gaze of the other, who for a moment is an innocent in the presence of something happening beyond the witness's knowledge. In a flash, hysterics projectively identify themselves into the other, bathing in innocence. Yet the need to know, to evade exclusion by the parental couple from their power, compels the hysteric to 'face' the primal scene, the quintessential conundrum that evokes the self's need to know. So the hysteric explores this scene by appropriative identification, omnisciently enacting it so that it can be incorporated (not internalised) into the self. It is the bite of the apple, not the search for knowledge.

The frozen singularity of the ascetic hysteric – like Lot's wife – is the sign of the self paralysed by the sight of fucking. Although the ascetic hysteric is obviously less overtly theatrical than the precocious hysteric, he or she incorporates into his or her bodily being the annulments of the primal scene. One sees in the anorectic above all the ascetic self's dramatic effectiveness. As this self wastes away, the body is relentlessly reduced to signify only death-at-the-doorstep. Life has been taken from the body and now is to be found only in the agitated surrounding community (parents, friends, doctors), who become a mockery of the primal scene. For all their collective intercourses, the community cannot conceive of a way to stop the anorectic's death drive, ultimately a chilling attack on others as useless fuckers.

Hysterical theatre is always polymorphous as the self releases its sexual history in the devolution to becoming an event. Oral, anal, urethral, phallic, as well as visual, auditory and kinaesthetic component instincts now have momentary places on centre stage, shown off to the object world, in what can become a deeply disturbing regression to early sexual representations. We are now bordering on what is termed the 'malignant hysteric' and it is to this most demanding of all patients that we turn next.

Note

1 For further discussion of this topic please see my 'Origins of the therapeutic alliance', in *The Mystery of Things* (Bollas, 1999).

Chapter 11

The malignant hysteric

There is unlikely to be a clinic in Europe which is not visited every so often by what some of its staff will call a 'malignant hysteric', something of an awesome figure in the psychoanalytical world. Yet when they do materialise, one sees why analysts speak in rather hushed tones and with some trepidation, because these are remarkably disturbing people. If one looks through the analytical literature, however, there are very few references to these people who are talked of so much and whose appearances are so memorable. So what is a malignant hysteric?

It was Michael Balint who distinguished between 'benign' and 'malignant' forms of regression in analysis. Patients who gradually abandon higher-level functioning in the course of the natural regressions that occur through transference experiencing are those for whom the experience is likely to be benign. Even if they discover deeply meaningful self experiences and encounter painful but essential news about the self, and discover through transference dependence a renegotiation of fundamental disturbances in the self–other relation, they seek a path to independence. However, some people in analysis, violently abandon higher-level functioning in immediate transferential response to the analyst and demand care and reparation from the environment; their regression is very likely to be malignant.

A regression is malignant if the patient seeks self devolution in order to coerce an other – in this case the analyst – into unconditional care. The analyst is meant to be there on demand, for as long as needed, and in whatever way the patient determines. The condition is malignant because there is no unconscious intention of returning the self to independence. On the contrary, the analysis is regarded as the fulfilment of a promise made by the monsters of the environment to make their bad behaviour up to this patient by providing an object that would constitute class-action reparation.

Schizophrenic patients will often regress in violent ways, abandoning all self control, and perhaps insisting that the analyst look after them. Chronically depressed patients will also seek such interpersonal asylums in which they pressure the analyst to look after them. One can speak, then, of these situations as often – though by no means always – being malignant regressions, with the analysand using the analytical space as an end in itself and having no intention of returning the self to the world.

But the schizophrenic and the depressive (amongst others) usually give the analyst fair warning of his or her intention, and analysts have the opportunity to engage the patient's ideas over the course of some time. This is not so with the malignant hysteric, who often takes the analyst by surprise, and it is one of the reasons why in a clinic setting, for example, when analysts *think* one of the newcomers may be such a patient the intake team becomes unusually anxious.

Perhaps this is because so often the patient arrives in a state of obvious desperation. Perhaps it is because he often searches the faces of those who greet him with anguished and skilful gaze. Perhaps it is because the patient verbalises his or her plight with such evocative power and seems so precariously perched in reality. Certainly, it is distressing when he or she begs not to be rejected by the analyst, not to be abandoned by the world. Certainly, it is disarming when he or she says that he promises to do whatever the analyst requests. Certainly, it is unusual when he or she passionately confirms the analyst's observations.

Here is how one analyst described the first consultation with such a patient.

> I was on duty when she was referred up to my room and when she stood at the door I was immediately struck by the bizarre way she looked. She looked like someone who had come from a sixties outdoor wedding that had been rained out, so on the one hand she looked colourful and pretty in a sort of way, but also seemed like she had been drenched. Her lipstick was slightly askew, her mascara had run, there was a tear in her dress, her shoes were partly broken, and instead of a purse, she had a slightly worn but beautiful Liberty's bag. She immediately called me by my first name, complimented me on my office, sat in my chair, and without pausing told me she was in a terrible mess, said she assumed we had fifty minutes and would tell me everything as fast as she could. I found the account of her immediate life circumstances deeply moving and worrying. She was in a terrible crisis at work and in her love life. She searched my face in a way that is unforgettable and when I said something – I recall saying that I thought she hurried herself as if she believed she would never have the proper time to tell anyone about herself – she burst into tears of gratitude and said 'yes that's true, that's absolutely true' in a way that made me feel unrealistically bonded to her. As the session proceeded I was dominated by two completely different states of mind. On the one hand, I found her immensely appealing and deeply moving, and totally in need of help. On the other hand, she scared the hell out of me and I was wondering whatever was I going to do with her, and who could I find to 'take her on'.

This analyst, although young, was not clinically inexperienced. But he noted that with this patient there was a different type of transference in which he felt profoundly over-involved with the analysand, even though he feared her. He repeatedly emphasised her way of looking at him.

