

HYSTERICAL ACTION, IMPERSONATION, AND CARETAKING ROLES: A DESCRIPTIVE AND PRACTICAL STUDY

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ABSTRACT

The present study comprises three parts. In part one, a case is made, expanding upon Szasz's (1974) earlier analysis, that hysterical action represents the impersonation of a disabled person, or even of a nonperson, in which the individual does not realize that he or she is impersonating. In part two, a common constellation of reasons why persons resort to such impersonation is described. In part three, a number of therapeutic recommendations are made.

The purpose of this study is to provide a constructive and useful picture of hysterical action and hysterical persons. I will attempt to accomplish

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this purpose in a threefold manner. First, the concept of "hysterical action" will be defined. Second, one frequently encountered constellation of reasons why individuals resort to such action will be described. Third and finally, some therapeutic strategies that I have found to be especially effective with these persons will be delineated.

PRELIMINARY CONSIDERATIONS

The clinical descriptions and therapeutic recommendations put forth in this paper are often status dynamic in nature. That is to say, I will be concerned with the hysterical individual's statuses as crucial determinants of the range of actions in which he or she is able to participate (Ossorio, 1976). Defined in a manner consistent with its Latin etymology (approximately, "where one stands"), an individual's statuses are his or her various "positions-in-relation-to." To stand in certain places, to occupy certain positions in relation to other persons, objects, states of affairs, or even oneself, enhances one's freedom and ability to act; to occupy others constricts such freedom and ability. For example, an individual in the military might occupy the position of private or of general. The mere occupation of the latter position by an individual, quite apart from his or her social skills, belief systems, or other personal characteristics, carries with it a greatly expanded power and range of possible behaviors in the military community, in comparison with the former. In like manner, statuses such as "person," "perpetrator," or "therapist" convey different powers and eligibilities than do other statuses, for example, "organism," "victim," or "patient."

From a status dynamic point of view, the task of psychotherapy is status enhancement; that is, helping clients to occupy positions of enhanced power from which they may better participate in life. Typically, this entails helping clients to realize statuses which they have had all along (e.g., free agent or perpetrator) but which, for whatever reason, they have failed to realize and to exploit. At other times, it entails helping individuals to occupy new, more viable statuses.

In using the designation "hysterical person" throughout this paper, I refer to persons who engage excessively in hysterical actions on an enduring basis. This term should be regarded as a *behavioral summary term*. It is *not* used here to designate any underlying pathological entity, either physical or psychological in nature.

It is widely acknowledged (e.g., Blinder, 1966; Halleck, 1967) that the majority of persons who engage excessively in hysterical self-presentation are female. Further, almost all such individuals whom I have personally treated have been women. For this reason, and also because it is very awkward stylistically to repeatedly refer to "he or she," "him

or her," and so on. I will use feminine pronouns throughout this paper to designate hysterical persons.

THE PHENOMENA

What are the behavioral phenomena in question? Here I will merely recall those phenomena which classically have been designated "hysterical" and which encompass both what has been termed "hysterical neurosis" and "hysterical personality style."

Under the rubric "hysterical neurosis" we have those more or less circumscribed reactions of persons which fall into two general classes. The first of these is, of course, the conversion reactions—those paralyses, blindnesses, anesthetics, and so forth with no discernible organic basis which constituted the original interest of Breuer and Freud in 1895. Secondly, we have those states termed "dissociative" in nature, especially here amnesia, fugue, and multiple personality.

The rubric "hysterical personality" has been used to designate, not such circumscribed reactions, but a relatively enduring and pervasive style of interpersonal functioning which encompasses the following:

1. Extensive presentation of self as a victim in life with no control over, or responsibility for, certain of one's actions.
2. Extensive presentation of self as helpless, especially (but not exclusively) in the sense that one is swept away by emotion in difficult circumstances at the expense of logical problem-solving and coping behavior. These ostensible logical defects often take the form of displays of very poorly concentrated, impressionistic, nonfactually oriented intellectual activity (Shapiro, 1965) which is ill-suited to the solution of problems in living.
3. Extensive presentation of self as hyperdependent, that is, as in need of a stable, competent, logical individual who will function as a strong protective leader. The relationship between this factor and the previous one should be obvious.
4. Presentation of self as physically ill in the absence of any demonstrable physical pathology.
5. Presentation of self as considerably younger and less mature than one is in fact.
6. Hyperdramatic self-presentation.
7. "Labile and extreme, but shallow" emotional display (Chodoff & Lyons, 1958).

