregoes psychology for biology, psychodynamics for neurochemistry, it might itself be seen as hysterical and resistant to psychoanalysis.

In order to meet the objective of plausibly establishing “cause and cure outside the self,” patients must work within the parameters that the culture will allow, for all cultures maintain their respective “legitimate symptom pool[s],” and it is a hallmark of hysteria to “mimic culturally permissible forms of distress” (Showalter, 1997, p.15). This tendency of hysteria to remain within certain bounds of convention was also described by Krohn (1978): “Hysteria makes use of dominant myths, assumptions, and identities of the culture in which it appears. The hysteric may play out a somewhat caricatured version of an accepted role in an effort to enlist caring, attention, help, or to satisfy other needs; however, he rarely goes far enough to be considered substantially deviant...the hysteric characteristically forms his sense of himself around an identity granted a high degree of approval in the culture” (p.160).

Thus, while symptoms change, and contemporary symptoms are, naturally, congruent with current cultural concerns and preoccupations, the function of the “symptoms” is the same as it was in the nineteenth century: to manifest an allegedly physical condition “that firmly places cause and cure outside the self” or, more precisely, that solidly places cause and cure within the body but outside the self, thereby expressing pain and conflict in “acceptable”

forms of bodily illness (Showalter, 1997, p.4) without the taint of psychological forces at work. This differentiation between conditions that are in the body but not of the self—that is to say, *in* the patient but not *of* the patient—is an important one. The adaptive character of hysteria is also described by Shorter (1992) who, in *From Paralysis to Fatigue*, writes that “hysteria offers a classic example of patients who present symptoms as the culture expects them, or, better put, as the doctors expect them” (pp.8-9).

But to explain this flight from psychology simply in terms of the cultural stigmatization of illness recognized as psychogenic is to overlook the deeper reasons for this very stigmatization. If cause and cure lie not outside but within the self, then such “illnesses” are in some way unconsciously engineered (not consciously as in malingering) by the patients themselves. Hence, we are led to ask why hysterics (and we are all hysterical at times and to varying degrees) feel the need to bring pain and suffering upon themselves in these ways? There is no doubt that, as Freud would say, such phenomena are “overdetermined,” but among their multiple causes (such as the need to suffer to maintain important ties to internal or external objects) we think the role of aggression, guilt and the unconscious need for punishment have received insufficient attention. For these are concepts that are distinctly unpopular among many postmodern intellectuals, including those post-Freudian and post-Kleinian psychoanalysts who have come to conceptualize psychopathology less in terms of intrapsychic conflict than in terms of structural defects and deficits arising from parental failure, and therapy less as analysis, insight and self-mastery than as reparative provision of allegedly missing psychic structure through processes of internalization and identification with the therapist as a kind of

substitute parent (Carveth 1998).

While it is most likely the case that the hystero-paranoid fugitive from guilt has always been with us, the varieties of contemporary psychoanalysis in which the discourse of guilt and self-punishment is downplayed are poorly prepared to come to grips with the dynamics that underlie this type of suffering. In other words, a psychoanalysis that is itself in flight from guilt is in no position to understand the hystero-paranoid fugitive from guilt, for to do so it would have to understand and cure itself. Needless to say, it is the aim of this paper to contribute to such curative self-understanding.

* * *

Of what are arguably the three most important recent books on hysteria—Elaine Showalter’s (1997) *Hystories: Hysterical Epidemics and Modern Media*; Christopher Bollas’s (2000) *Hysteria* and Juliet Mitchell’s (2000) *Mad Men and Medusas: Reclaiming Hysteria*—Bollas’s work is notable for its single-minded, early Freudian emphasis upon sexuality and its relative neglect of the role of aggression in hysterical conditions. Freud himself never revisited his early work on hysteria in light of his later positing of Thanatos (and its outward manifestation as an aggressive drive) as the “immortal adversary” of Eros in a human nature driven by these two “Heavenly Powers” (Freud, 1930, p. 145).^[5] For Bollas, as for Freud, “the heart of the matter” of hysteria is “the hysteric’s disaffection with his or her sexual life” (p. 12).

Bollas argues, I think correctly, that “Hysteria has disappeared from contemporary culture only insofar as it has been subjected to a repression through the popular diagnosis of ‘borderline personality disorder’” (frontispiece): “... thinking the hysteric through the theoretical lenses of the borderline personality had become something of a tragedy” (p.2). He sets out to recover and elaborate upon an earlier psychoanalytic understanding of hysteria. But in so doing he loses sight of the elements of this condition that were at least brought into focus through the theoretical lens of the borderline concept, whatever its inadequacies in other respects: namely the paranoid-schizoid dynamics of splitting, projection, sado-masochism, disavowed aggression and hostility, and the resulting unconscious need for punishment.

Bollas praises Showalter’s work and endorses her view that “hysteria is alive and well in the form of attention-deficit disorder [actually not addressed by Showalter[6]], chronic-fatigue disorder, alien-abduction movements and the like” (p.178), as well as her emphasis upon the role of both clinicians and the media in creating such conditions. “It is more than sad,” he writes, “that the hysteric’s capacity to fulfill the other’s desire has meant that many people have dedicated their lives to romances with clinicians, presenting new ‘sexy’ diagnoses—such as multiple personality disorder—which inevitably earn accolades for the clinicians founding a new term or re-founding an old one, now rendered dramatically potent” (p.178). (Recall in this connection Frederick Wolfe’s regret at having pioneered the “fibromyalgia syndrome” diagnosis.) But whereas Showalter does not shrink from the evidence of the dynamics of hatred and paranoid projection in the new hysterias, Bollas himself writes almost exclusively within a pre-

1920 Freudianism that, however enriched by later object-relational and Lacanian perspectives and insights, focuses almost exclusively on sexuality. He summarizes his theory of hysteria as follows: “The hysteric specifies the body as the agent of his or her demise because its bio-logic brings sexual mental contents to mind” (p.178). If the hysteric has been repressed in recent decades by the borderline, in Bollas the borderline (schizo-paranoid) is repressed by an old-fashioned, pre-1920, view of the hysteric.