What he experienced was her *effect* upon him and the way the hysteric transforms the self into an event (see Chapter 9). The malignant hysteric believes

that it is only through being 'effective' that the other will 'listen' and take the self into consideration. The other must be taken captive, must suffer the consequences of being in captivity and must believe that any future is in the hands of fate. To convey these views, the malignant hysteric will act in and act out in almost equal doses, as soon as analysis begins, coercing the analyst into being a paralysed witness to what seems an almost terrifying course of events, that not only draw the analyst into the situation, but suggest a dire fate.

In a sense, the malignant hysteric passes on to the other those parental projective identifications that have been communicated to the hysteric in the first place, from the mother, and also very possibly from the father. As discussed in Chapter 1, maternal projective identification is essential to the baby's psychic development. If this contact, however, is operating as a substitute for sensual engagement of the infant, such that maternal projective identification is the only form of touch, then the infant will be disposed to overvalue such inner effects. Further, as with the malignant hysteric, if the mother is the intermediary of her parent's evacuative projective identifications, then she too will violently project her inner objects into her child, who will be possessed by them. This is the aetiology of hysterical possession by foreign and invading spirits. Malignant hysterics feel displaced by a melange of others who have long since crowded out the self by their cacophonous, exacting nature. In hysterical psychosis one sees the self emptying itself of these objects, thing presentations operating under the thin veil of language.

The hysteric's surprise at what he or she contains, often a prelude to self dissociations, seems psychic testimony to this registration of parentally projected objects, long resident within the self. How do we name these internal objects, the ones constructed by the other inside the lexicon of the self's inner object world? For these are not introjects, but the other's projects. Elsewhere I have suggested that we name such internal objects *interjects*[1] to distinguish their psychic origin, status and future from the introject. An interject is that object projected into a self by the other which interrupts and momentarily disorients the self, which can proceed only insofar as it accepts the interjection. The dissociative state of the hysteric testifies to the act of self interruption. The seemingly affective surprise of the hysteric registers the shock over what is found inside.

Let us move on by considering a clinical example provided by an experienced therapist.

> When I first took on Sydney in psychotherapy, I knew this was not going to be easy, as he was volatile, intelligent, and 'innocent', and he said he felt at times 'possessed' by his 'demons'. In the second session he arrived an hour early and sobbed so loudly in the waiting room that the previous patient and I were made anxious by this and I did not know whether to go or to stay. But when I saw him, he was 'serenely calm', almost beatific, and he made no mention of his sobbing. Five minutes into the hour, however, and he turned over on the couch, looked intently at me, and then said that he wanted to feel his penis's impact on the couch; he wanted to feel himself 'grinding into analysis' and he

said, 'I promise I will not fail to discuss my sexuality. I know you need my experience in here, don't you!' and then he turned over on his back, said in a different tone of voice 'but I should behave myself' and went on to another subject.

I took up with him what he was doing, telling him that I thought he sought to substitute actions for words and to bring about in me an anxiety about what to expect from him. He replied that he was 'in analysis' and he did not care what effect he had on me as he only intended to talk to me about himself. If I was affected he was sorry but he could not let my feelings get in his way.

After the hour, which seemed both bizarre yet crafted, I was left wondering if indeed this was an hysteric and was I to be the object of hysterical disorder. I did not have to wait long. The next session he decided I needed to meet his best female friend, and he brought her to the hour, and was irritated that I would not see both of them together. Every so often he would attack me for being a stupidly cold 'shrink', but immediately – and bizarrely – apologise, all the while looking at me to see what I was making of this. I said as much. He said 'you do not believe me?', implying that I thought this was only an invention and then he fled from the hour. That night he left a message on my answering machine saying he did not think he could go on any longer with life and before hanging up banged the receiver about a few times. I was left worried and alarmed about his safety. He showed up for the next hour as if nothing had happened.

What this therapist then went on to describe was a series of such actings out which continuously disarmed him. He sought to talk matters through, only to find the patient was equally determined to prove that talking was the hope of fools, and would be displaced by actions that speak far louder than words. At a point when the patient seemed decompensated the therapist undertook involuntary hospitalisation, which was ineffective, as upon admission assessment the patient was calm and lucid, and discussed this 'incident' as the actions of an inexperienced and overly anxious therapist who 'should know better'. The hospital staff agreed with the patient.

In this first year of work there were to be many enactments as the patient 'infiltrated' the analyst's life – from finding out his wife's place of work and 'bumping into her', to finding out the children's school and giving them bouquets; from attending professional meetings where the therapist delivered a paper and where the patient rose from the audience to make a rebuttal, to writing passionate replies to critics of psychoanalysis, declaring that his analyst was living proof of the selfless and intelligent work of the psychoanalyst.

Not a week went by without the analyst feeling this patient's violation of his privacy and his own fear of what the patient might do. At the same time, he had dismissed what he considered very worrying diagnostic understandings. Although at times apparently psychotic, manic and psychopathic, the patient was not regarded as either borderline, schizophrenic, manic depressive or psychopathic,

precisely because each of these diagnostic possibilities seemed momentary and, furthermore, stage-managed. The analyst felt that the patient was watching him endure each of these unfolding possibilities and, although he was very anxious at times, he also found this man unnervingly engaging and endearing. He had strong wishes to rescue the patient from himself.

Several months into treatment the clinician realised that the patient interpreted the analytic situation as a promise that could be exploited to a certain end: the analyst, and the 'promise' that is psychoanalysis, could be employed as a witness of a bizarre type of enacted testimonial, in which the self dangerously unravels its innards. In one period of ten days, the patient resigned from his job, stopped eating, and stood vigil outside the House of Commons in protest against a certain piece of legislation. Although he was hypomanic during this period, each action served momentarily to realise an inner presence – what he called important repressed parts of himself – as he acted them out. As a self-appointed medium of his own internal objects, he looked stricken and exhausted when he arrived for his analytic hours. He said he did not know how long he could survive and the analyst found that each time he made a comment his patient changed facial expression, posture and tone of voice. In the course of fifty minutes he manifested something like ten differing selves.