The question has been raised by Chodoff (1974) whether or not all of these phenomena, seemingly so disparate, deserve to be lumped together

under a common rubric. The position taken in this paper is that, while perhaps the term "hysteria" itself (etymology: "wandering uterus") is almost totally uninformative, these behavioral phenomena do share a basic intelligibility which justifies their inclusion under a common label. This intelligibility will be articulated in the following sections of this paper.

INTELLIGIBILITY OF HYSTERICAL ACTION

Fundamentally, hysterical phenomena represent impersonative status claims. We may best understand the hysterical individual, ostensibly beset with illness, forgetfulness, helplessness, and so forth, much as we would an entertainer doing mime. She is acting out in a bodily, iconic language of physical representation a mimicry of these things. She is masquerading as one who is ill, forgetful, or helpless, and thus making a bid to be regarded and treated as such.

The content of this simulation is most importantly of two related sorts. First, a great deal of hysterical simulation is taken up with the imitation, in one form or another, of a defective, damaged person. Historically, authors have stressed only two versions of this, namely the impersonations of physically ill persons and of insane persons (Chodoff, 1965; Sullivan, 1947; Szasz, 1974). However, if one goes down the list of hysterical phenomena presented above, it is easy to see that a broader spectrum of personal deficiencies are being impersonated. These include: (a) radical memory impairment (e.g., forgetfulness of past events or even, in extreme cases, of one's identity), (b) helplessness, (c) intellectual incompetence, and (d) personal and physical immaturity (e.g., a woman of twenty-eight may look and act like a girl of eighteen).

The second major form of impersonation that is of interest here represents an extreme version of the above. Here the person at times impersonates, not merely a damaged or deficient person, but in effect a nonperson. The simulation here is of a nonagent, of an organism whose behavior is purely the result of internal and external forces acting upon it, and one which does not engage in intentional or deliberate action and is not responsible for its behavior. This impersonation is typically conveyed in locutions such as, "I *found myself* in situation X," "I don't know what *made me* do it," or "My anger just *took over*." The simulation, one is tempted to say, is of a puppet or of a robot.

Two of the classical attributes of hysterical individuals are that they have a dramatic or histrionic personal style, and that they exhibit "labile and extreme but shallow affectivity" (Chodoff & Lyons, 1958). It is easy to see that, insofar as an individual is engaging in extensive impersonation, she is being not only stylistically but literally dramatic; in the

extreme, her life becomes largely a drama in which she is enacting impersonative roles. Secondly, it is not surprising that much of the emotional expression which goes with such extensive role-playing should, like emotion in a stage drama, be quickly changeable, exaggerated in nature, and not deeply felt. Thus, both of these general attributions are exactly what we would expect from a person whose self-presentation is often, literally, a dramatic presentation.

Thus far my analysis would suggest an identity between the concepts "hysterical action" and "malingering." There is, however, a crucial difference between the two. In an hysterical act, unlike an act of malingering, the individual engaging in it genuinely *does not know what she is doing*; that is, she genuinely does not know *that she is acting, that she is impersonating*. The person who resorts to an act of hysterical impersonation is, like the person malingering, one who has reason enough to engage in deception. Unlike the latter, however, she also has strong reasons not to know that what she is doing constitutes a deception and, further, strong reasons not to know that she does not know, lest the entire structure of ignorance be subverted (see Ossorio, 1966, pp. 40-44). The substance of certain of these reasons will be described in the following section of this paper. (This is not to say that hysterical persons, i.e., persons who engage excessively in hysterical acts, never consciously or deliberately lie or deceive. In fact, as Szasz has noted, in addition to what we might term their "unconscious deception," they seem more given to such conscious deception than the ordinary person.)