In contrast, like Showalter, Juliet Mitchell draws attention to the dynamics of aggression in hysterical conditions. She does so by re-focusing our attention upon two sets of facts that, although recognized by Freud, were later downplayed both in his own work and in that of his followers. The first is Charcot’s and Freud’s early recognition of the existence of male hysteria. Mitchell cites two main reasons for the fact that while “the critical claim that inaugurated psychoanalysis was that men could be hysterical ... psychoanalysis too slipped from explaining to endorsing its proclivity in women” (p. x). First, there is “the non-elaboration of the hypothesis of a death drive in general, but in particular in relation to hysteria.” (Here, by “death drive” we understand Mitchell to be referring to aggression, violence and hostility.) She writes: “as with feminists’ accounts of hysteria, what is missing [in psychoanalytic accounts such as Bollas’s] is that there is violence as well as sexuality in the seductions and rages of the hysteric” (p. x). The feminization of hysteria extended sexist blindness to female aggression to the hysteric. In addition, the failure to revise the psychoanalytic theory of hysteria in light of the dual-drive theory introduced by Freud in 1920, long after his pioneering work on this condition at the turn of the century, contributed to ignoring the role of aggression, whether

conceptualized as primary or secondary to frustration, in hysterical conditions.

The second set of initially recognized but subsequently downplayed facts concerns the role of sibling rivalry in personality formation, “the omission of the key role played in the construction of the psyche by lateral relationships” (p.x). Mitchell writes, “When a sibling is in the offing, the danger is that the hero—‘His Majesty the Baby’—will be annihilated, for this is someone who stands in the same position to parents (and their substitutes) as himself. This possible displacement triggers the wish to kill in the interest of survival” (p. xi). In the sibling rivalry that inevitably accompanies sibling love, “murder is in the air” (p. 20). Mitchell acknowledges, of course, that such violence may take a sexual form—“to get the interests of all and everyone for oneself”(p.xi). In connection with the link between violence and hysterical hyper-and pseudo-sexuality, we are reminded of a remark made by a seasoned, older male clinician in an initial interview with an overtly seductive, scantily clad, hysterical young woman: “Why are you trying to destroy me?” Just as Carol’s stepson Rory is not blind to the manipulation and passive-aggression beneath his stepmother’s manifest helplessness, this seasoned clinician was alert to the destruction in seduction.

Like Bollas and Showalter, Mitchell affirms the continuing presence of hysteria in our culture, despite psychiatric attempts to deny it. “It has been fashionable in the twentieth-century West to argue that hysteria has disappeared. To my mind, this is nonsensical—it is like saying ‘love’ or ‘hate’ have vanished. There can be no question that hysteria exists, whether we call its various manifestations by that

name or something else”(p.6). For Mitchell, there is nothing intrinsically feminine about hysteria, which she views, like love and hate, as an intrinsic potential of human nature as such, arguing instead that “hysteria has been feminized: over and over again, a universal potential condition has been assigned to the feminine; equally, it has disappeared as a condition after the irrefutable observation that men appeared to display its characteristics”(p.7).

Like Showalter and Krohn, Mitchell emphasizes hysteria’s adaptation to the sociocultural surround: “Hysteria migrates. Supremely mimetic, what was once called hysteria manifests itself in forms more attuned to its new social surroundings. What was once a subsidiary characteristic becomes dominant and vice versa” (p.ix). Nevertheless, “hysteria’s many manifestations have shown some striking similarities throughout the ages—sensations of suffocation, choking, breathing and eating difficulties, mimetic imitations, deceitfulness, shock, fits, death states, wanting (craving, longing)If the treatments and conceptualizations vary, mimetic hysteria will look different at different times because it is imitating different treatments and different ideas about hysteria” (p.13).[7]

Referring to the introduction in DSM II and III of “histrionic personality disorder” to replace “hysteria,” Mitchell comments that “The irony of this triumph of the diagnostic is that the doctors who no longer recognize hysteria’s existence continue to refer to it daily.” She comments, “given the history of hysteria, one must surely ask: Is it hysteria itself or its classification—psychiatric, medical or psychoanalytic—that has become redundant?” (p. 15)[8]

CASE 2: Mr. B

During the second year of his analysis, Mr. B., a thirty year old academic with a flamboyantly rebellious cultural and political outlook who entered analysis due to work inhibitions, relational problems and diffuse anxiety and unhappiness, suddenly started experiencing dizzy spells. For example, he might be in a supermarket when, suddenly, he would have to clutch his cart to stop from falling over as the store seemed to slowly begin to move and spin around him. Although suspecting that this was a symptom of an hysterical order, the analyst recommended a complete neurological investigation which yielded nothing. As the analysis continued evidence accrued that the dizzy spells amounted to a kind of body language in which the patient communicated the defensive message that he was not at all a phallic, competitive, oedipally aggressive male but, on the contrary, more like a swooning woman. With this analysis the symptoms disappeared, never to return.