The analyst stood his ground, however, and told the patient that he seemed to think he could hold the analyst hostage to being a pure witness to mad scenes in which any attempt to speak would only create more madness. The analyst remained calm, undramatic and interpretive. He said that he knew the patient came from a family where the parents regularly enacted their mad scenes in the presence of the children and that he believed the patient was showing him this. When this brought up a new facial–bodily–vocal self he replied that the patient reckoned he could coerce his analyst into believing that he himself was no longer there, but was now inhabited by many others. He said he thought the patient was intoxicated by the idea that, like mother and father, he could enact whatever crossed his mind without consequence, and said that the patient now thought he had found a witness, helpless though he was, as a child upon whom to inflict each of these happenings.

No single case typifies the character disorder it is meant to represent. But clinicians who work with malignant hysteria will note certain features in this patient's presentation in common with those of other malignant hysterics and the problems raised in working with them.

As we have seen, these patients use the opportunity which analysis provides to receive their enactments but exploit this as an end in itself. They seek to drive the analyst into a helpless state wherein he or she is meant to witness a parade of characters and events which reconstitute in the analyst's countertransference the child's experience of overwhelming sexuality. Unlike the borderline patient, who seeks effectively to bond with the analyst in a fusion of turbulence, thus constituting the primary object, the malignant hysteric seeks to impose an inequality upon this dyad, in which a helpless and paralysed self is further enervated by the passing by of powerful visual scenes.

To an extent, the malignant hysteric displays a confusion between wakeful perceptions and dream-like representations, creating indigestible dream scenes which challenge the ability of any wakeful person to transform them into meaning. They are not meant to be so transformed, but instead to be terminal[2] objects that stick inside the self as unforgettable hauntings of past others and events.

In this respect we may see an insistence upon the imaginary order in defiance of the symbolic order, a militant presentation of scene upon scene upon scene, which visually overpowers anything like a verbal associative process. The malignant hysteric believes that the self is caught up in such an imaginary order, directed by an other equally possessed. The acute sense of the visual is important, as these patients seek visual impact as a thing in itself, and in this respect they merge the imaginary and the real, so that the witness watches not the movement of the imaginary as a field of illusionary representations of those who are absent, but as the scene-making order itself – the movement of a kind of god who displaces (or annihilates) any self aiming to imagine anything, as the presented scenes become equivalents to any reality. What the hysteric presents are not imagined scenes, then, but thing presentations of the self's early experience of the seen, which overpowered the senses and the psyche.

Think of it in terms of the mirror stage. Instead of experiencing an image of the self as a bound or complete speculation of the other, the hysteric gazing at the mirror is confronted with moving images or motion pictures. The maternal imaginary, overflowing with representations of its internal objects, acts them out upon the other, so that the mirror is now handed over to the child, who is meant to reflect the mother. Looking into the maternal mirror the child not only does not see a reflection of the self (instead, the mother's emptying of her internal world) but the child is used by the mother to see how she affects – i.e. is mirrored by – her child.

In analysis the malignant hysteric immediately dismantles the self, so that the clinician looks into a mirror – held by the patient – which releases into reality spectral images that should otherwise be held in the patient and talked into reality. Enacted in reality, the imaginary is transformed into the real, and the analyst is now living at the intersection of a violent collision between all of the orders, as both the imaginary and the symbolic are conflated by their change of function into materialisations of the real, moving through a self like a tornado ripping apart a landscape. The sheer force of this hysteric's presentations usurps its contents.

Transferentially, then, the malignant hysteric brings a psychotic-type reality to the analytical setting, overpowering the self with images and words functioning as the real. All along, however, this is an erotic reverie inherited from the mother's narrations and enactments. It is a bizarre means of sexually exploiting internal objects at the expense of actual others. As the internal is erotically articulated, the witness–other is paralysed with fear. This reverses the original conflict when the mother found the actual body of the infant, and especially the genitalia, too physically repulsive to transform imaginatively. Instead, the mother-become-malignant turns to an internal object that bears the name of her infant, and erotises the child. Not only does she erotise all of her internal objects, but the process of

object formation itself is sexualised. In her relations to her child, to her other children, to her husband, she enacts scenes of erotic intensity that have a chilling effect upon the others.

This chilling effect occupies the analyst. And it is part of the analyst's task to interpret how the malignant hysteric deconstructs his or her person in order to intensify expressed internality in a defiant erotic exhibition of desire that refuses and annuls the other. It is part of the task to point out what it means that one's expression of desire should neutralise another's desire. It is part of the task to indicate what it means that the imaginary is only supposed to have impact and not be transformed into meaning. And it is part of the task to indicate through speech the power of the word to transform the image.

The hysteric has not experienced the mother's narrations and enactments as *from* the mother, but as *through* her. She is seen as a medium of powerful and terrifying forces moving through her body. These forces are not only indistinguishable from the impact of the instincts, they constitute the representation of the instinct. The power of instinctual states has seemingly occupied the mother from within and driven through her body with *its* mental representations – rather like Freud's theory of the instinct that chooses its object solely on the grounds of expediency. For Freud, the instinct chooses its object in a totally arbitrary way and the mother of the malignant hysteric stands as outraged witness to this very process, showing the self's experience of being driven by instinct.

Malignant hysterics empty themselves into the analytical holding space as a violent force that transfers their psychic status as mediums of the sexual instinct. Even seasoned analysts treating malignant hysterics experience an unprecedented level of fear, unknown with borderline or schizophrenic patients. These psychic 'cousins' may be more impaired, but the hysteric is remarkably skilled at portraying the self and its inner dilemma. They may present as borderline or schizophrenic (or as having other character disorders), but the hysteric's particular skill is to get inside the other and enact that other's character – a skill which is unnerving when it operates malignantly, portraying the dismantling of erotic life, the violent movements of displacement as a function of the drive, in which the scenes conveyed to the analyst present the sexual as dementing.

A patient, and her psychotherapist.