Not to know that one is impersonating is, obviously, to be taken in by one's own act. Thus, the hysterical individual comes to believe her own impersonative status claims. She comes to believe that she is a sick, illogical, crazy individual and/or that she is (at least in regard to certain actions) a nonagent. Breuer and Freud (1895/1965) asserted that an individual beset with an hysterical symptom was, with respect to this symptom, in a "hypnoid state." Paraphrasing this, I would say that the conviction with which some persons believe their own impersonations assumes hypnotic proportions. In terms of Schwartz's (1980, Note 1) definition of the trance state, these persons seem literally unable or not at all disposed in their own case to perceive the anomalous as anomalous. Thus, they may be genuinely convinced, for example, that an arm is really paralyzed, that they are weak and helpless, or that they are in no sense the authors of their own actions.

Such beliefs about oneself are obviously of the utmost significance. The individual who sincerely believes that she is sick, helpless, stupid, immature, and not in charge of her own actions is obviously going to conduct her life far differently than a person who does not entertain such beliefs. Her self-concept, her summary formulation of her status and

thus of her relationships to the rest of the world, verges in extreme cases on that of a puppet (i.e., a thing whose movements are determined by forces external to it) or of a lunatic (i.e., a person, but one whose actions are now, temporarily or permanently, under the control of some mysterious disease process, not under the control of self). Puppets and lunatics, although they are entitled to make special claims on others for help and care, enjoy far fewer powers and eligibilities than ordinary persons. The constraints inherent in such a self-assigned status, especially one which over the course of time has almost always been heavily authenticated by others, are enormous.

There are two traditional issues which the present analysis, I believe, handles better than previous analyses. First, as mentioned earlier, Chodoff (1974) has questioned the accuracy and the utility of employing one concept, hysteria, to designate both neurotic phenomena, such as conversions and dissociative states, and characterological phenomena. The analysis outlined above, which states that *both* sorts of phenomena constitute the impersonation of disability or deficit in which the individual does not know what she is doing, provides a justification for continuing to link them under one rubric. I agree with Chodoff, however, that some other designation (he suggests "histrionic") might prove more apt and more informative.

Secondly, there is here, as elsewhere, much historical controversy among therapists about differential diagnosis. What should we designate "hysterical neurosis," what "hysterical personality," what "hysterical features" in other personality types? I suggest that the more important diagnostic questions, where hysterical actions are concerned, are questions such as the following: To what degree does this person resort to hysterical impersonative tactics? How central or how peripheral a role do these assume in her problems in living? To what extent, and for what reasons, is this person committed to the use of such tactics? What is it that this person cannot do which, if she could do, would eliminate the need to resort to hysterical impersonation? It is the answer to these questions, not those concerning in what nosological pigeonhole this person belongs, which provide the psychotherapist with truly useful information.

RATIONALE: WHY WOULD A PERSON ENGAGE EXTENSIVELY IN SUCH IMPERSONATION?

In this section I will present a constellation of reasons, beliefs, and life experiences which I have observed with considerable frequency in hysterical persons. In describing these, I am not making the claim that these constitute the only reasons why people engage in hysterical actions. They do not. I do claim, however, that the picture presented below is

very common, is very important to the understanding of much hysterical impersonation, and provides the psychotherapist with more leverage to bring about useful change than do most previous accounts.

Much of the hysterical behavior which I have observed seems to have been engaged in most importantly for two related reasons: (a) to be exempted from caretaking roles and (b) to get other individuals to assume such caretaking roles in relation to the hysterical individual. Hysterical impersonative acts thus represent dramatic, extortive bids to avoid the caretaker role and to assume instead the role of recipient of care. For example, if one engages in highly dramatic portrayals of an individual in great pain or in the throes of a seizure, this places powerful ethical constraints on others to avoid demanding that this individual be a caretaker. Further, others are also ethically constrained to provide help and support for her.

What kind of person would typically adopt this sort of measure in order to secure these ends? In my experience, such a person usually possesses two features which, taken together, make it clear why she would resort to this sort of strategic impersonation.

First, in contrast with previous accounts, which assert that beneath her impersonative dramatics the hysterical individual is factually quite simple, incompetent, and inadequate (Sullivan, 1947; Szasz, 1973), I have observed that typically the hysterical individual possesses many factual competencies. In particular, the hysteric is typically in many respects a competent caretaker, but one who is given to the assumption of excessive responsibilities when she is functioning in helping roles. This is a person whom some family systems theorists would describe, not as inadequate, but as *overadequate* when they are fulfilling such role responsibilities (Bergner, 1977; Bowen, 1966). This is the boss who can't delegate. This is the parent given to overprotection and untoward servility.