Some years later, while the analysis continued, Mr. B. began to experience severe pain in both hip joints. By the time he sought medical help for this, he was at times using a cane. A physiatrist x-rayed the joints and informed Mr. B. that he had sustained serious damage to both in the course of a mysterious illness he had suffered between the ages of three and five that had been accompanied at the time by rheumatoid arthritis. The physician informed him

that double hip replacement surgery would eventually be necessary but, as the technology in this field was improving at a rapid pace, it would be in his interest to postpone the surgery as long as possible with the use of anti-inflammatory medication. He was prescribed a large daily dose which he gradually reduced by about two thirds and maintained at that level for several years. After viewing a television report about sudden bleeds caused by such medication, he decided he needed to get a second opinion. He retrieved the original x-rays and took them to the head of the rheumatology department at a local hospital who looked at them and examined him and then informed him there was nothing whatsoever wrong with him. The patient was dumbfounded. He asked what he was to do with all the medication. The specialist told him to flush it down the toilet. As he had been told he would never be able to run or play sports such as tennis, he asked about this and was told to "start gradually." Incredulous, he sought the advice of another rheumatologist who confirmed the diagnosis that neither the original x-rays nor examination revealed any pathology whatsoever. The patient stopped taking the anti-inflammatory medication, replacing it with coated aspirin when necessary, and soon even dispensed with that. There were no subsequent episodes of hip joint pain. (He cast off his crutches and walked.) In his analysis, the patient realized that, once again, he had been communicating, psychosomatically and hysterically, that he was not an intact, phallic and competitive male, but a wounded, in fact, a crippled man.

One can only speculate as to the nature of Mr. B's infantile

illness. The combination of high spiking fevers and rheumatoid arthritis suggests Still's Disease, a condition some view as an autoimmune disorder which may have emotional causes. The patient's mother suffered from periodic severe depression throughout her life and became recognizably alcoholic by the time he was five or six. The illness seems to have manifested around the time that a boy of the same age, who had been taken into the family and raised for a year as the patient's informally adopted brother, was returned to his family of origin when they refused to allow him to be formally adopted. In other words, what might have been Still's Disease emerged when a "sibling" who had suddenly arrived in his life, dethroning him from his status as only child, disappeared from it just as suddenly. This was followed by the patient's dim awareness of his mother's serial "illnesses" (several miscarriages) and his growing recognition of her worsening depression and alcoholism. As a little boy, the patient appears to have associated these miscarriages with memories of his father's burial of several of the family canaries in large matchboxes in the backyard. In the sibling rivalry that inevitably accompanies sibling love, "murder is in the air" (Mitchell, 2000, p. 20). It may be that Mr. B's repetitive need to enact the role of a swooning woman and a castrated and crippled man had its roots both in his preoedipal relationship with a disturbed mother and in unconscious oedipal "guilt" (or, rather, an unconscious need for punishment) for the "crime" of survival and triumph over both his real, albeit temporary, and potential siblings.

* * *

The varieties of hysteria Showalter describes exhibit an important trait that she touches on only briefly: paranoia. Many of the hysterical symptoms she explores contain distinctly paranoid features, as she acknowledges in describing the particular vulnerability of American culture to hysterical movements: "...such movements have centred on the Masons, Catholicism, communism, the Kennedy assassination, and the fluoridation of water. In the 1990's, hysteria merges with a seething mix of paranoia, anxiety, and anger that comes out of the American crucible" (p.26). She quotes *New Yorker* writer Michael Kelly (1995), who gives the term "fusion paranoia" to the mélange of conspiracy theories flourishing in the United States: "In its extreme form, paranoia is still the province of minority movements, but the ethos of minority movements—anti-establishmentarian protest, the politics of rage—has become so deeply ingrained in the larger political culture that the paranoid style has become the cohering idea of a broad coalition plurality that draws adherents from every point on the political spectrum" (Showalter, 1997, p.26, citing Kelley, 1995, pp. 62, 64). Further on, Showalter observes that this "fusion paranoia" has taken up residence in medicine and psychiatry, allowing for the proliferation of conspiracy theories to explain "every unidentified symptom and syndrome" (pp.26-27). This observation is elaborated by Sherrill Mulhern, an American anthropologist critical of such recent excesses, who observes "...the emergence of conspiracy theory as the nucleus of a consistent pattern of clinical interpretation. In the United States during the past decade, the clinical milieu has become the vortex of a growing, socially operant conspiratorial mentality,

which is undermining crucial sectors of the mental health, criminal justice, and judicial systems” (Showalter, 1997, p.27, citing Mulhern, 1994, p. 266).

The close connection between hysteria and paranoia—and even, perhaps, their interdependence—does not appear to have been explicated and developed by psychoanalytic writers who have tended to address either one or the other condition, treating them, implicitly at least, as discrete entities. It is due to this insufficiently theorized linkage that we refer to the psychological conditions we are addressing as *hystero-paranoid*. It is consistent with the tendency of psychoanalytic writers to treat hysteria and paranoia as non-related subjects that Melanie Klein wrote extensively about the subjects of anxiety and paranoia but was “silent on the subject of hysteria” (Rycroft, 1968, p.64). However, certain insights into the origins of hysteria can be extrapolated from her writings. We contend that there is a relationship between hysteria and Klein’s paranoid-schizoid position, so much so that hysteria may be viewed as an offshoot of PS functioning which almost inevitably produces hysteric symptoms, albeit often minor ones that frequently go unrecognized.