Judy was a 27-year-old woman when she entered hospital for the third time. She was diagnosed as borderline because she was, amongst other things, impulsive, given to manic flights of affect, easily enraged, infantile and inclined to throw off boundaries.

When she entered a room, even if calm, she always suggested that she could transform herself from what looked like an attractive and ordinary human being into a possessed figure, deeply demented and driven by forces she never even saw, much less contained. So when she entered the patients' lounge, for example, she would walk up to a vase, lift it in a way that suggested she might then throw it against the wall, but then calmly replace it. Or she might walk into a room with ten chairs and several couches, and sit on the same couch occupied by one of only four

people sitting in the room, in a way that suggested she was up to something. Or whilst others were watching a particular television programme, she might walk up to the table where the television guide lay and pick it up, glancing at it intently, indicating that she might abruptly change the channel. Such ideas would occur to the group because on previous occasions she had picked up an object and thrown it against the wall, she had sat next to a patient and then punched him in the groin, and she had abruptly changed the television channel. The group began to suffer its reminiscences.

Part of what was so disconcerting was that her 'attacks', as they were called, were so sudden. The group was paralysed and even the staff were thrown into momentary enervation. Furthermore, she could – and occasionally did – suddenly desist, right in the midst of a tempest. For example, one day she threw strawberries across the room, yelled insulting remarks about the cook, and shoved another patient against the wall, but suddenly stopped. The room about her was a hive of flight and recuperatory activity, frozen by her cessation. She calmly walked away from the scene and entered the lounge. An amiable member of staff gave her a few minutes and then walked into the room and sat with her in silence before venturing to speak. He told the staff later that he was frightened to speak for fear it might 'set her off'.

But the anxiety of speaking *to* such a person is a common anxiety in the clinician, who also fears that speech might evoke a sudden outburst of scene-making. And if the ordinary hysteric transforms himself or herself momentarily into an event, watched by an observant ego to its own pleasure, the malignant hysteric's same self-observation is much more bizarre. Although the malignant hysteric witnesses himself or herself as an unfolding scene, he or she is split off into that infant or child self for whom the mirror reveals not the image of one's self, but its own hidden internal objects, passed off as one's self. The malignant hysteric who witnesses the self as evolving chaos observes something more like the pure force of the instinct choosing objects in spite of the self and the other, shoving the relational aside in the wake of the instinct's path.

If we take an ordinary instinct such as thirst, for example, let us imagine that whilst the self is out gardening on a hot day the instinct forces the mind to think, 'I am thirsty.' Perhaps the self will say, 'I would like a drink of water.' The object of the instinct and the object that will please the self are compatible. Imagine a different instinct in a more complex setting. The self has a full bladder, giving rise to the instinct to urinate, and the self thinks, 'I need to urinate.' The aim of the instinct is to urinate and the object of the instinct would be that idea through which such a pressure could be imaginatively extinguished. So the object might be, 'I need to go to the toilet.' Once again, the object of the instinct and the self's actual fulfilment of it are compatible: a toilet can be found. But what if the same instinct – let's say in a man – gives rise to the following thought: 'I need to pee on my foot.' Why would the instinct choose *that* object? Because each instinct will have had its own peculiar history 'in' each self and in the example I have selected, the self has changed the customary object for a different one. What if the same instinct is

represented through the following: 'I need a woman to pee on my foot, whilst I am being called an ungrateful asshole'? What one sees here is that the instinct and its history constitute the self's sexuality, which over time records and becomes the subject's desire.

For reasons described in previous chapters, the hysteric regards the sources of sexuality – especially the genitalia – as disturbing, and there is a feeling that it is disruptive and vile. The mother of a malignant hysteric experiences sexual mental contents as violently determined by the drive, with which she refuses to associate. Her dissociation is intense and effective, as she transfers them from inside herself to her external world through forms of narrative and performance, although, as mentioned before, the specific mental contents will have been displaced, so that she is transferring seemingly non-sexual states of mind into the outside world by narrative–performative expulsion. When the hysteric observes himself or herself or observes the analyst relating to him or her, he or she is watching the effect of drives upon the mind, indicating why and how they can wreak havoc with human lives.

When Judy walked into a room she created an illusion that she would be unable to contain herself should she ever be occupied by the drives. She also created the illusion that much of the time she was drive free, suspended for a time, or in a more petrified state of mind. She would, for example, sit in one position for hours, looking very calm and serene. Passers-by would be as unnerved by this as they would be by her more tempestuous states. But, unlike the schizophrenic's catatonic serenity, derived from a killing-off of mental functions that might process the drives, the hysteric's statuesque calm is only the curtain lowered in an interval that announces the certainty of another outbreak of the self's inner life, one that will leave the world caught up in a sexual turmoil. As such, the serenity and its opposite are linked, just as Lot's now petrified wife is linked to the forbidden sexual scene upon which she gazed.

In the preceding chapter, following Freud's theory of infantile sexuality, we suggested that hysterical regression involves a return to polymorphous sexuality, in which the component instincts seem cut loose from the integrations imposed by genital organisation. In subtle or gross ways, for example, Judy would release these instincts to fellow patients and clinicians. She would pee on the floor, often giggling uncontrollably, and fart and celebrate the odour – gross offences to the group. At the dinner table there were times when she would eat by smacking her lips, holding the food in her mouth for long periods before swallowing, sucking solids off a spoon, or putting her hands in the dish to play with mashed potatoes or salad. Perhaps we could term this the mid-grotesque. In a more subtle vein, however, she would gaze at a man or woman with an equal quality of ravenous licentiousness, or she would call to someone with sonic seductiveness, releasing her voice into the group as an auditory instinct seeking some hapless sex object. In one day alone she could be all of these things, a moving theatre of the infantile, celebrating the polymorphous.

