SOME GENERAL REMARKS ON HYSTERICAL ATTACKS - (1909)

A

When one carries out the psycho-analysis of a hysterical woman patient whose complaint is manifested in attacks, one soon becomes convinced that these attacks are nothing else but phantasies translated into the motor sphere, projected on to motility and portrayed in pantomime. It is true that the phantasies are unconscious; but apart from this they are of the same nature as the phantasies which can be observed directly in day-dreams or which can be elicited by interpretation from dreams at night. Often a dream takes the place of an attack, and still more often it explains it, since the same phantasy finds a different expression in a dream and in an attack. We might expect then that by observing an attack we should be able to get to know the phantasy represented in it; but this is seldom possible. As a rule, owing to the influence of the censorship, the pantomimic portrayal of the phantasy has undergone distortions which are completely analogous to the hallucinatory distortions of a dream, so that both of them have, in the first resort, become unintelligible to the subject's own consciousness as well as to the observer's comprehension. A hysterical attack, therefore, needs to be subjected to the same interpretative revision as we employ for night-dreams. But not only are the forces from which the distortion proceeds and the purpose of the distortion the same as those we have come to know through the interpretation of dreams; the technique employed in the distortion is the same too.

(1) The attack becomes unintelligible through the fact that it represents several phantasies in the same material simultaneously - that is to say through condensation. The elements common to the two (or more) phantasies constitute the nucleus of the representation, as they do in dreams. The phantasies which are thus made to coincide are often of quite a different nature. They may, for instance, be a recent wish and the re-activation of an infantile impression. The same innervations are in that case made to serve both purposes, often in a most ingenious way. Hysterical patients who make a very extensive use of condensation may find a single form of attack sufficient; others express their numerous pathogenic phantasies by a multiplication of the forms of attack.

(2) The attack becomes obscured through the fact that the patient attempts to carry out the activities of both the figures who appear in the phantasy, that is to say, through multiple identification. Compare, for instance, the example I mentioned in my paper on 'Hysterical Phantasies and their Relation to Bisexuality' (1908a), in which the patient tore off her dress with one hand (as the man) while she pressed it to her body with the other (as the woman).

(3) A particularly extensive distortion is effected by an antagonistic inversion of the innervations. This is analogous to the transformation of an element into its opposite, which commonly happens in the dream-work. For instance, an embrace may be represented in the attack by drawing back the arms convulsively till the hands meet over the spinal column. It is possible that the well-known arc de cercle

which occurs during attacks in major hysteria is nothing else than an energetic repudiation like this, through antagonistic innervation, of a posture of the body that is suitable for sexual intercourse.

(4) Scarcely less confusing and misleading is a reversal of the chronological order within the phantasy that is portrayed, which once more has its complete counterpart in a number of dreams which begin with the end of the action and end with its beginning. Supposing, for instance, that a hysterical woman has a phantasy of seduction in which she is sitting reading in a park with her skirt slightly lifted so that her foot is visible; a gentleman approaches and speaks to her; they then go somewhere and make love to one another. This phantasy is acted out in the attack by her beginning with the convulsive stage, which corresponds to the coitus, by her then getting up, going into another room, sitting down and reading and presently answering an imaginary remark addressed to her.

The two last-mentioned forms of distortion give us some idea of the intensity of the resistances which the repressed material must take into account even when it breaks through in a hysterical attack.3

B

The onset of hysterical attacks follows laws that are easily understandable. Since the repressed complex consists of a libidinal cathexis and an ideational content (the phantasy), the attack can be evoked (1) associatively, when the content of the complex (if sufficiently cathected) is touched on by something connected with it in conscious life; (2) organically, when, for internal somatic reasons and as a result of psychical influences from outside, the libidinal cathexis rises above a certain degree; (3) in the service of the primary purpose - as an expression of a 'flight into illness', when reality becomes distressing or frightening - that is, as a consolation; (4) in the service of the secondary purposes, with which the illness allies itself, as soon as, by producing an attack, the patient can achieve an aim that is useful to him. In the last case the attack is directed at particular individuals; it can be put off till they are present, and it gives an impression of being consciously simulated.C

Investigation of the childhood history of hysterical patients shows that the hysterical attack is designed to take the place of an auto-erotic satisfaction previously practised and since given up. In a great number of cases this satisfaction (masturbation by contact or by pressure of the thighs, or, again, by movements of the tongue, and so on) recurs during the attack itself, while the subject's consciousness is deflected. Moreover, the onset of an attack that is due to an increase of libido and is in the service of the primary purpose - as a consolation - exactly repeats the conditions under which, at the earlier time, the patient had intentionally sought this auto-erotic satisfaction. The anamnesis of the patient shows the following stages: (a) auto-erotic satisfaction, without ideational content; (b) the same satisfaction, connected with a phantasy which leads to the act of satisfaction; (c) renunciation of the act, with retention of the phantasy; (d) repression of the phantasy, which then comes into effect as a hysterical attack, either in an unchanged form, or in a modified one and adapted to new

environmental impressions. Furthermore, (e) the phantasy may even reinstate the act of satisfaction belonging to it which had ostensibly been given up. This is a typical cycle of infantile sexual activity: repression, failure of repression, and return of the repressed.

The involuntary passing of urine is certainly not to be regarded as incompatible with the diagnosis of a hysterical attack; it is merely repeating the infantile form of a violent pollution. Moreover, biting the tongue may also be met with in undoubted cases of hysteria. It is no more inconsistent with hysteria than it is with love-making. It occurs more readily in attacks if the patient's attention had been drawn by the doctor's questions to the difficulties of making a differential diagnosis. Self-injury may occur in hysterical attacks (more frequently in the case of men) where it repeats an accident in childhood - as, for instance, the result of a romp.

The loss of consciousness, the 'absence'[1], in a hysterical attack is derived from the fleeting but unmistakable lapse of consciousness which is observable at the climax of every intense sexual satisfaction, including auto-erotic ones. This course of development can be traced with most certainty where hysterical absences arise from the onset of pollutions in young people of the female sex. The so-called 'hypnoid states' - absences during day-dreaming -, which are so common in hysterical subjects, show the same origin. The mechanism of these absences is comparatively simple. All the subject's attention is concentrated to begin with on the course of the process of satisfaction; with the occurrence of the satisfaction, the whole of this cathexis of attention is suddenly removed, so that there ensues a momentary void in her consciousness. This gap in consciousness, which might be termed a physiological one, is then widened in the service of repression, till it can swallow up everything that the repressing agency rejects.D

What points the way for the motor discharge of the repressed libido in a hysterical attack is the reflex mechanism of the act of coition - a mechanism which is ready to hand in everybody, including women, and which we see coming into manifest operation when an unrestrained surrender is made to sexual activity. Already in ancient times coition was described as a 'minor epilepsy'. We might alter this and say that a convulsive hysterical attack is an equivalent of coition. The analogy with an epileptic fit helps us little, since its genesis is even less understood than that of hysterical attacks.

Speaking as a whole, hysterical attacks, like hysteria in general, revive a piece of sexual activity in women which existed during their childhood and at that time revealed an essentially masculine character. It can often be observed that girls who have shown a boyish nature and inclinations up to the years before puberty are precisely those who become hysterical from puberty onwards. In a whole number of cases the hysterical neurosis merely represents an excessive accentuation of the typical wave of repression which, by doing away with her masculine sexuality, allows the woman to emerge.[2]

[1] [The French term.]

[2] Cf. my Three Essays on the Theory of Sexuality (1905d).