Human beings are never free from the task of managing their primal passions, phantasies and anxieties, including their aggression, nor from the simultaneous need to order and regulate the world of internal objects and form meaningful connections with external ones. Because of Klein’s recognition that these tasks of mental life are ongoing and permanent rather than occurring in discrete stages, the mental “positions” she expounded are fluid, dynamic states that are present in varying degrees throughout every phase of life. The

infant's early pre-ambivalent paranoid-schizoid state, characterized by splitting of the object (and the self) into all-good and all-bad part-objects (and part-selves), persecutory anxiety, envy, manic defenses, "symbolic equations" (Segal, 1957) and "beta elements" (Bion, 1962), hopefully gives way to the depressive position's ambivalence, whole object (and self) relating, guilt, reparation, gratitude, capacity for "symbolic representation," "alpha function" and creativity. But elements of PS functioning, both healthy and pathological, remain operative in all persons throughout life. In current post-Kleinian theory, development is no longer conceived as a unilinear progression from PS to D, but dialectically (PS \leftrightarrow D), with pathology being conceptualized as breakdown of the dialectic into a fixation upon either pole (Ogden, 1986).

It should go without saying that at this stage in the development of object-relations theory, it is unnecessary to adhere to any literalistic notion of a biologically-grounded aggressive drive, let alone any literal death-instinct, in order to credit Mrs. Klein's insight into the fact that, even with the most attuned and devoted caretakers imaginable, all infants must encounter some degree of frustration which inevitably generates aggression that, when projected, returns in the form of persecutory anxiety. In its state of cognitive immaturity, it is plausible to assume that the infant experiences any frustration as an attack, and any absence of "good" as an indication of the malevolent presence of "bad." It is as if the infant assumes that it is the job of the good part-object to protect and gratify and it experiences any pain and frustration not merely as an indication that the good part-object is failing at this task, but that it has actually turned into a bad part-object—i.e., a persecutor. Needless to say, any "surplus" frustration, beyond the unavoidable existential minimum,

arising from objective environmental failure of various types, will only aggravate a paranoid dynamic that is in varying degrees universal.

In the face of frustration and feelings of persecution, the infant reacts with both fear and aggression which is itself frightening and that, when projected, only adds to its persecutory anxiety. Here, in the realm of disowned aggression, lies the particular insight of Kleinian theory into the development of hysteric illness. The subject operating in the paranoid-schizoid position cannot escape the feeling of attack, having repudiated its own aggressive and destructive impulses and situated them squarely in the outside world. This move fails to dissolve the aggression, however. It still exists in all its strength on the outside, which is now rendered threatening and dangerous. The ensuing tangle of conflict is compounded when the subject also projects perceived good objects and impulses in order to protect them from the contamination of badness inside, and introjects or even identifies with perceived external persecutors in an attempt to gain control of them. Segal (1964) comments that "...in situations of anxiety the split is widened and projection and introjection are used in order to keep persecutory and ideal objects as far as possible from one another, while keeping both under control. The situation may fluctuate rapidly, and persecutors may be felt now outside, giving a feeling of external threat, now inside, producing fears of a hypochondrical nature" (pp. 26-27). Hysteria may likewise be interpreted as the product of a paranoid-schizoid dynamic in which individuals who have split off and disowned their own aggressive and destructive impulses suffer from phantasies of attack and an abiding sense of being made ill by hostile forces, either within the body (as in "fibromyalgia syndrome" and "chronic fatigue

syndrome”) or outside it in the environment (as in “environmental illness” or “multiple chemical sensitivity”), but in any case from outside the self.

We have described the tendency of hysteric patients to regard their symptoms as residing in the body but unrelated to the self, that is, existing as a foreign, invading force, *in* but not *of* the patient. In paranoid-schizoid functioning, the subject may disown or evacuate his internal bad self and objects, project the split-off contents and, as a consequence, perceive the external world as independently bad and dangerous. To complicate matters further, in an attempt to manage the external persecutors thus created, he may reintroject them. Segal’s observation regarding the introjection of persecutors and subsequent hypochondria (in which the persecutors are felt to be attacking from within the body) illustrates the conjunction between paranoia and hysteria.[\[9\]](#)

According to Segal, “The projection of bad feelings and bad parts of the self outwards produces external persecution. The reintrojection of persecutors gives rise to hypochondrical anxiety” (p.30). While there are grounds for maintaining the distinction between hypochondria and hysteria, viewing the former as one type or manifestation of the latter, it is reasonable to extrapolate a reciprocal connection between paranoia and hysteria by way of this connection between paranoia and hypochondrical anxiety. Both involve projection and a resulting experience of attack and persecution, in one case from without, in the other from within. But the psychoanalytic literature has tended to treat paranoia and hysteria as discrete conditions, and these citations from Segal (1964) may be one of the few places where paranoia and

hypochondria, and correspondingly hysteria, are explicitly brought together.

The splitting characteristic of the paranoid-schizoid position produces an austere, one-dimensional, concrete mode of thinking and an inability to relate to others as whole persons: “Where the persecution anxiety for the ego is in the ascendant, a full and stable identification with another object, in the sense of looking at it and understanding it as it really is, and a full capacity for love, are not possible” (Meissner, 1978, p.13, citing Klein, 1964, p.291).

Conceiving of the world in terms of part-objects and keeping good and bad thoroughly separated allows the subject to feel as though he is protecting good objects from contamination by the badness inside him. But paranoid-schizoid functioning exacts a high price for the manufacture of this apparent “safe” zone through projection of the badness, if not in the form of persecutory fantasies, feelings and outright paranoid delusions, then in that of the hysterical (and psychosomatic) disorders which embody the return of the disavowed badness and simultaneously punish the subject for it in ways that evade the experience of unbearable guilt.

