Freud's Case Histories

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STUDIES ON HYSTERIA

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II

CASE HISTORIES

(Breuer and Freud)

CASE 1

Fräulein Anna O. (Breuer)

At the time of her falling ill (in 1880) Fräulein Anna O. was twenty-one years old. She may be regarded as having had a moderately severe neuropathic heredity, since some psychoses had occurred among her more distant relatives. Her parents were normal in this respect. She herself had hitherto been consistently healthy and had shown no signs of neurosis during her period of growth. She was markedly intelligent, with an astonishingly quick grasp of things and penetrating intuition. She possessed a powerful intellect which would have been capable of digesting solid mental pabulum and which stood in need of it—though without receiving it after she had left school. She had great poetic and imaginative gifts, which were under the control of a sharp and critical common sense. Owing to this latter quality she was *completely unsuggestible*; she was only influenced by arguments, never by mere assertions. Her will-power was energetic, tenacious and persistent; sometimes it reached the pitch of an obstinacy which only gave way out of kindness and regard for other people.

One of her essential character traits was sympathetic kindness. Even during her illness she herself was greatly assisted by being able to look after a number of poor, sick people, for she was thus able to satisfy a powerful instinct. Her states of feeling always tended to a slight exaggeration, alike of cheerfulness and gloom; hence she was

sometimes subject to moods. The element of sexuality was astonishingly undeveloped in her.[1] The patient, whose life became known to me to an extent to which one person's life is seldom known to another, had never been in love; and in all the enormous number of hallucinations which occurred during her illness that element of mental life never emerged.

This girl, who was bubbling over with intellectual vitality, led an extremely monotonous existence in her puritanically minded family. She embellished her life in a manner which probably influenced her decisively in the direction of her illness, by indulging in systematic day-dreaming, which she described as her "private theater." While everyone thought she was attending, she was living through fairy tales in her imagination; but she was always on the spot when she was spoken to, so that no one was aware of it. She pursued this activity almost continuously while she was engaged on her household duties, which she discharged unexceptionably. I shall presently have to describe the way in which this habitual day-dreaming while she was well passed over into illness without a break.

The course of the illness fell into several clearly separable phases:

(*A*) Latent incubation. From the middle of July, 1880, till about December 10. This phase of an illness is usually hidden from us; but in this case, owing to its peculiar character, it was completely accessible; and this in itself lends no small pathological interest to the history. I shall describe this phase presently.

(*B*) The manifest illness. A psychosis of a peculiar kind, paraphasia, a convergent squint, severe disturbances of vision, paralyses (in the form of contractures), complete in the right upper and both lower extremities, partial in the left upper extremity, paresis of the neck muscles. A gradual reduction of the contracture to the right-hand extremities. Some improvement, interrupted by a severe psychical trauma (the death of the patient's father) in April, after which there followed

[1] [Freud quoted this sentence (not quite verbatim) in a footnote to the first of his *Three Essays on the Theory of Sexuality* (1905*d*), *Standard Ed.*, 7, 164 *n.*, and in Chapter II of his autobiography (1925*d*).]

(*C*) A period of persisting somnambulism, subsequently alternating with more normal states. A number of chronic symptoms persisted till December, 1881.

(*D*) Gradual cessation of the pathological states and symptoms up to June, 1882.

In July, 1880, the patient's father, of whom she was passionately fond, fell ill of a peripleuritic abscess which failed to clear up and to which he succumbed in April, 1881. During the first months of the illness Anna devoted her whole energy to nursing her father, and no one was much surprised when by degrees her own health greatly deteriorated. No one, perhaps not even the patient herself, knew what was happening to her; but eventually the state of weakness, anaemia and distaste for food became so bad that to her great sorrow she was no longer allowed to continue nursing the patient. The immediate cause of this was a very severe cough, on account of which I examined her for the first time. It was a typical *tussis nervosa*. She soon began to display a marked craving for rest during the afternoon, followed in the evening by a sleep-like state and afterwards a highly excited condition.

