Youth Support - Professional Training

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"The invisible woman - working with the hysterical personality"

'The Invisible Woman'
- The Hysterical Personality type -

"The invisible woman"

Imagine going through life as an invisible being. Your first thought might be of the fun of surprising and entertaining with tricks such as disembodied cheese sandwiches floating through the air as portrayed in film and TV versions of the classic story - but I imagine that it would not be long before the more sinister aspects of HG Wells' novel occured to you. The torment of a lost soul, unable to communicate, distancing himself more and more from human kind.

How would such an experience appear to a child? What would it be like to be an invisible baby, left crying alone in her cot? An invisible boy, going about his business unseen, unheard, unheeded. Unable to be held, to be loved. Entirely unrecognised.

The invisible girl, at home, her mother indifferrent to her actions, thoughts and feelings. At school unnoticed in class. How can that child draw attention to herself? How can she be heard?

How often have we heard someone say - often someone who should have known better - "Oh, it's just attention seeking behaviour"? Attention seeking behaviour is a nuisance in the classroom, especially when a teacher has a class full of children demanding her attention. Such behaviour will often be regarded as just naughty, something to be ignored. "Don't let her think she can get her own way". And of course, in a school, one cannot have anarchy, the needs of the individual must be subjugated in relation to the needs of the group. However the child who is ignored and rejected may clamour for our attention and if we then punish that attempt to engage us, once more dismiss her from class, place her out of sight and out of mind - are we not compounding her misery - forcing her to escalate her cries for help?

It is such 'invisible children' such attention seeking young people who are often said to demonstrate a 'hysterical' personality.

My first contact with a case of 'hysteria' was via the television screen when as a teenager I watched the elegant young Dr Kildare brilliantly diagnose and cure hysterical blindness. He proceeded to earn our intense admiration the following week with a 'get up and walk' approach to a wheelchair bound blonde beauty who suffered a hysterical paralysis. Then there was the hysterical elective mute - struck dumb after a fire - and my first days in 'real' emergency service were enlivened by my treating a case of hysterical over-breathing by placing a paper bag over her face - just as I had seen in 'Emergency ward 10'. Hysteria makes good dramatic television!.

What picture does the term hysteria conjure up? The very words 'hysterical personality' engender a sense of denigration - of not taking the person seriously and of lacking compassion for that person's predicament. Traditionally we have been led to regard hysteria as a complaint of rather tiresome women - histrionic outbursts by boring females who earn the antipathy of their doctors. .. 'Hysteria', 'histrionic' all terms originally derived from the Latin 'Hyster' or womb since it

was believed that this was the organ responsible for hysterical symptoms.

The French neurologist Charcot made a particular study of hysteria and his demonstrations of hysterical conversion symptoms at La Salpetrierre in Paris attained the level of theatrical farce. Students and Physicians from all over Europe flocked to see women in extreme states of hysterical paralysis 'perform' on the stage of the lecture theatre and modify their behaviour under the influence of the newly introduced techniques of hypnotism. We in modern society should thank these hysterical patients, since one of Charcot's eager spectators was the young Freud. After experimenting with hypnotism in such cases Freud went on to develop his theories of psychoanalysis and psychotherapy.

The 'old fashioned' patient with classic 'full blown' hysteria is not often seen, but nevertheless we are meeting patients with 'hysterical personality' and hysterical traits practically every day whose symptoms, while not as dramatic as previously described, are nevertheless equally distressing and equally meriting our sympathy and intervention.

There are not many of us who would like to be labelled 'hysterical'; yet most of us have at some time in our lives experienced 'hysterical' symptoms which we have not recognised as such. Such symptoms are often a form of covert communication, our bodies trying to say something that we cannot, will not, or are afraid to express in any other way. Understanding the underlying message and bringing it to consciousness can thus provide relief from the symptom, which is now redundant as a means of communication. Hence the sometimes rapid 'cure' which can come about - particularly in children or the young.

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Dawn and Michael were a 'perfect' couple. Childhood sweet hearts who had been together since secondary school. She had proudly shown off her engagement ring in the fifth year at school but was concerned that they should not get married until they had good jobs and a secure future. Michael started work as a bank clerk and Dawn became an apprentice hairdresser. All their earnings were placed in a joint account to save towards their house deposit.

Finally the mortgage came through, the marriage date was set, and in keeping with Dawn's precise planning, the couple attended the local family planning clinic so that the contraceptive pill could be fully effective in time for the honeymoon which was, naturally, planned at the correct time of Dawn's cycle.

One year later the couple attended clinic again. Their marriage had not been consumated, Dawn was experiencing pain each time Michael tried to make love to her and she thought she must be 'too tight'. Michael a gentle, submissive boy, was very distressed that he may be hurting his wife, he wanted reassurance that he had not been too rough - although nowadays even the suggestion of sex brought on the pain.