The malignant hysteric seeks a formal regression, a regression in the basic form of the self, from higher-level functioning to something else – which I hesitate to

term lower-level functioning. The formal change is to absent the self as the recipient of the instincts and move it slightly to the side – from associate to dissociate – as the drive now arrives pure and simple in its disturbing choice of object. Judy once reached over very calmly and put her hand on another patient's breast as if she were in a trance and her hand was being guided by a force over which she not only had no control but no knowledge. When she masturbated in public it was as if another's hand was performing the action.

Such patients try to convince the analyst that whatever they release in this presence is not of their making even if it derives from them. They implore the analyst not to reject them, for 'they know not what they do'. In North America such personalities are finding paradoxical refuge in the category of multiple personality, where clinicians, when agreeing to talk to different alters, implicitly accept the fate of a self which is absent at the moment of mental release. In the spiralling regressions typical of such patients, as they release inner states which effectively destroy conventional self functioning and intimate relations with the other, they indicate that original experience of being at the mercy of one's own drives.

One of the best illustrations of malignant hysteria in the literature is in Harold Stewart's essay 'Problems of management and communication' (1992). Referred by a colleague from hospital, Stewart's young patient 'looked rather wild and scruffy, wore torn jeans' (p. 84) and complained of depressions that had begun some ten years ago after her first sexual experience. We may speculate that the depression registered the unconscious catastrophe posed by sexuality itself, which, as I have argued, results in the destruction of the hysteric's relation to the mother.

Stewart's patient felt unloved, was having an affair with a married man in which she was sexually subservient yet frigid, possessed little sense of self, wanted to be a man, and 'was a compulsive clitoral masturbator' (p. 84). She held her father in contempt and feared her mother, who used to burst into wild physical acts of violence during her childhood and then blame the children for causing these outbursts. She did have a kind maternal grandmother to whom she was close, although the grandmother saw ghosts and had a tenuous hold on reality.

In the beginning of the analysis the patient would be good for several sessions and then suddenly burst into provocative and scathing verbal attacks, for which she apologised. Stewart understood these outbursts as cautious testings of his capability. She then became more infantile and acted out physically in sessions by trying to grab his penis. For a very long period of time she was preoccupied with the analyst's genitals and when trying to grab them would be met by his physical holding of her.

Stewart does not write this paper to discuss hysteria per se, but focuses on management issues. He notes that there are certain patients – and this patient is one of them – for whom verbal intervention would not have sufficed and for whom a physical form of holding had to take place. He mentions but does not elaborate his countertransference, but it is not difficult to imagine from his account of the patient the imaginative turmoil that he had to undergo during her analysis. We may consider his physical intervention as an important symbolic action as he brought the

body of the other to the patient for the binding of sexual states of mind. In the course of her regression in treatment the patient developed delusional and hallucinatory ideas of her sexuality, which we may understand as the inevitable effect of sexuality upon a mind desperate to avoid it.

The analyst must, then, bind sexuality – which Stewart does by physically restraining his patient – so that it might find another route of expression, which in this case it does as the patient turns to drawing and painting as a medium of self expression. It also seems to release her to intensified hallucinatory states, for example, when she talked about 'a persistent vision of her genitals rotting away'. Stewart tells us: 'On putting her hand there' – referring to her genitals – 'she felt a large hole where they had rotted away and was terrified' (p. 92). She realised this was a negative hallucination and then touched herself to rediscover their existence. We may interpret this hallucination as the outcome of her attack on her genitals, which, as an hysteric, she understands as the root cause of her loss of a loving world.

Later in the analysis, during dark winter evenings, the patient entered a type of reverie and wanted only one light on in the consulting room, demanding absolute quiet. If Stewart stirred she accused him of masturbating. She had fantasies of sucking his penis, his breast, her thumb and of masturbating. She actually did masturbate and then was shocked at what she had done. There was confusion over who was manipulating whose genitals. We may see, however, that the patient had regressed to a place where she could express her confusion over who controls the scenery of the erotic, given her conviction that erotic life derives exclusively from any self's auto-erotic interests. In the presence of the other she is unclear whether her sexual self-stimulations or the other's sexual self-stimulations will determine the course of sexuality between the two.

This patient recovered from her analysis, went on to marry and find a profession, and the case report ends with her expressed wish to have children. Stewart takes up the controversy surrounding some of his techniques – especially physical restraint – but does not discuss what is probably obvious to any reader, namely, that success with this type of patient takes a great deal of clinical acumen. For every one of these patients who meets with a successful outcome from an analysis, there are unfortunately too many who do not profit from the experience, probably due to the analyst's lack of experience of work in this area. But, sadly enough, the malignant hysteric's unconscious need to sabotage the work of insight may also contribute to these failures. For 'looking into' is understood as the preferred option to 'acting out', which is unconsciously interpreted as a refusal of the patient's exhibition of the self, a 'showing' that is the self-as-genital, intended to captivate, control and subdue the other, who will accept that such mind-boggling theatricals are beyond control.

Another patient.

Roger was a smart university graduate who refused professional education and instead worked in a bookstore much of his life. A voracious reader, he fancied himself something of an expert in many differing fields. He was in a long-standing

relation with Fred and they were very supportive of one another and well liked by their friends. Every so often, however, Fred would have to hospitalise Roger because of the latter's sudden toxic states of anxiety, which gave rise to manic and delusional states of mind. These would be announced by a sudden intensification of Roger's otherwise – at least so far as Fred was concerned – charming habit of believing he could 'enter' into a problem (or a person, or a couple, or a political issue, etc.) with special powers of intuition from which he could then deliver an oracle that would predict how things would be. He had studied astrology for a long time, could read anyone's chart, and had interests in paranormal phenomena and the like.

Fred had a hard time describing the quality of Roger's more intense imaginings, as they were somehow 'sexual' but he found it hard to say exactly in what way. Roger would go into a kind of trance, which he often did, but on these occasions he seemed transported by his very invocation of the medium. He became very dominating and demanding, and would caress his body and insist that his physical presence was vibrating with the effects of communicated truth. Fred said that it was like watching a porno film gone bad, or a porno plot that had left the director and was now walking loose in the world at large as a performance in itself. Roger seemed to have no idea of how he was coming across or of how out of hand things had become.