A central feature of the paranoid-schizoid position is an inability to achieve the type of guilt and remorse that are operative in the depressive position (Meissner, 1978, p.13) and that reflect attainment of what Winnicott (1963) called “the capacity for concern.” Instead of such mature, “depressive guilt” (Grinberg, 1964), what we find in PS is either an intense “persecutory guilt,” self-attack that is entirely narcissistic reflecting little or no concern for the object (and which, therefore, as we have argued above, should not be described as guilt

at all), or a variety of tormenting states (including hysterical and psychosomatic conditions) that operate as substitutes for and defenses against unattainable or unbearable depressive guilt. In the context of the depressive position, a continual state of rage and feelings of destructiveness will be accompanied by simultaneous feelings of conscious guilt, concern and the need to make reparation. In PS, however, such destructiveness is split off and projected resulting in persecutory anxiety and unconscious masochistic needs for expiation through self-punishment (Reisenberg-Malcolm, 1980). Safan-Gerard (1998) describes a patient whose career has collapsed after he leaves his wife and children to pursue one of his numerous affairs. At the end of one session the patient ponders, “I don’t know what changed after my separation. Because I used to make good money before. Did I change or did reality change?” (p.365). This patient’s enormous load of unbearable guilt, which he verbally acknowledges but really evades since he cannot allow himself to actually feel or suffer from it, must nevertheless be expiated in some way. In this light, the collapse of his career and his financial difficulties, events which seem to be “just happening” to him, may be viewed as products of self-punishment through self-sabotage.

Carveth (2001) has expounded the theory that the unconscious need for self-punishment is not, contrary to Freud’s view, a manifestation of unconscious guilt. Unconscious guilt does not exist. The unconscious need for self-punishment that Freud equated with unconscious guilt serves precisely to defend against the experience of unbearable *conscious* guilt. We believe the unconscious need for self-punishment is expressed in a wide range of psychopathological conditions—including hysterical and psychosomatic disorders. But just as the hysterical or somatizing subject takes flight from

unbearable guilt into self-tormenting symptoms as guilt-substitutes, so a de-moralizing post-Freudian psychiatry and psychoanalysis repress the dynamics of the superego—i.e., the dynamics of the *soul* (Frattaroli, 2001)—in favor of one or another form of reductionism in which the meaningful communications of the psyche (soul) are reduced to meaningless symptoms of neurochemical malfunction or the results of trauma and deprivation. Even when a de-moralizing post-Freudian psychoanalysis views patients as victims of bad parenting, it seeks to protect such parents from guilt and responsibility by viewing them, in turn, as victims. The irony is that even when both patients and their psychiatrists, analysts and analysts, are in agreement in their repression of the discourse of sin and guilt, the unconscious superego is alive and well and busy in both groups: it torments the patients for their evasion of conscious guilt; and it finds expression in the moralizing of the psychiatrists and psychoanalysts who attack the supposed abusers of their patient-victims, including those who would see them as hysterical.

* * *

When self-defeating and self-destructive patterns and symptoms are observed in patients, they are almost always manifestations of an inability or unwillingness to acknowledge guilt. Not guilt in the analyst's opinion, for that would involve moral judgments on the analyst's part. Although the making of such judgments is an inevitable aspect of the analyst's countertransference, this is to be contained and understood, not acted-out. We are addressing guilt as estimated by the patient's, not the analyst's, superego.

When we acknowledge the voice of the superego, make conscious the painful sense of responsibility, the stab of conscience, that our superego has caused us to experience, we can understand our wishes and impulses, apologize, make reparation, and become strong, not sick. It is our observation that most people can realistically promise to live in a way that doesn't repeat what their superego judges as destructive, once they recognize their superego introjects and injunctions. At the point of conscious recognition and apology, we can let go of self-torment (sickness) and move on.

When the badness (as judged by the patient's superego) involves phantasies and wishes, the uncontrollable creations of the id, rather than actual inappropriate behaviors, the only promise we can make is to understand the distinction between wishing and acting. The more the corrupt wish is allowed conscious expression, the less chance there is the person will need to act it out. When any evil impulse or wish (as judged by the patient's superego) is made conscious and verbal rather than unconscious and acted upon, the ego is strengthened and symptoms as compromise-formations become unnecessary.

On the other hand, when a patient represses or otherwise manages to remain unconscious of his superego's judgment that he's done or wished something immoral, he becomes symptomatic and/or destructive, suicidal or homicidal, emotionally or literally. The analyst examines the patient's symptoms to understand what the patient's superego is pressing the patient to acknowledge and

resolve.

Unfortunately and with good intentions, psychoanalysts' avoidance over time of being linked to either the world of the lawyer or the world of the priest has led to a neglect of the superego's need to clamor for conscious (verbal) recognition—i.e., for naming, describing, acknowledging and tempering. The psychoanalysts' understandable aversion to being the superego for the patient has led, in many areas of clinical practice and theoretical writing, to an aversion to examining superego functioning at all. It is possible in some situations that an analyst's countertransference inability to tolerate the pain of a patient's badness finally being revealed—such badness being judged primarily by the patient's superego, but sometimes also by the analyst's—is another reason analysts unconsciously steer clear of the topic.