Dawn's vaginismus was so intense that she could not be examined. 'See, it's like that all the time. There must be something wrong with me. Michael is so patient, I so want to let him make love to me, but my body just isn't right for it somehow'.

Dawn's body was saying what she could not - that she was afraid and revulsed by sex. She was happy with Michael as a compliant, close friend. Someone safe who would be there for her like a devoted puppy ... but not as a threatening sexual man. Dawn was a child needing attention, the exclusive friendship that they had experienced in school, a good 'clean' predictable alliance, not the 'unwholesome' sexual stuff which could so easily get out of control. While Michael had grown up and needed an adult relationship, Dawn was unable to respond.

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There is often a sense of gain inherent in a 'hysterical' symptom, whereby the sufferer has a distinct pay off associated with the demonstration of his pain, disability or difficulty. This gain is often fairly obvious to the observer and hence the conclusion is often that it must be 'put on' and that the patient is play acting. There is very frequently a quality of play-acting about the whole event and children sometimes enact these scenes for their parents apparent gain. For instance the family who cannot go to see the (covertly disliked) grandmother in the next town because the daughter becomes car sick. More usually however, children demonstrate hysterical symptoms in an attempt to be noticed, recognised as individuals, and for their fears to be acknowledged and dealt with.

The parent who loved school (perhaps), who remembers only the good times, wants his children to be bright and successful will not listen to his son who is too afraid to enter the playground because of bullies - but he accepts the abdominal pain which keeps him away from school.

The father who sees his son, not as an individual but as an extension of himself, someone who will be a champion at junior Judo - will raise a boy who can only leave the sports hall with a recurrent injury, or a daughter who passes out from the effects of over-breathing.

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Sara was a very bright twelve year old who had always been top of her class and had obtained a scholarship to a private school. This term her grades were slipping due to her frequent visits to sick bay with severe headaches. The headaches were described as occurring every day for the past six months, in fact since the previous summer holiday in Hong Kong. The family had been through the inevitable gamut of investigations postulating tropical infections and neurological disorders to no avail and mother, by now distraught, asked to see me.

My request to see the family together resulted in Sara, her mother and three year old brother Jake coming to the unit. Mother entered in a rushed and harassed manner apologising for being late. She had come from work and had collected the

children on her way home. Jake played boisterously with the available toys while mother tried to maintain a composed posture. Sara at my request, began to draw a family scene. She drew competently and accurately with small controlled strokes.

Sara drew a happy child like figure, with a smiling face cuddling a teddy bear - this was her brother. Next to it was a woman's figure, her mother; and behind the two another small figure sat at a table - 'That's me, upstairs'.

'It looks as if Jake is having fun'

'Yes, he is. He has fun all the time. And he's cuddly like the Teddy bear'

'Are you cuddly too?'

'Not really, I don't think so. .... I'm a bit too old for it ... I haven't got time to play and have fun and be cuddly like Jake does'

'Is Mummy cuddly?'

'Not now, she used to be before'

'Before what?'

'Before my headaches started'

'When do you get the headaches?'

'All the time'

'Have you got one now?'

'Yes, I have it all the time, it never goes away'

'You don't seem to be too bothered by it at the moment, is it worse sometimes?'

'Well it is there all the time, but I have to put up with it sometimes. I have to try to carry on to do my homework and I have to look after them.. ' She pointed to the figures.

'Sometimes though it just gets too bad and I have to go and lie down in the sick room and Mummy has to come and take me home from school'.

'And where is your father in the picture?'

'Oh he's away. That's why I have to look after them.'

It transpired that father was a diplomat who had met her mother while on tour of duty in Africa. Mother was very well educated although from a poor family and worked very hard to maintain a superior position in an international company. It seemed to me that she also worked hard to prove herself worthy of her husband and considered her origins socially beneath his. The family had been together on several foreign tours and had then been based in England for two years. Last summer father was posted to the east and the family joined him during the summer holiday. It was then considered that he should remain there alone while Sara continued her studies since she had now reached an age when study was important to her future.

Mother worked hard and would never allow her husband to know that she was finding it hard to cope with a demanding job and two children. Jake was a handful but it was OK for him to have fun and be a bit unruly, he was quite young and he was a boy - but she knew that Sara would have to study hard if she wanted to keep up her position in life. Mother hated to think that Sara could be play acting and putting on her headache, sometimes it did seem that way, seemed too convenient - like the time she had to leave the board meeting - 'I'm really sorry Mummy, I really didn't want to disturb you today' and the day Henry rang from Hong Kong - she could have tried to sound happier on the phone, not worry her father about things.