At the beginning of December a convergent squint appeared. An ophthalmic surgeon explained this (mistakenly) as being due to paresis of one abducens. On December 11 the patient took to her bed and remained there until April 1.

There developed in rapid succession a series of severe disturbances which were *apparently* quite new: left-sided occipital headache; convergent squint (diplopia), markedly increased by excitement; complaints that the walls of the room seemed to be falling over (affection of the obliquus); disturbances of vision which it was hard to analyse; paresis of the muscles of the front of the neck, so that finally the patient could only move her head by pressing it backwards between her raised shoulders and moving her whole back; contracture and anaesthesia of the right upper, and, after a time, of the right lower extremity. The latter was fully extended, adducted and rotated inwards. Later the same symptom appeared in the left lower extremity and finally in the left arm, of which, however, the fingers to some extent retained the power of movement. So, too, there was no complete rigidity in the

shoulder-joints. The contracture reached its maximum in the muscles of the upper arms. In the same way, the region of the elbows turned out to be the most affected by anaesthesia when, at a later stage, it became possible to make a more careful test of this. At the beginning of the illness the anaesthesia could not be efficiently tested, owing to the patient's resistance arising from feelings of anxiety.

It was while the patient was in this condition that I undertook her treatment, and I at once recognized the seri-ousness of the psychical disturbance with which I had to deal. Two entirely distinct states of consciousness were present which alternated very frequently and without warning and which became more and more differentiated n the course of the illness. In one of these states she ecognized her surroundings; she was melancholy and anx-ous, but relatively normal. In the other state she hal-ıcinated and was "naughty"—that is to say, she was busive, used to throw the cushions at people, so far as ıe contractures at various times allowed, tore buttons ff her bedclothes and linen with those of her fingers 'hich she could move, and so on. At this stage of her ill-ess if something had been moved in the room or some-ne had entered or left it (during her other state of con-iousness) she would complain of having "lost" some me and would remark upon the gap in her train of con-ious thoughts. Since those about her tried to deny this ıd to soothe her when she complained that she was go-g mad, she would, after throwing the pillows about, cuse people of doing things to her and leaving her in nuddle, etc.

These *"absences"* [1] had already been observed before e took to her bed; she used then to stop in the middle a sentence, repeat her last words and after a short use go on talking. These interruptions gradually in-ased till they reached the dimensions that have just en described; and during the climax of the illness, when contractures had extended to the left side of her dy, it was only for a short time during the day that was to any degree normal. But the disturbances in-led even her moments of relatively clear consciousness. ere were extremely rapid changes of mood leading to

[1] [The French term.]

excessive but quite temporary high spirits, and at other times severe anxiety, stubborn opposition to every therapeutic effort and frightening hallucinations of black snakes, which was how she saw her hair, ribbons and similar things. At the same time she kept on telling herself not to be so silly: what she was seeing was really only her hair, etc. At moments when her mind was quite clear she would complain of the profound darkness in her head, of not being able to think, of becoming blind and deaf, of having two selves, a real one and an evil one which forced her to behave badly, and so on.

In the afternoons she would fall into a somnolent state which lasted till about an hour after sunset. She would then wake up and complain that something was tormenting her—or rather, she would keep repeating in the impersonal form "tormenting, tormenting." For alongside of the development of the contractures there appeared a deep-going functional disorganization of her speech. It first became noticeable that she was at a loss to find words, and this difficulty gradually increased. Later she lost her command of grammar and syntax; she no longer conjugated verbs, and eventually she used only infinitives, for the most part incorrectly formed from weak past participles; and she omitted both the definite and indefinite article. In the process of time she became almost completely deprived of words. She put them together laboriously out of four or five languages and became almost unintelligible. When she tried to write (until her contractures entirely prevented her doing so) she employed the same jargon. For two weeks she became completely dumb and in spite of making great and continuous efforts to speak she was unable to say a syllable. And now for the first time the psychical mechanism of the disorder became clear. As I knew, she had felt very much offended over something and had determined not to speak about it. When I guessed this and obliged her to talk about it, the inhibition, which had made any other kind of utterance impossible as well, disappeared.