Secondly, as one might anticipate from the above, the hysteric is typically a person who has never established a workable definition of what constitutes reasonable limits to her own responsibilities. Characteristically, she has become tremendously oversold on the ethical demands imposed by needy others and, further, developed what amounts in practice to a rather grandiose conception of her own powers; that is, she implicitly believes that she can control the conduct and the happiness of others. When fulfilling caretaker roles, then, she has very strong senses of moral compunction and of exaggerated personal power and responsibility which lead her to give more and more, and to place virtually no limits on how much she should and will give. In doing so, she renders herself highly vulnerable to becoming exploited and depleted, and in fact often becomes so.

There is undoubtedly no one way in which a person acquires the disposition to overfunction in caretaker roles and the beliefs which accompany this disposition. However, there is one pattern which is sufficiently common to warrant mention. Many of the hysterical individuals whom I have known have had a personal history in which one of their parents, most often the same-sex parent, became seriously dysfunctional, for example, with alcoholism or physical invalidism. These individuals, in response to this state of affairs, were prematurely and coercively charged with the adoption of adult, caretaker roles and ultimately spent a good many of their developing years in the excessive discharge of these role responsibilities. Further, in contrast with some families in which the children who fulfill such roles are lavishly rewarded, in the hysteric's family, the rewards were very meager; on balance her experience was one of distasteful submission and exploitation. In effect, in the adoption of such roles, this person became a parent to her own same-sex parent and her siblings, and a spouse to her opposite-sex parent. In the latter regard, furthermore, when a young girl takes on her own mother's caretaking responsibilities as her mother abdicates them, she simultaneously functions in the role of generational equal, or spouse, to her own father. It is highly likely that the Oedipal feelings and the maternal deprivation so often documented by psychoanalytic authors often arise out of such familial role-taking patterns.

A child who is prematurely and excessively charged with parental roles, and who acquiesces to such role expectations, frequently develops a very powerful sense of moral obligation about caretaking roles (Boszormenyi-Nagy & Spark 1974). She becomes so used to a life of service to others, and so sold on the vital necessity of her rendering such service, that she becomes almost a slave to her own sense of responsibility in this area. Further, such a child has usually been given a status assignment (the "child who is competent enough to be a parent") which represents an unrealistic, exaggerated appraisal of her powers by others in the family. Little wonder, then, that she grows into adulthood with such a misappraisal of her own powers.

Finally, the literature on observational learning (Bandura, 1969) tells us that a child learns, through observation, a great deal which he or she may not immediately exhibit. This learning becomes part of a behavioral repertoire which can be manifested should circumstances warrant such display. The parental child, as she engages in extensive caretaking behaviors, simultaneously observes the complementary role behaviors manifested by those in her care. She thus learns, for future reference as it were, the roles of "helped" and even "helpless."

It should by now be clear why the impersonation of disability represents a sensible solution for the sort of person I have been describing.

Here we have an individual who has been excessively socialized in the "game," one might say, of "helper-helped" and, within the role possibilities afforded by this game, has remained primarily in the helper role. This person has severe difficulties setting limits on how much caretaking she is willing to give—she is being exploited and depleted by others but cannot in good conscience take the overt, straightforward stance, "No, I won't give any more." A solution which makes sense, then, is for this person to make a position shift within the game she knows best and *herself became disabled and in need of help*. Now, since we cannot for the most part simply will ourselves to be sick when we are not, or stupid when we are not, and so forth, the solution must be to *impersonate these things*. It now becomes important, however, given this person's moral abhorrence of deceitfully opting out of caretaking responsibilities and extorting others into taking them on, that she *not know* that she is impersonating disability. She must see herself as genuinely disabled and genuinely in need of the care of others. Finally, she must not know that she does not know she is impersonating, since any subversion of the structure of ignorance would seriously impair her ability to pursue the impersonative act.