Analysts aren't required to judge whether or not a patient *should* feel guilty about his wishes or actions. In fact, it works against the psychoanalytic aim of making unconscious conscious for an analyst to weigh in with his values and opinions about right and wrong over the course of a patient's treatment. For various reasons, many psychoanalysts feel that soothing a patient's superego is part of their job. It is not uncommon for an analyst to communicate to a patient that he or she has nothing to feel guilty about—for example in the case of murderous oedipal fantasies which are, as we know, universal, “natural”, the human condition. But, even in the case of real-life actions, such as ignoring Mother on Mother's Day, psychoanalysts have been known to attempt to de-guilt the patient, communicating in some way that there is nothing to feel guilty about.

Setting aside for a moment the fact that, according to the patient's superego, there is indeed quite a lot to feel guilty about—guilt that must be reckoned with, not avoided—the act of soothing a patient's superego voice implies that the analyst has taken a stand in regard to value judgments (they're okay if they're nice but apparently not if they're not) and has brought her own value judgments into the patient's session. In contradictory fashion, these analysts come down hard on those who recognize that the patient's superego's judgements (e.g., “you *should* feel guilty”) represent an important aspect of the patient's personality and therefore must necessarily occupy an essential and valid place in the patient's analysis.

In analyzing the patient's superego functioning, it is our belief that we should strive as far as possible to maintain the classical stance of technical neutrality in which, according to Anna Freud (1937), the analyst takes up a position “equidistant from the id, the ego, and the superego” (p. 28). Admittedly, perfection in this matter is impossible and, for this reason, we should seek to be as conscious as possible of our moral biases as significant aspects of our countertransference.

Departures from the stance of technical neutrality may take the form either of inappropriate moral soothing or inappropriate moral condemnation. It is our impression that the former departures from technical neutrality seem more acceptable in today's climate than the latter.

Soothing gives the patient the message that his or her badness should probably be concealed from an analyst who thinks everything is okay, or who just cannot tolerate intense feelings of remorse. The patient hides his feelings of badness. This type of analyst will aid the patient in further symptom-forming self-punitiveness, rather than helping to bring his unconscious moral conflicts to consciousness where they might be resolved.

Condemning gives the patient the message that they are in the presence of a priestly confessor, not an analyst, who will, ironically, also aid them in more symptom-forming self-punitiveness rather than analyzing. The patient hides his feelings of badness.

It is notable that almost all unanalyzed people display, to some degree at least, the dynamic of the modern hysteric: murderous wish, leading to guilt denied, leading to an inhibited or symptomatic life. We have rarely encountered patients who haven't been affected in some way by being taught to silence both their rage and their remorse, with the consequence of a life spent engaged in hysterical and destructive behavior.

CASE 3: Mr. C.

A man who began analysis at age 45 has had bodily preoccupations since childhood. He is compelled to stare into

mirrors to “see if I’m here.” He somatizes with various illnesses (such as Graves disease) whenever he hates. That is, he has developed unconsciously a systematic somatic defense against the feeling of hate. Before he consciously identifies that something or someone has stimulated his rage, Mr. C. will have a fever, heart palpitations, or diagnosable thyroid alterations. Along with illnesses Mr. C has had elective surgeries for various ailments leading to vague post-operative medical regimens and prescriptions. He reports that his wife (whom he would like to avoid touching) is annoyed at night when he lines up his multitude of pill bottles, then swallows them in a ritual that drives her to fall asleep before they can be intimate.

Born fourth of eight children to a cold, inattentive, phobic and distracted mother, Mr. C. has only two pleasant memories of childhood. The first is that at age five he contracted an illness that was serious enough for him to miss two months of school but not serious enough to warrant hospitalization. A bed was placed in the living room so his mother could take care of him without having to run upstairs. That time of being ill, which he was told damaged his heart slightly and permanently, was the only time in his life that he had his mother to himself (remember he was one of eight children).

Mr. C’s only other nice memory of his mother occurred when his baby brother was born. His brother, the last of the eight, made the mother happier than the others for no

apparent reason. Mr. C sensed his mother's unusual calm (she was usually depressed and cold) and he was allowed to sit beside her as she fed his brother.

Mr. C feels an inextricable link between disease and attachment. He experiences both horror and excitement at signs of illness, as his childhood illness was the only time he had a mother.

A year after Mr. C was born his sister D, the fifth child, was born. This sister is the identified root (now conscious in the analysis) of Mr. C's history of denied hate, sneaky sadism, guilt evasion and psychosomatic illness, predictably occurring in order: hate ---> some denied sadistic activity ---> evasion of responsibility ---> physical illness.

For the first half of his analysis he could recall torturing sister D in many ways but he did not know why. The motivation for torturing D was a total mystery to Mr. C. No clue, can't say he resented or hated his sister: "we all love each other so much in my family."

He could remember coldly pushing D off the bed, demeaning her, abandoning her on the busy city street when he was six and D was five. But all with no conscious recollection of the accompanying feelings (later recalled: disgust, jealousy, resentment, murderous rage). His motives were a big mystery

in the first years of analysis. Why would someone, anyone, push his sister off the bed? Mr. C couldn't answer. (Long pause). "I'm truly puzzled... we all loved each other so much." He was entirely unaware of any feelings of rivalry, hate, frustration, craving or envy. He could access only memories of feeling sorry for D: for never being as popular as he, for D. developing debilitating anxieties and not being able to go to college because of her anxieties, while Mr. C went on to receive a Master's degree. Typical of this dynamic, *when murderous impulses are acted on with complete repression of affect, responsibility and subsequent contrition can be evaded. Then the still- unconscious aggression is turned against the self that continues to deny having acted criminally.* The patient enacts the parts of both the criminal *and* the sentencing judge and jury.