This change coincided with a return of the power of movement to the extremities of the left side of her body, in March, 1881. Her paraphasia receded; but thenceforward she spoke only in English—apparently, however, without knowing that she was doing so. She had disputes with her nurse who was, of course, unable to understand

her. It was only some months later that I was able to convince her that she was talking English. Nevertheless she herself could still understand the people about her who talked German. Only in moments of extreme anxiety did her power of speech desert her entirely, or else she would use a mixture of all sorts of languages. At times when she was at her very best and most free, she talked French and Italian. There was complete amnesia between these times and those at which she talked English. At this point, too, her squint began to diminish and made its appearance only at moments of great excitement. She was once again able to support her head. On the first of April she got up for the first time.

On the fifth of April her adored father died. During his illness she had seen him very rarely and for short periods. This was the most severe psychical trauma that she could possibly have experienced. A violent outburst of excitement was succeeded by profound stupor which lasted about two days and from which she emerged in a greatly changed state. At first she was far quieter and her feelings of anxiety were much diminished. The contractures of her right arm and leg persisted as well as their anaesthesia, though this was not deep. There was a high degree of restriction of the field of vision: in a bunch of flowers which gave her much pleasure she could only see one flower at a time. She complained of not being able to recognize people. Normally, she said, she had been able to recognize faces without having to make any deliberate effort; now she was obliged to do laborious "recognizing work"[1] and had to say to herself "this person's nose is such-and-such, his hair is such-and-such, so he must be so-and-so." All the people she saw seemed like wax figures without any connection with her. She found the presence of some of her close relatives very distressing and this negative attitude grew continually stronger. If someone whom she was ordinarily pleased to see came into the room, she would recognize him and would be aware of things for a short time, but would soon sink back into her own broodings and her visitor was blotted out. I was the only person whom she always recognized when I came in; so long as I was talking to her she was always in contact with things and lively, except for the sudden inter-

[1] [In English in the original.]

ruptions caused by one of her hallucinatory *"absences."*

She now spoke only English and could not understand what was said to her in German. Those about her were obliged to talk to her in English; even the nurse learned to make herself to some extent understood in this way. She was however, able to read French and Italian. If she had to read one of these aloud, what she produced, with extraordinary fluency, was an admirable extempore English translation.

She began writing again, but in a peculiar fashion. She wrote with her left hand, the less stiff one, and she used Roman printed letters, copying the alphabet from her edition of Shakespeare.

She had eaten extremely little previously, but now she refused nourishment altogether. However, she allowed me to feed her, so that she very soon began to take more food. But she never consented to eat bread. After her meal she invariably rinsed out her mouth and even did so if, for any reason, she had not eaten anything—which shows how absent-minded she was about such things.

Her somnolent states in the afternoon and her deep sleep after sunset persisted. If, after this, she had talked herself out (I shall have to explain what is meant by this later) she was clear in mind, calm and cheerful.

This comparatively tolerable state did not last long. Some ten days after her father's death a consultant was brought in, whom, like all strangers, she completely ignored while I demonstrated all her peculiarities to him. "That's like an examination,"[1] she said, laughing, when I got her to read a French text aloud in English. The other physician intervened in the conversation and tried to attract her attention, but in vain. It was a genuine "negative hallucination" of the kind which has since so often been produced experimentally. In the end he succeeded in breaking through it by blowing smoke in her face. She suddenly saw a stranger before her, rushed to the door to take away the key and fell unconscious to the ground. There followed a short fit of anger and then a severe attack of anxiety which I had great difficulty in calming down. Unluckily I had to leave Vienna that evening, and when I came back several days later I found the patient much worse. She had gone entirely without food the

[1] [In English in the original.]

whole time, was full of anxiety and her hallucinatory *absences* were filled with terrifying figures, death's heads and skeletons. Since she acted these things through as though she was experiencing them and in part put them into words, the people around her became aware to a great extent of the content of these hallucinations.