The casualty officer of the hospital, who had treated Roger on an intensive basis before, found him almost always in the same state: he was usually drenched in perspiration, wearing inappropriately revealing clothes, yet apparently oblivious to his self-presentation. He was rather offensively rude and grandiose, and talked in a loud and contemptuous voice and, as he was quite bright, his criticisms of staff and the hospital were often irritatingly accurate. He seemed to be in some sort of trance and appeared caught up in an erotic delusion in which he believed he was the centre of the universe – a kind of sexual centre – from which he could divine the future and pre-ordain the most important meetings to come. For example, he would now and then visit other patients in the waiting-room, touching them on the head or shoulders like a kind of sexual Pope giving benediction. He procured a drink from the dispenser and flourished his cup of water as though it were filled with elixir.

Although there are obvious manic symptoms to Roger's breakdown, he responded every time to heavy sedation and spent only two days at most in hospital. Once discharged, he was mildly embarrassed and yet charming and all was forgiven until his next episode. In fact, these episodes always followed his discovery of an important new author, or an interesting new field that he did not know about, and an intense period of immersive reading when he felt joined to the new object. This new discovery was sexualised, and he would then begin to act out in sexual ways that were otherwise atypical of him, alarming Fred, whom he treated with disdain.

When Roger entered intensive psychotherapy he broke down in the transference through deep intoxication with the analyst, whom Roger assumed he knew better than the analyst knew himself. He invented all kinds of words and concepts to

explain the analyst to himself. He spoke in a special voice, which was a curious mixture of the intimate talk between lovers and aggressive coerciveness, oscillating between being affectionate and being threatening. In the course of his treatment it became clear that he regressed to an hysterical core in which he imagined himself the auto-erotic centre of the universe, always set off by his attempt to form a relation to a new-found object, which he then interpreted as having its 'vibration' – i.e. erotic core – which he could only fathom by merging with the object in what amounted to two self-stimulating orders in one. The aim of his communications to the other from that point on – Fred or the analyst – was to show that he did not need the other, indeed, that the other should take its own auto-erotic stimuli from Roger's pronouncements and then join him as a fellow self-stimulator in his orbit.

Roger experienced analytical interpretation as insulting. That he should develop insight into himself, rather than procure a licence for the export of his ideas, seemed to him ludicrous. Although his analyst was highly experienced, Roger was determined to set up a 'counter-analysis' in which each and every interpretation was to be transformed, if not into its opposite, then into an 'alternative', and sessions were at best like strange sporting events, with Roger matching the analyst's comments with his own views. In time the analyst was faced with a difficult decision. It became clear that whenever Roger was at risk of understanding something about himself, inevitably bringing him toward depressive anxieties, he would engage in violent self dismantlings, tearing himself into mental pieces. He would drink and take drugs, forgo sleep, and go on social binges that resulted in both physical and psychic emaciations that drove desperate forms of thought, always verging on the hallucinatory. The analyst knew that such dissolutions of the self were aimed at eradicating any reliable form of consciousness in order to rid the self of emergent insight. The analyst interpreted this, often commenting on how Roger took to self-destruction to ensure that he would always be an event beyond the influence of anyone other than himself. He aimed, so the analyst maintained, to keep the other in a state of enervated bewilderment, so that he could register his existence through the toxic effects on the other. The fact remained, however, that interpretation in itself did not mitigate this aspect of Roger's mental state, and as time went on it became very clear that the patient was hell-bent on further self dissolution.

When Roger talked frankly about suicide, partly to coerce the analyst, partly to terrify Fred, the analyst nonetheless took the threat as a serious possibility and arranged for a transfer to hospital, where Roger was placed for an extended period of time. The analysis did continue afterwards, but Roger was also in the care of a psychiatrist, who determined that he should be on maintenance medication for the remainder of his life, with the mixed result that the patient 'stabilised' but was in a somewhat permanent state of chemo-mediation, rather as if a perversion had been fashioned to foreclose the possibility of a neurosis. The analyst was distressed by this state of affairs, but the patient had pushed him – he told himself – to the limits of his capability and there was nothing that could be done to affect the situation.

Looking from the previous chapter to this – from the theatre of the hysteric to the malignant hysteric – we see a spectrum that we may locate in the self's experience of 'family life'. As we know, a self enters the family first through the maternal order, with the paternal order functioning as the third element: one which precedes the self's birth and waits for the child to emerge into language and naming. But 'family' is a fourth object, which includes the three existing orders, and is a different composition.

A family is a group to which the members belong and although bearing the father's name – i.e. 'the Smith family' – it is a small world. In the countless negotiations among members a family evokes its myths, legends, facts, history, aesthetics, visions and laws. Any child development is a self's movement into this world, internalising its constituent elements carried as an inner object to function in the name of the family. The self may reject its constituents, but it cannot erase its registration, so we shall carry with us our family's elements, which together become a composition.

Although family therapy exists as the first treatment programme for this object – and has produced very interesting texts – arguably we still have to think to ourselves what a family is. Certainly, this fourth object proves a puzzle to the hysteric. Driven to identify and represent the other's desire, destined therefore to oscillate between representing the inner worlds of mother and father, what does the hysteric do with the fourth object? By an act of discriminating internalisation, the elements of this world become cathected as sub-erotic phenomena, available for sexual reverie and later for erotic transmission. The hysteric takes the laws of the family as a set of interdictions that form an erotic matrix, an inner set carried by each hysteric into other families and later into the self's family, in order to employ it (or to impose it) as the desired set through which all other sets are filtered.

The hysteric, then, does not simply identify with and represent the inner worlds of the parents; he or she also expresses at certain moments the elements of his or her family, either acting out a family fact (such as a move or death), or engaging a family of others with the self's own fourth object as erotic object.

A patient.