In Mr. C's case, though, even his self-torment has always been tinged with an excitement that can only be described as sexual, though such sexual excitement is a physical consequence, not the aim of the violence. In the sequence--denied rage, sadistic action, and evasion of responsibility--he is observed to be quite taken over physically. His heart flutters and pounds as his thyroid "kicks up." He gets flushed and breathes heavily. He sweats and smiles weakly as his eyes roll back and his lashes flutter. During this theatrical demonstration of falling ill Mr. C maintains a cheerful demeanor, impeccable grooming, and meticulous orderliness. His analytic group has been perplexed watching the discrepancy between Mr. C's alarming medical symptoms, his thrill at being swept away by them and his determination

to remain perceived as cheerful and impeccable all at the same time. Psychoanalysts know how hard it is to be hysteric. It is one of the most exhausting and often permanently debilitating defenses against rage that we treat.

In summary, what leads to his somatization? Denied hate. He hates and is unconscious of his homicidal rage towards the person he hates. Someone had been disrespectful; someone had threatened to leave him; someone turned down an invitation. Mr. C denies to himself that he'd love to knock these offending people right off the bed. He doesn't push overtly anymore. *He gets sick instead of conscious*, sick instead of feeling and talking.

The analyst and Mr. C, working together for seven years, along with help from his analytic group, have gradually been able to make conscious the great dark rage that underlies his pose of "nothing's wrong," his sneaky aggressive actions, the evasion of responsibility and subsequent self-punishments via illnesses. Where it used to take Mr. C literally a year of analysis to acknowledge the progression from rage to illness, he now identifies it quickly. In fact he is now beginning to *interrupt the hysterical sequence by substituting feelings and words for symptoms*, that is, becoming healthy by becoming real.

Conclusions

With Showalter, Shorter, Bollas, Mitchell, and others, we believe that hysteria has not disappeared but transformed, nowadays taking the form of environmental illness, multiple chemical sensitivity, chronic fatigue syndrome, multiple personality disorder, fibromyalgia syndrome, alien abduction syndrome, Gulf War syndrome, intestinal toxins and parasitic infestation syndrome and, in proxy form, attention deficit disorder and attention deficit hyperactivity disorder, among other syndromes—e.g., the hysteria around video display terminals; Mad Cow Disease; the Y2K hysteria; the mass hysteria around asbestos or around molds—and the list goes on.

Because Freud never revised his sex-centered theory of hysteria after he introduced the dual-drive theory (Eros/Thanatos) in 1920, the role of aggression in this condition was never adequately recognized. As late as the year 2000, Bollas still viewed hysteria in largely sexual terms. On the other hand, the Kleinians, who emphasized the role of aggression in psychopathology, had little to say about hysteria, except for their understanding that hypochondria, a subtype of hysteria, involves a paranoid sense of persecution by bad objects imagined to reside *inside* rather than *outside* of the body. But the Kleinians failed to develop the connection between hysteria and the paranoid-schizoid position—a connection so profound that we regard the various forms of hysteria as sub-types of a more general hysteroparanoïd syndrome.

In our view both the old and the new hysterias involve a paranoid-

schizoid retreat from and defense against the depressive position—i.e., a retreat from what Winnicott called the “capacity for concern” for the object into a narcissistic and schizoid non-relatedness, combined with repression and projection of destructive hatred and envy of the object, resulting in a paranoid state of persecution by the bad objects into which the subject’s hate has been projected. The resulting state of paranoid torment serves the archaic superego’s demand for punishment for both the schizoid coldness toward and hatred of the object world.

Such self-torment has been called “persecutory guilt” as distinct from “depressive guilt” by Grinberg (1964), but elsewhere Carveth (2001) has argued that it is misleading to refer to such disparate phenomena as paranoid self-torment and concern for the object by the same word, “guilt”—especially since the former serves as a defense against the latter on the part of those unable to bear the guilt, concern, and drive toward reparation characteristic of the depressive position.

Carol “White”—a personality purged by externalization of all darkness—suffers from a schizoid state of demoralization resulting from her de-moralizing flight from concern and guilt—i.e., from human relatedness—and from a paranoid state of persecution resulting from projection or externalization of her hostility, a state of torment that simultaneously defends against unbearable guilt and punishes her for her evasion, irresponsibility and hatred.

Carol’s personal demoralization and the de-moralizing flight from

morality—i.e., object relations—that causes it, mirrors that of the wider culture. We live in a society in which we can say we disagree with someone, but can no longer say that he or she is wrong, let alone that he or she is bad. From the politician to the intellectual we are all aided in avoiding contrition, remorse, responsibility and the need to make reparation. Our cultural mantra is Carol's: "I can't help it."

We are in no way claiming that people were morally better in the past when the Judeo-Christian discourse of sin and responsibility was still in force. In fact, owing to that very discourse (among other factors) the brutality of the Middle Ages has been significantly transcended in liberal democratic societies. It is such moral progress (insofar as our actions as distinct from our wishes and feelings are concerned), such an increase in civilization and the strengthening of superego demands, that makes it more difficult for us to bear the discontents of civilized life—that is, the powerful guilt feelings arising from our brutal impulses that must either be endured and, if possible, creatively transformed, or evaded through the patterns of unconscious self-torment.

One thing is clear: the de-moralizing trend evidenced in the demoralization and unconscious self-torment seen in the new hysterias is mirrored by the de-moralizing trend and the demoralization of contemporary psychoanalysis. For unlike its Freudian and Kleinian forbears, various trends within post-Freudian psychoanalysis retreat from helping patients discover their agency and assume responsibility for their suffering and instead collude with the cultural discourse of victimhood in which patients are held to be

products of their traumatic childhoods, parental failures, disordered neurochemistry, or whatever. Although such therapists are not blaming a polluted environment but toxic neurochemistry, not alien abduction but the absent father or unempathic mother, they share the defensive externalization of responsibility with their hysterical patients. Furthermore, where these mothers and fathers are themselves in analysis, they too are helped to understand themselves as victims.