The regular order of things was: the somnolent state in the afternoon, followed after sunset by the deep hypnosis for which she invented the technical name of "clouds."[1] If during this she was able to narrate the hallucinations she had had in the course of the day, she would wake up clear in mind, calm and cheerful. She would sit down to work and write or draw far into the night quite rationally. At about four she would go to bed. Next day the whole series of events would be repeated. It was a truly remarkable contrast: in the day-time the irresponsible patient pursued by hallucinations, and at night the girl with her mind completely clear.

In spite of her euphoria at night, her psychical condition deteriorated steadily. Strong suicidal impulses appeared which made it seem inadvisable for her to continue living on the third floor. Against her will, therefore, she was transferred to a country house in the neighborhood of Vienna (on June 7, 1881). I had never threatened her with this removal from her home, which she regarded with horror, but she herself had, without saying so, expected and dreaded it. This event made it clear once more how much the affect of anxiety dominated her psychical disorder. Just as after her father's death a calmer condition had set in, so now, when what she feared had actually taken place, she once more became calmer. Nevertheless, the move was immediately followed by three days and nights completely without sleep or nourishment, by numerous attempts at suicide (though, so long as she was in a garden, these were not dangerous), by smashing windows and so on, and by hallucinations unaccompanied by *absences*—which she was able to distinguish easily from her other hallucinations. After this she grew quieter, let the nurse feed her and even took chloral at night.

Before continuing my account of the case, I must go back once more and describe one of its peculiarities which

[1] [In English in the original.]

I have hitherto mentioned only in passing. I have already said that throughout the illness up to this point the patient fell into a somnolent state every afternoon and that after sunset this period passed into a deeper sleep—"clouds." (It seems plausible to attribute this regular sequence of events merely to her experience while she was nursing her father, which she had had to do for several months. During the nights she had watched by the patient's bedside or had been awake anxiously listening till the morning; in the afternoons she had lain down for a short rest, as is the usual habit of nurses. This pattern of waking at night and sleeping in the afternoons seems to have been carried over into her own illness and to have persisted long after the sleep had been replaced by a hypnotic state.) After the deep sleep had lasted about an hour she grew restless, tossed to and fro and kept repeating "tormenting, tormenting," with her eyes shut all the time. It was also noticed how, during her *absences* in day-time she was obviously creating some situation or episode to which she gave a clue with a few muttered words. It happened then —to begin with accidentally but later intentionally—that someone near her repeated one of these phrases of hers while she was complaining about the "tormenting." She at once joined in and began to paint some situation or tell some story, hesitatingly at first and in her paraphasic jargon; but the longer she went on the more fluent she became, till at last she was speaking quite correct German. (This applies to the early period before she began talking English only [p. 59].) The stories were always sad and some of them very charming, in the style of Hans Andersen's *Picture-book without Pictures,* and, indeed, they were probably constructed on that model. As a rule their starting-point or central situation was of a girl anxiously sitting by a sick-bed. But she also built up her stories on quite other topics.—A few moments after she had finished her narrative she would wake up, obviously calmed down, or, as she called it, "*gehäglich.*"[1] During the night she would again become restless, and in the morning, after a couple of hours' sleep, she was visibly involved in some other set of ideas.—If for any reason she was unable to tell me the story during her evening hypnosis

[1] [She used this made-up word instead of the regular German "*behaglich,*" meaning "comfortable."]

she failed to calm down afterwards, and on the following day she had to tell me *two* stories in order for this to happen.

The essential features of this phenomenon—the mounting up and intensification of her *absences* into her autohypnosis in the evening, the effect of the products of her imagination as psychical stimuli and the easing and removal of her state of stimulation when she gave utterance to them in her hypnosis—remained constant throughout the whole eighteen months during which she was under observation.