Luciana was courted by Carlos and introduced to his family. They were both Catholics, from the same medium-sized town, and of the same social class. At first she seemed content with being a new member of Carlos's family, but not long after their wedding serious problems emerged. Luciana was very insistent that Carlos follow certain rules in the house, such as washing up the salad plates before sitting down for the next course, or hanging the bath mat on the side of the bath and not on a hanger. Each room of the house had certain laws. Luciana also had very particular tastes, in painting, decoration, music, clothing and literature.

Carlos had found this difference to be one of Luciana's attractions – she was so wonderfully unique. But Luciana rather violently removed Carlos's aesthetic objects from the house or complained about his tastes so vehemently that he put them away. For example, first thing in the morning Carlos loved to pick up the

newspaper with his coffee and absorb himself in the sports page, but in Luciana's family the day began with a collective discussion of what to do that day, followed by preparations for departure. Newspaper reading was done at the end of the day, after the dishes were washed and the house tidied.

Carlos wondered why Luciana could not tolerate at least 'some' of his ways. When interviewed by a marital therapist, the therapist wondered if Luciana was an obsessive or a narcissist. What could not be seen at first was Luciana's 'remembering' of her fourth object as a structure, a recalling of a set which brought its sub-erotic elements into an erotic object that sustained her reveries during the day. She had also insisted that each day she recall an aspect of her family's history, or tell one of her family's stories, often musing on her family's visions of reality and the future.

Everyone but the psychotic personality internalises the fourth object, but only the hysteric cathects it as an erotic object to serve as a matrix for subsequent defensive experiencing. What we call family life is the movement in space and time of this fourth object, of which the self is a member. For the hysteric, being a family member is an erotic expression, as the self – already dispersed in acts of representative identification – is further disseminated by the logic of the constellation of which the hysteric is a working member.

Most ordinary people rarely give this any thought and do not activate the sub-erotic elements of the fourth object. It is part of the self's ego – a part of its way of processing lived experience – along with other internal objects that constitute self experiencing. But the hysteric feels driven to express this object when in a fourth space or thinking about a fourth space. Some of the thoughtless perambulations of the hysteric in the household are forms of remembering the fourth object, constituting the matrix of an erotic reverie which always feeds the secret agony or the self's pining for its past.

Helena, another patient, walked through her house, dusting and arranging its contents in a daydreaming motion. These contents – her family's objects – were erotic members of the sense of the family, and as she walked into the different rooms – living-room, library, kitchen, laundry, children's room, bedroom – she entered space that suggested many things. She followed differing paths, according to her sense of the moment, quite content to commune in her family space. However, her walkings were always in the circles of her home, tracing and retracing footsteps.

The hysteric cannot accept his or her destiny as the unconscious articulation of the self's idiom through the use of objects, but instead has erotised his or her fate as the order into which one was born and through which one was predestined. Even as he or she repeatedly institutes the auto-erotism of fate as opposed to the allo-erotism of destiny (as fate repeats the self in easily recognised patterns and destiny opens the self to its infinite diversities), the hysteric may betray a form of rage against this narrowing of the self and its relations. Thus, there is a curious rage blending into the hysteric's auto-erotics, infiltrating representations of the fourth object with a certain violence. It is not simply an attempted cancellation of the

other's fourth object – which is often accomplished – but a bitterly unconscious eradication of the self's diverse potential, a form of suicide by family identification. It is as if the self says: 'I am deferred as a member of this royal court, from which I derive my power and position. My own personal desires – whatever they might be – are to be set aside in the interests of participation in the royal family.'

To some extent this is each person's struggle. How am I defined by my family? If I have belonged to it, what was this act of belonging? And, if I differ from it, what are the terms of the difference? Perhaps for many, the self's idiom – always a singular intelligence of form – has long since differed from all others, and although it uses common objects (including the family) it does so idiosyncratically, creating its colloquial dialect in being. The hysteric, however, fights against this differing because the articulating destiny of idiom seems to separate the self from its family of origin. Part of the technique of resistance is the continuous theatre of remembrance as the hysteric enacts, again and again, parts of the family within a mentality that expresses the family matrix.

The analyst is to be found in the fourth object, a figure inside a mad family, whose intersecting internal worlds find a collecting logic of sorts in the family as group. He is inside an object that is the locality of a culture. He or she is a single thinker questioning an other who is only a medium for a group. Without knowing it, perhaps, the analyst is actually a group psychoanalyst when working with the malignant hysteric. By captivating the analyst in the topsy-turvy world of enactments, the hysteric teaches the analyst what it is like to find one's true self masticated by group madness. Like the hysteric, the analyst looks to this other to see himself or herself. Often, it is not a matter of choice, as the group of the patient's transferential object representations is so bizarre that the analyst is at a loss to find out which part of him or her is being addressed by the patient. The hysteric will subvert the analyst's ordinary relation to reconstructions. In work with other patients the analyst listens to the patient's history – and recalls the history of the analytical sessions as well – in order to find unconscious nourishment from these sources. Out of the past one finds the present and its future. The malignant hysteric presents a bewildering fourth object, which necessitates history-taking, of the patient's family and, more importantly, an intense recollection of analytical sessions. In trying to answer the questions 'What does this mean?', and 'Where are these communications coming from?' the analyst sinks into the past, from which it is not intended that he or she will return. Like the hysteric before the fourth object, the analyst is meant to drown in the sorrows of the past, to be swept up in the agonies of the ancestors. It is intended that the analyst will never find his or her place in the present, and the future is meant to evaporate as an imaginative possibility. More than a few psychoanalysts, when they reach this point in the analysis, end treatment or send the patient on to a colleague for another analysis.

As with the Siren seducing Odysseus, hysterical narrative–performance is meant to entrap any self that would assume its intended journey. Knowing that psychoanalysis is his or her co-invention, the hysteric assumes possession of the

psychoanalyst, and demands that the analyst sacrifice his or her own personal ambitions to the violent charms of the other. The analyst is meant to be spellbound and shipwrecked. He or she is meant to give up the profession. As we shall see in the next chapter, the hysteric becomes addicted to the transference, and, as we shall discuss in Chapter 13, he or she insists that the analysis become sexualised and the analyst become its victim.