In my experience, the hysterical individual's bid to be taken care of is often not total; that is, she does not abdicate all caregiver responsibilities. Rather, this bid represents an attempt to balance out what is simultaneously going on in other current relationships. For example, a highly successful teacher/administrator whom I once treated exhibited the following pattern. During the day she functioned as a very competent professional, but one given to the excessive assumption of the responsibilities of those under her. Upon entering her front door at night, however, she routinely shifted to a tremendously helpless, illogical, hyperemotional role with her husband (the additional element of impersonating disability so as not to threaten one's spouse with one's success and competence may be noted here). By way of further example, an overly involved and overly responsible psychotherapist with a large, lucrative private practice would lapse into the appearance of being a totally insecure nervous wreck in the presence of her own psychotherapist.

Such individuals will often convey an implicit or explicit world-view with the following general outline: "The neediness of a sick or helpless person represents the ultimate moral imperative. In the face of such neediness on the part of others, I must therefore give, and give even to the point of personal depletion. Then, however, I myself am entitled to go, present my own neediness to another, and be 'refueled' without limitation by this other." In this world-view, it should be underscored, there is little notion that one can help oneself; help must always come from without.

The foregoing descriptions and explanations may be utilized as a paradigm case. That is, the clinician may be able to delete certain features of the complete, paradigmatic picture outlined above, and still generate adequate explanatory accounts of some hysterical phenomena. For example, an hysterical blindness at the battlefield may be taken as the impersonation of physical disability by a person who does not know what he is doing, who wishes to be exempted from responsibility, and who cannot take the overt personal stand that "I won't do this." However, in this case, the further elements delineated in the analysis presented above need not be present to account adequately for his behavior.

THERAPEUTIC RECOMMENDATIONS

Therapeutic Goals

In my experience, therapy with hysterical individuals requires that the therapist take a good deal of initiative in determining the crucial issues and goals to be discussed. The therapist who fails to do so, whether through the adoption of a passive, laissez-faire stance or through personal uncertainty as to just what are the core issues, invites this individual to lead him or her down numerous blind alleys. The predictable outcome is a therapy with no direction and no progress. It is incumbent on the therapist, therefore, to focus discussion on the important issues. This may entail asking the client to temporarily shelve some others. Or, perhaps somewhat better, the therapist might adopt a policy of going along with whatever content the client introduces, but consistently relate this content back to the core issues.

With this in mind I suggest the following goals as those which are most important and profitable to pursue:

1. The hysterical individual would ideally alter her belief that she is a defective, sick, virtual nonagent and realize her actual status as that of a person (i.e., an agent capable of intentional and deliberate action) and one who, through the impersonation of deficit, has believed her own act and thus greatly misappraised her own powers and eligibilities.
2. The hysterical individual would ideally become able to question and to alter her belief that the giving of care to others represents some sort of absolute moral imperative in the face of which she must give until totally depleted. Further, resolving this, she would become more able honestly and straightforwardly to set and enforce personal limits on how much care she is willing to give so that she does not have to resort to impersonation and extortion to escape the demands of others.

3. The hysterical individual would ideally become able, in the reciprocal, care-getting role, to *ask* honestly and straightforwardly for care from others, again without resorting to impersonation and extortion to secure these ends. If this can be accomplished, the individual no longer has to win by losing, that is, secure care by presenting herself to the world as an irrational, helpless, sick, virtual nonperson.
4. The hysterical individual would ideally become more able to engage in social practices with few or no caretaking elements. Lacking socialization in practices other than those involving the coercive giving and getting of care, she would make good this developmental lack and expand her forms of relating.
5. The hysterical individual would ideally become more able to help herself.

Therapeutic Attitude

It is a truism that the psychotherapist's optimum attitude toward the hysterical (or any other) client ought to be an accepting one. Notwithstanding its status as a truism, this attitude is so frequently lacking toward hysterical clients that something needs to be said here. Therapists are very often angry at their hysterical clients. They believe that they are being lied to and manipulated—which is often true—but they sometimes lack a perspective on such behavior which would help them to maintain a more therapeutic attitude.

A therapist who adopts the conception of hysteria I have presented here should encounter less difficulty in maintaining an accepting therapeutic attitude toward clients who are hysterics. For example, this conception makes it clear that, in the case of true hysterical action, the individual is not deliberately lying or impersonating, but is substantially convinced by her own act. An attitude toward the client which says, "I believe that you believe what you're saying; however, it's probably not true," will generate less therapist anger than one that says "You're deliberately conning me."