The stories naturally became still more tragic after her father's death. It was not, however, until the deterioration of her mental condition, which followed when her state of somnambulism was forcibly broken into in the way already described, that her evening narratives ceased to have the character of more or less freely created poetical compositions and changed into a string of frightful and terrifying hallucinations. (It was already possible to arrive at these from the patient's behavior during the day.) I have already [p. 62] described how completely her mind was relieved when, shaking with fear and horror, she had reproduced these frightful images and given verbal utterance to them.

While she was in the country, when I was unable to pay her daily visits, the situation developed as follows. I used to visit her in the evening, when I knew I should find her in her hypnosis, and I then relieved her of the whole stock of imaginative products which she had accumulated since my last visit. It was essential that this should be effected completely if good results were to follow. When this was done she became perfectly calm, and next day she would be agreeable, easy to manage, industrious and even cheerful; but on the second day she would be increasingly moody, contrary and unpleasant, and this would become still more marked on the third day. When she was like this it was not always easy to get her to talk, even in her hypnosis. She aptly described this procedure, speaking seriously, as a "talking cure," while she referred to it jokingly as "chimney-sweeping."[1] She knew that after she had given utterance to her hallucinations she would lose

[1] [These two phrases are in English in the original.]

all her obstinacy and what she described as her "energy"; and when, after some comparatively long interval, she was in a bad temper, she would refuse to talk, and I was obliged to overcome her unwillingness by urging and pleading and using devices such as repeating a formula with which she was in the habit of introducing her stories. But she would never begin to talk until she had satisfied herself of my identity by carefully feeling my hands. On those nights on which she had not been calmed by verbal utterance it was necessary to fall back upon chloral. I had tried it on a few earlier occasions, but I was obliged to give her 5 grammes, and sleep was preceded by a state of intoxication which lasted for some hours. When I was present this state was euphoric, but in my absence it was highly disagreeable and characterized by anxiety as well as excitement. (It may be remarked incidentally that this severe state of intoxication made no difference to her contractures.) I had been able to avoid the use of narcotics, since the verbal utterance of her hallucinations calmed her even though it might not induce sleep; but when she was in the country the nights on which she had not obtained hypnotic relief were so unbearable that in spite of everything it was necessary to have recourse to chloral. But it became possible gradually to reduce the dose.

The persisting somnambulism did not return. But on the other hand the alternation between two states of consciousness persisted. She used to hallucinate in the middle of a conversation, run off, start climbing up a tree, etc. If one caught hold of her, she would very quickly take up her interrupted sentence without knowing anything about what had happened in the interval. All these hallucinations, however, came up and were reported on in her hypnosis.

Her condition improved on the whole. She took nourishment without difficulty and allowed the nurse to feed her; except that she asked for bread but rejected it the moment it touched her lips. The paralytic contracture of the leg diminished greatly. There was also an improvement in her power of judgment and she became much attached to my friend Dr. B., the physician who visited her. She derived much benefit from a Newfoundland dog which was given to her and of which she was passionately fond. On one occasion, though, her pet made an attack on a cat, and it was splendid to see the way in which the frail girl

seized a whip in her left hand and beat off the huge beast with it to rescue his victim. Later, she looked after some poor, sick people, and this helped her greatly.

It was after I returned from a holiday trip which lasted several weeks that I received the most convincing evidence of the pathogenic and exciting effect brought about by the ideational complexes which were produced during her *absences*, or *condition seconde*, and of the fact that these complexes were disposed of by being given verbal expression during hypnosis. During this interval no "talking cure" had been carried out, for it was impossible to persuade her to confide what she had to say to anyone but me—not even to Dr. B. to whom she had in other respects become devoted. I found her in a wretched moral state, inert, unamenable, ill-tempered, even malicious. It became plain from her evening stories that her imaginative and poetic vein was drying up. What she reported was more and more concerned with her hallucinations and, for instance, the things that had annoyed her during the past days. These were clothed in imaginative shape, but were merely formulated in stereotyped images rather than elaborated into poetic productions. But the situation only became tolerable after I had arranged for the patient to be brought back to Vienna for a week and evening after evening made her tell me three to five stories. When I had accomplished this, everything that had accumulated during the weeks of my absence had been worked off. It was only now that the former rhythm was re-established: on the day after her giving verbal utterance to her phantasies she was amiable and cheerful, on the second day she was more irritable and less agreeable and on the third positively "nasty." Her moral state was a function of the time that had elapsed since her last utterance. This was because every one of the spontaneous products of her imagination and every event which had been assimilated by the pathological part of her mind persisted as a psychical stimulus until it had been narrated in her hypnosis, after which it completely ceased to operate.