What then is the direction forward? Certainly it is not the path of an instinctual liberation that would seek to return us to the brutality of a pre-moral era, or to brutal interpretations of guilt—for it is unnecessary to be brutal in the interpretation of guilt to help people confront and bear it. But neither is it the continuation of our current de-moralizing trends that merely intensify the unconscious need for punishment. What is called for is neither the de-moralizing nor the re-moralizing of psychoanalysis, but rather the analyzing of unconscious superego dynamics, so that patients are helped to transform unconscious self-torment into conscious guilt and to find ways to bear it, to make creative reparation, and to change.

Notes

* *American Imago*, Vol. 60, No. 4 (Winter 2003): 445-479. A much earlier version of this paper, written with the assistance of Naomi Gold, was presented at a scientific meeting of the Toronto Society For Contemporary Psychoanalysis, October 4, 2000; and in a somewhat abbreviated and revised form to the Group for Applied

Psychoanalysis, University of Florida, Gainesville, February 14, 2002. The present version, presented at the scientific meetings of the Canadian Psychoanalytic Society, Vancouver, June 8, 2002, has been substantially revised in collaboration with Jean Hantman Carveth, who also supplied illustrative clinical case material. It also incorporates some of what was presented as "Notes on the Hysterias, New and Old" at the Seventh Annual Day in Applied Psychoanalysis, Trinity College, University of Toronto, October 4th, 2003. The conception of unconscious self-punishment as an evasion of guilt rather than its equivalent (as in Freud's view) that is here applied to the understanding of hysteria was developed in an earlier paper (Carveth 2001), "The Unconscious Need for Punishment: Expression or Evasion of the Sense of Guilt?" *Psychoanalytic Studies* 3, 1: 9-21. Available online here: [Guilt](#).

[1] We place the word "guilt" in inverted commas here to indicate our belief that the "persecutory guilt" that Grinberg (1964) contrasts with what he calls "depressive guilt" is not really guilt at all: it is persecutory anxiety. The term "guilt" should be reserved, in our view, for what Grinberg calls "depressive guilt" or what Winnicott (1963) termed "the capacity for concern." As Alexander (1925; 1930; 1961) was among the first to recognize, true guilt (in what Klein called the depressive position) is an ego function: it involves thinking of the consequences of our behaviour for others. In this way it contrasts with the essentially narcissistic nature of the "persecutory anxiety" (mislabelled by Grinberg as "persecutory guilt") that entails a superego attack on the self that is notable for its lack of concern for the injured other. It is the paranoid-schizoid and narcissistic nature of the superego that enabled Alexander to define the aim of the analytic cure as its elimination.

[2] Some three decades ago, Menninger (1973) was already asking *Whatever Became of Sin?* We have heard psychoanalytic colleagues, not Freudians or Kleinians but self psychologists and some relational analysts, report that they seldom if ever encounter guilt or the unconscious need for punishment as significant dynamics in the lives of their patients. A technique of empathic attunement to patients' conscious and preconscious experience that rejects attention to their *unconscious* experience as no more than the analyst's imposition of his theories might be expected to ignore these dynamics.

[3] In keeping with Freud's acknowledgement that the "choice of neurosis" is often beyond the powers of psychoanalysis to explain, so the development of one sub-type of the hystero-paranoid syndrome as distinct from another may not be fully accountable in particular cases.

[4] Some recent evidence has appeared that calls into question the hystero-paranoid basis of at least some cases of so-called Gulf War syndrome. Like Showalter, we have no reluctance to acknowledge an organic basis for conditions such as multiple chemical sensitivity, environmental illness or fibromyalgia syndrome, if and when consensually validated scientific evidence in support of such claims leads to their medical recognition as diseases.

[5] In emphasizing the role of aggression in psychopathology we imply no commitment to either the notion of a death instinct or a somatically grounded aggressive drive. We merely recognize the fact that frustration (an unavoidable feature of human existence) leads to

aggression which then must be directed outwardly (in constructive or destructive ways) or bottled up and retroflected against the self.

[6] We would argue that in the case of so-called attention-deficit disorder the hysteric is less the child so diagnosed than the parents, teachers, psychologists and school officials who redefine boredom, dreaminess, fidgetiness and passive aggressiveness as an organically-based disorder—in the absence of evidence of the “minimal brain dysfunction” (or whatever) that is alleged to underlie it.

[7] Such difficulties are well depicted in the case of Carol White in *Safe*, a film that ought to be required study for physicians and psychotherapists working with hysteria.

[8] The same might well be said for the classification “psychosomatic illness” which many doctors now no longer officially recognise, but continue to refer to daily.

[9] This dynamic as it is illustrated in a Kleinian analysis of the film *Alien* (Gabbard & Gabbard, 1987) is discussed in “The Pre-Oedipalizing of Klein in (North) America: Ridley Scott’s *Alien* Re-analyzed” (Carveth & Gold, 1999). There is an unforgettable scene in this film in which, thinking they had successfully eliminated the alien creature that had plastered itself like a bad breast over the mouth of one member, the crew are enjoying a celebratory meal when the alien stirs and begins to move inside him and then suddenly smashes its way through his chest cage and skuttles off into the interior of the ship.

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