By way of further example, it is helpful to keep in mind that even when she may be deliberately lying, the hysterical individual is not, as a rule, doing so out of simple malice, but because she genuinely believes, within her world-view, that she has good reason to do so. A helpful, if imperfect, analogy here comes from the novel *Roots* (Haley, 1977) in which the character Chicken George impersonates illiteracy because he believes (correctly) that not to do so would invite oppression from his master. The hysteric has her own good reasons to do as she is doing, and an optimum therapeutic attitude acknowledges this fact without condoning these acts, excusing them, or being victimized by them, all of which would be countertherapeutic.

Some Therapeutic Stances and Tactics

The essential business of psychotherapy with the individual I have been describing in these pages is to accomplish the goals set forth above. Obviously, there is no one way to do so and no particular techniques that would guarantee success in this attempt. There are, however, a number of strategies and stances which I have found particularly helpful in working with hysterical clients.

Responding to Impersonative Status Claims

One of the therapist's most fundamental and most difficult tasks with hysterical individuals is to see to it that they are successful in their relationship with the therapist (Ossorio, 1976). This is often rendered especially difficult by the fact that much of the behavior of the hysterical individual in this relationship consists in making impersonative status claims which place the therapist in a difficult predicament. If he or she straightforwardly accepts these claims, this represents the authentication or confirmation of the hysterical individual in her problematic, impersonative roles. The therapeutic relationship, then, merely replicates other unsuccessful relationships. On the other hand, if the basic therapeutic response toward these status claims is simply to reject them, the result is a disconfirmation of the person in this relationship and, again, relationship failure.

Let us suppose that an individual's self-presentation has roughly the following content: "I'm in terrible, terrible (psychic) pain. My life is a living hell, and I'm totally unable to figure out what is causing my pain. You've got to figure this out for me." The therapist has two obvious choices in how he or she will respond to this, and both of them spell trouble. First, the therapist's response may be essentially, "Yes, I believe that you are in terrible pain, that you can't figure it out, and that you can't help yourself. I will figure it out for you." While no therapist but the most naive beginner would ever *say* such a thing, I have observed many therapists who implicitly *treat* hysterical clients in this fashion. They make this assertion not in words, but in actions. Such a response confirms the individual's impersonative claim to pain and helplessness, and amounts to joining the hysterical person in one more relationship where she can win by losing.

Secondly, the therapist's response may be essentially this: "I don't believe you. I don't believe you're in that much pain and I don't believe that you are so dumb that you can't figure anything out at all." I know a therapist once who took this stance and exhibited an admirable terse-ness. He simply kept saying "bullshit" to his hysterical clients. I believe that this response is preferable to the other. When this is the basic stance

of the therapist, however, the relationship then becomes one in which the client is rejected and disconfirmed.

The difficult task then becomes to *accept* the impersonative relationship bids of the hysterical individual, but *not at face value* and *not in a way which authenticates this individual in a problematic role*. This takes considerable ingenuity (more ingenuity, I must confess, than I am often able to muster on the spot). Let me illustrate a few examples of such therapeutic responses for the individual mentioned above who is claiming "terrible, terrible" pain and a total inability to discern what the source of this pain is. Let us further assume that the therapist has ample reason to conclude that indeed there is some pain here, but not "terrible, terrible" pain, and that this person does possess the wherewithal to determine the reasons for this pain. Consider the following responses (all of which are severely condensed for illustrative purposes):

1. "You know, I was just remembering how you often help your friends with their problems. I'd like to ask you to try something. Would you move over here into my chair and pretend that a good friend has told you that she is in the sort of pain and the sort of circumstances you have been describing. What would you tell her was probably the matter?" This reply is responsive to the client's relationship bid without accepting it *prima facie* or rejecting it. The therapist does comply with the request for help, but in a way which accredits the client as herself a competent problem-solver and which calls upon her to help herself. This sort of tactic, employed repeatedly, can be extremely effective with the more competent and more cooperative hysteric. The individual who is determined to pursue the game of helplessness with a vengeance, however, will often summarily reject this sort of therapeutic request.