When hysterics become psychotic they abandon themselves to the many characters whom they have contained. With unnerving skill, they hallucinate or act out in a fugue-hallucinatory manner a small colony of others. The so-called multiple personality is a kind of charade of hysterical psychosis, giving each character a seemingly complete and full identity. The hysteric who presents as a multiple seeks a doctor who desires a patient's illness as the form of his own phallic empowerment. The hysteric will be the maternal phallus, acting out the psychoanalyst's desire.

Hysterical psychosis is a particular form of decompensation in which the self stands to one side, as it were, and projects scenes through the actions of the self's body. An eerie feature of this psychosis is that the patient witnesses himself or herself in his or her madness, creating the illusion that the psychosis is directed by a psychotic voyeur, who gains satisfaction at the sight of the self impacting the other – a primal scene created by the imaginary which impresses itself upon the real. The psychosis intends to reverse the process of internalisation. Internal contents are meant to project themselves into the environment, transforming the imagery of the real into reflections of the hysteric's inner life. The violence of this intended projection is unconscious revenge against its opposite: the self's sufferings from its own internalisations. Indeed, the world is now meant to suffer its own agony of reception, as the other is intended to be overwhelmed by the self's internal world.

Hysterical psychosis presents undigested images, visual scenes that defy meaning, because any self is meant to forget them in self-protection. Clinicians working with the psychotic actions of the hysteric do indeed find them very hard to think about, precisely because the hysteric has presented himself or herself in a grotesquely vivid manner. This is a kind of sexual psychosis, as the patient wraps these scenes in sexual lining, all too often driving the analyst into further bewilderment by an erotism gone awry. Scene follows scene, and character follows character in bits and pieces across the hysteric's stage. No schizophrenic shows such directorial skill; no schizophrenic could ever portray all the psychoses in one single performance; no borderline patient's psychotic regression is accompanied by a split-off part of the patient sitting in as a revelling audience; and yet, even in the midst of the most bizarrely psychotic states, the hysteric watches the psychosis-as-primal-scene. For this is a psychosis that represents sexuality. Sexuality that drives the self mad. An intercourse that blinds any witness, that forces the other to avert its gaze.

In this respect hysterics-in-psychosis pose the one scene they cannot bear. They can look upon the depressed mother. They can watch the enraged father. They can

bear loss of the other, whether it leaves them off at school, or whether it dies. Yet none of them wants to bear witness to parental intercourse. The idea – much less the sight – is unthinkable. In a psychotic way? No. This is not an attack on linking as such, that is to say, an attack on the very perceptual apparatus. Rather, this is an assault on a very particular idea, or more properly, a sight-idea. This is what Iago calls the 'beast with two backs', the sight of a monster, that drives the child into a sense of horror over what he or she sees. Hysterical psychosis always portrays violating intercourse. Between the warring characters in hysterical theatre one finds representation of violent intercourse between male and female characteristics.

Set against this opera of grotesqueries is the other side of hysterical psychosis, what Donnet and Green (1973) call a 'blank psychosis', although I use the term here in a somewhat different way. For in the midst of seemingly uncontrollable madness, the hysteric can suddenly cease all representations and return to remarkable lucidity – back to normality, then, or into blank psychosis: into an elected mutism, body often rigid, self immobile, gaze fixed, and sonic attention closed off. In this opposition one sees, as discussed in earlier chapters, the other hysteric route, that driven by the death drive. In this ascetic hysteria one finds the self returned to its deep freeze, the precocity of florid psychotic representations completely silenced. The juxtaposition of these two self states – florid psychosis/blank psychosis – expresses a different type of intercourse, one between the cold anti-sexual self and the sexually possessed. Between the violence of the nun and the violence of the prostitute, the hysteric lives – a directorial presence that transcends its represented extremes.

More than a few psychoanalysts have hoped to speak to the hysteric off stage. More than a few psychoanalysts have felt privileged with what they take to be an audience with the director. But betrayal is the name of the game. The hysteric takes the other into trust in order to break it before the eyes of the other. How many clinicians, having worked diligently and apparently with success, have brought the psychotic hysteric to a point of apparent psychic change, only to have this belief shattered, often in a very public way? How many clinicians have returned from holiday to find that the patient who has made so much apparent progress has in fact attempted suicide?

Trust built on reciprocity often feels like an insult to the hysteric. It seems like a lie. Such trust is the work of suckers, people lulled into infant-like soporifics. Such trusts should be busted up. They should be violated by the sights and sounds of another coupling, one that is all wrapped up in itself, one that refuses the meaningful participation of any other. Becoming this beast with two backs, the hysteric-in-psychosis breaks up the therapeutic alliance by means of the auto-erotic primal scene, a vision of a self fucking itself up, enclosed in a mad embrace that defies any other to intervene.

We are unlikely to know how many of the diagnosed schizophrenics, manic depressives and borderlines in mental hospitals are in fact malignant hysterics. The very fact that psychoanalysis, infatuated with psychiatric categories after the

Second World War, desired 'primitive mental states' in the form of the borderline, has meant that hysterics would always satisfy this desire, especially as it promised progeny out of the psychotic primal scene. Each analyst engaged in these new intercourses felt he or she was at a new frontier, espying a new psychic entity, ready for its writing and its naming. The fact that psychoanalysis in hospitals gradually expunged hysteria from its lists meant that it had to reappear in other forms.

We shall continue our discussion of psychosis and hysteria in the last chapter of the book. But now we turn to a more common form: the hysteric who inhabits psychoanalysis as an alternative to living.

Notes

1 For further discussion of this concept see my *The Mystery of Things* (Bollas, 1999).
2 For further discussion of this concept, see my *Cracking Up* (Bollas, 1995).