It was awful to think that way, after all she did seem so ill some times, and she was genuinely sorry to be missing so much school .... but if all the doctors could find nothing wrong...., and if she went on this way she would fail her end of term exams.

Sara had found a way of telling her father that they were not coping without him, her pain was an expression of her sadness at his absence and possibly also of resentment at his abdicating his responsibilities towards his family and leaving her to care for mother and Jake. It was also a substitute for her mother's unsaid feelings.

At the second interview father unexpectedly attended with Sara. He had asked for a transfer to keep the family together. Sara's headache had gone.

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Psychological symptoms, whether of hysterical origin or otherwise, are nevertheless only a part of the whole. Trying to treat symptoms as such is like talking to someone through a keyhole. What of the personality type which is most likely to produce such symptoms rather than say depressive symptoms, or obsessional symptoms? Margaret, a girl of nineteen, illustrates some of the features of what we might call an attention seeking or hysterical personality type.

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Margaret was pretty much ignored and neglected as a child. Her parents split up when she was quite young and her father remarried soon after. He was unable to devote much time to his daughter in any event, because shortly after his marriage he developed Multiple Sclerosis and very quickly became a complete invalid. Her mother was a selfish woman who had little patience with Margaret and who was more fond of her younger sister who was less bother, more compliant and did not interfere so much with her social life.

Margaret attempted to gain her mother's interest by various forms of mainly unsuccessful attention seeking behaviours culminating in an overdose attempt at the age of thirteen. Mother was by now so fed up with Margaret's attempts to gain attention, she saw the suicide attempt as an entirely selfish act (which in many ways it was) - that she relinquished any further attempt to care for Margaret and placed her in care of the social services.

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The seeds of a hysterical personality are here laid in childhood rejection. Margaret was seen not as the developing young child with needs that her parents might meet, with feelings and ideas that her parents might share, but as a nuisance, an intrusion on her parent's life. Her needs could not be met by father, by virtue of his illness (providing a convenient model); or by mother by virtue of her seeming selfish preoccupation in herself and younger child. Margaret therefore learned from an early age that she would not be noticed for herself, she could not communicate in a direct way

with her parents, and that she thus had to resort to other ways of gaining attention. Her actions and her displays of anger became more extreme ranging from childhood tantrums to overdose attempts. She could not get attention for being good so she tried to get attention for being bad and when that did not work she escalated her emotional display by appearing to want to die.

The frustration inherent in such failed attempts to obtain recognition can be enormous but the way in which such an individual continues to make vain attempts can lead to further denial. Margaret's mother recognised her suicide attempt as attention seeking behaviour and thus discounted it. The overdose was not meant as an attempt to die and thus was not taken seriously. Professional staff also take this attitude. The 'play acting' flavour of the hysterical overdose can be seen as time wasting and willful and hardly conducive to eliciting the empathy and help deserved. Resentment and a feeling of being lied to or having the wool pulled over one's eyes can preclude the recognition of the painful rejection underlying the need to behave in such a manner.

Further insights are possible in considering the following extracts of a report on Margaret's progress in a therapeutic unit where she had been admitted for assessment of her relationship with her two children to whom she had given birth at the age of 15 and 16.

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Margaret is a girl who has had a depriving childhood with her adolescence spent 'in care'. Thus as a developing young woman she has had many of her emotional needs unmet. She therefore entered motherhood at an emotionally immature stage resulting in her own emotional needs competing with those of her children.
It is very difficult to work with Margaret in formal therapy ... Any interpretations are challenged and denied and regarded as negative contentious statements. In fact ...She tends to be excessively confrontational with the result that one to one therapy can feel more like a court room cross examination (of the therapist).
Margaret is usually subtley and often overtly manipulative - she wants to call the tunes, to dictate what parts of her programme she will cooperate with .. She also dictates how her therapy will be conducted .. and she is resisting couples therapy with Ian (boyfriend).
One to one therapy effectively broke down after she physically attacked her therapist and then threatened that this was something that she may well do again. Her overall contact with the unit has become very threatening - refusing to do any therapy unless it involves one to one, and only with the person she attacked.

Margaret is very needy of attention. Hopefully she will get some positive help from her boyfriend Ian who seems attentive and caring. Ian needs to be involved in the programme of rehabilitation and seems keen to participate. Margaret is not happy with this at present.

When Ian visits he does not engage with the children - this may be due to Margaret's needs being so great that she is unable to share him with James and Lee. Margaret is very jealous of other's involvement with Ian.