2. "You know, what you're doing right now is extremely powerful. I feel almost backed against the wall. Do you suppose you could turn down the power a bit?" The therapist here accepts the impersonative bid, again not at face value (i.e., as a claim to the status of "helpless victim") but as a power tactic and a very good one. If the therapist is not sarcastic or otherwise abusive in the way this is said, he or she accredits the person as a very powerful individual, so powerful indeed that she needs to temper her exercise of her power.

3. "Whew, you must have really been hopping for your family this week. It looks like you're really rejecting that old helper role with a vengeance this morning." The therapist here responds empathically to what he or she guesses might be at the root of a given dramatic, helpless bid. Further, he or she reframes it status dynamically, not as an instance of genuine helplessness, but as the understandable rejection of a role the person is competent to play.

"Talk" to the Client in Iconic Language

As related earlier, the hysteric is an individual who is given to communicating with others in a language of iconic signs. Like an actress in a silent film, she communicates her messages to others with dramatic gestures and postures. Her motto, one might say, is that "one picture is worth 10,000 words." An obvious implication for the psychotherapist is that he or she should, when possible, "speak" back to the hysterical individual in her own language. For example, several years ago I was talking with a client who was presenting herself to an extreme degree as if she were merely a pawn of forces external to herself. To hear her talk, she was a totally passive creature whose emotions and behaviors were nothing but the products of external forces operating upon her. As she was speaking, I got up out of my seat, walked over to her, and started to wave my hands over her head much in the manner that a magician might who was demonstrating that there were no wires suspending a levitated body. "What the hell are you doing?" she asked me. "I'm looking for the strings," I replied. "You are talking to me almost totally as if you were a puppet and somebody else was pulling your strings, and I'm just looking for the strings. I can't find any." This message, communicated first in iconic signs, had a considerable impact. In fact, this client mentioned it at least a month later and told me it had started her thinking about how much she underestimated her control over her own conduct.

Be Somebody

If there is one sort of person who drives hysterical individuals crazy, it is the passive, ambiguous person who will never define where he or she stands on things (Bergner, 1977). In contrast, what the hysteric can best use is an individual who, without attempting to control her, will maintain a kind but *firm* adherence to his or her own limits. The therapist will almost inevitably have to define and enforce such limits during the course of therapy, typically in regard to such matters as after-hours phone calls, seductive bids, or other demands which the therapist does not want to, and should not, meet. Furthermore, from an observational learning standpoint, the hysterical individual genuinely needs to observe another person who is not controlling and not controlled, but rather is in charge of and comfortable with taking stands on what he or she is willing to give.

SUMMARY

The present study expands upon the seminal notion, proposed by Szasz (1974) and others, that hysterical phenomena represent the mimicry of

physical illness and/or insanity. The major theses advanced include the following:

1. Hysterical phenomena represent impersonative status claims in which persons present themselves to others as either defective persons or nonpersons, and thus make a bid to be regarded and treated as such. The actual forms which such bids assume include status claims other than those of sick person and insane person.

2. What distinguishes hysterical action from simple malingering is that in the former individuals do not realize that they are impersonating. Not realizing this, they are in effect taken in by their own impersonative status claims.

3. The consequences entailed in believing such self-assigned statuses as sick person, insane person, irrational person, and nonperson are enormous. While they do convey entitlement to care from others, in other ways they drastically restrict an individual's powers and eligibilities to participate in social practices.

4. Hysterical action is frequently engaged in in order to be exempted from caretaking roles and responsibilities, and to get others to assume such roles in relation to the hysterical individual. Developmental experiences in which this individual was prematurely and excessively charged with caretaker responsibilities are common, and provide a multiplicity of reasons why the hysteric resorts to such drastic and self-damaging measures to achieve these ends.

5. In doing psychotherapy with hysterical clients, it is important (a) to take a good deal of initiative in determining the crucial issues and goals to be pursued; (b) to maintain a charitable attitude toward the deceptions and manipulations of hysterical clients, yet one which stops short of excusing, condoning, or being victimized by these actions; (c) to set limits in a kind yet firm way regarding what one is willing and not willing to do in this relationship; and (d) to accept the impersonative relationship bids of hysterical individuals, but not at face value and not in a way that authenticates these persons in problematic roles.

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