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Margaret demonstrates many classical features of a hysterical personality - childhood emotional deprivation, a demanding attitude towards those who should exclusively care for her, testing out and attacks on therapy and the integrity of her carers. She was also very jealous of any attention she did receive, could not share her boyfriend with her children or with her therapist in couples therapy and constantly demanded exclusive attention. Margaret showed little insight into her childhood rejection and continued to 'attack' and test boundaries even in the light of repeated 'acceptance' and reassurance that her distress was understood and could be worked with.

Anthony Storr commenting on the difficulties of treating hysterical personalities in therapy states that 'insight plays less part in their improvement than does the emotional conviction that , in the therapist, they have found one person who understands and appreciates them'. It is difficult for a therapist to fulfil this position since, for Margaret, and many like her, the world is full of 'inadequate mothers' who are two faced, rejecting and punishing. Her own mother gave her sparse attention in childhood and reacted to her suicidal plea for help by 'marching her down to social services' to be placed in care. Hence her experience of escalating pleas for attention is that even extremes of behaviour are ignored.

While the therapist is trying to reassure and build up a positive 'transference' the hysterical patient will continue to attack and attempt to discredit therapists - pushing forward the boundaries of their behaviour until their fear of rejection brings them back into semi compliance and ingratiation. This extreme to and froing of emotion is illustrated in Margaret's report ..

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Margaret's behaviour (particularly towards her children) is that of a wonderful actress - unfortunately she also 'acts out' her distress in violent attacks on her carers. Margaret finds it difficult to express an appropriate level of affect. She is usually very well defended against showing any feeling and has a 'wall' around her. She will not express feelings spontaneously or talk about them when questioned. When functioning on this level, Margaret uses those around her to 'act out' or express her feelings for her. Her children are often used in this way as 'message carriers' or she may manipulate another resident to act out anger against a member of staff. Margaret is very powerful in this respect and can excite fear in others so that they comply with her wishes. This is often a very subtle process and is often accompanied by Margaret standing innocently watching a tirade with a finger in the corner of her mouth like a wistful child.

Within this process Margaret remains the good little child - the light side of Margaret, and the other person, or one of the children become her bad side - the naughty uncontrolled child. James and Lee enact this almost constantly when with their mother. They can then be very destructive and untidy, throwing things around, making messes and breaking things. When on their own for a time however they are tidy well behaved children.
When Margaret expresses emotion herself, she loses control and swamps herself and those around her. Her responses are all or nothing - as if there is no control valve - when angry she is consumed by rage like a toddler having a temper tantrum. ... Margaret's problem boils down to inability to appropriately express emotion - her fear of losing her children - and at the same time her fear of not being able to cope with them produces a panic reaction - and this is expressed in violent attacks on those around her. She sees others as the cause and source of her problems and bad feelings - she is unable to 'own' her bad feelings herself - and so they pour out onto Ian, the staff here and particularly the therapist. After such an outburst she is left 'spent' and worried like a naughty child awaiting some kind of retribution. She does not understand her emotions and the normally repressed 'good little Margaret' is unable to cope with the uncontrolled tidal wave of feelings. - hence her deep anxiety.
With regard to the children - Margaret is currently obtaining a lot of attention for being a mother. Her functioning as a mother is being observed, her relationship with her children is attracting professional attention. Also she has been placed in the unit, where she is able to 'rule the roost' and obtain a lot of attention - because of the children. Hence her protestations that she must love her children, otherwise she would not be with them - must be looked at from this point of view also - that Margaret's needs for attention are being served by the placement. Also, on a more 'malignant' note, Margaret's maintaining disturbance in the children and continuing to excite concern ensure continuing attention. Margaret is an intensely manipulative individual who is continually trying to undermine and discredit all the professionals involved with her. She has successfully dispensed with two social workers and changed team. She has also entirely disrupted the routine of the unit and keeps herself the centre of attention.

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In the face of such deeply destructive and 'primitive' emotions, manipulation, rejection and denigration, it can be difficult for the therapist to maintain a caring attitude and empathetic understanding for the hurt and pain which the patient carries with him. If the patient's attacks on the therapist can continue to be seen as an entirely understandable product of the patient's childhood rejection, then it can be possible to build a trusting relationship from which a healing process can begin. The patient is attempting to make the therapist pay for all the hurt and rejection meted out in childhood but it must be understood that however good, attentive and ever present the therapist would wish to be, he

or she can never redress or compensate for the parental love, acknowledgement and concern which was not there for the patient at the time when it was so needed and desired.

The therapist can never make up for the lack of a perfect parent - and the very best of therapists can only be 'good enough'. This may well not be good enough for the hungry child screaming for attention and demanding help in a way which may only serve to alienate her carers.

Perhaps the best we can do is to convince the desperate child that we can hear her and to persuade the 'invisible woman' that we can see her.