When, in the autumn, the patient returned to Vienna (though to a different house from the one in which she had fallen ill), her condition was bearable, both physically and mentally; for very few of her experiences—in fact only her more striking ones—were made into psychical stimuli in a pathological manner. I was hoping for a continuous

and increasing improvement, provided that the permanent burdening of her mind with fresh stimuli could be prevented by her giving regular verbal expression to them. But to begin with I was disappointed. In December there was a marked deterioration of her psychical condition. She once more became excited, gloomy and irritable. She had no more "really good days" even when it was impossible to detect anything that was remaining "stuck" inside her. Towards the end of December, at Christmastime, she was particularly restless, and for a whole week in the evenings she told me nothing new but only the imaginative products which she had elaborated under the stress of great anxiety and emotion during the Christmas of 1880 [a year earlier]. When the scenes had been completed she was greatly relieved.

A year had now passed since she had been separated from her father and had taken to her bed, and from this time on her condition became clearer and was systematized in a very peculiar manner. Her alternating states of consciousness, which were characterized by the fact that, from morning onwards, her *absences* (that is to say, the emergence of her *condition seconde*) always became more frequent as the day advanced and took entire possession by the evening—these alternating states had differed from each other previously in that one (the first) was normal and the second alienated; now, however, they differed further in that in the first she lived, like the rest of us, in the winter of 1881–2, whereas in the second she lived in the winter of 1880–1, and had completely forgotten all the subsequent events. The one thing that nevertheless seemed to remain conscious most of the time was the fact that her father had died. She was carried back to the previous year with such intensity that in the new house she hallucinated her old room, so that when she wanted to go to the door she knocked up against the stove which stood in the same relation to the window as the door did in the old room. The change-over from one state to another occurred spontaneously but could also be very easily brought about by any sense-impression which vividly recalled the previous year. One had only to hold up an orange before her eyes (oranges were what she had chiefly lived on during the first part of her illness) in order to carry her over from the year 1882 to the year 1881. But this transfer into the past did not take place in a general

or indefinite manner; she lived through the previous winter day by day. I should only have been able to *suspect* that this was happening, had it not been that every evening during the hypnosis she talked through whatever it was that had excited her on the same day in 1881, and had it not been that a private diary kept by her mother in 1881 confirmed beyond a doubt the occurrence of the underlying events. This re-living of the previous year continued till the illness came to its final close in June, 1882.

It was interesting here, too, to observe the way in which these revived psychical stimuli belonging to her secondary state made their way over into her first, more normal one. It happened, for instance, that one morning the patient said to me laughingly that she had no idea what was the matter but she was angry with me. Thanks to the diary I knew what was happening; and, sure enough, this was gone through again in the evening hypnosis: I had annoyed the patient very much on the same evening in 1881. Or another time she told me there was something the matter with her eyes; she was seeing colors wrong. She knew she was wearing a brown dress but she saw it as a blue one. We soon found that she could distinguish all the colors of the visual test-sheets correctly and clearly, and that the disturbance only related to the dress-material. The reason was that during the same period in 1881 she had been very busy with a dressing-gown for her father, which was made with the same material as her present dress, but was blue instead of brown. Incidentally, it was often to be seen that these emergent memories showed their effect in advance; the disturbance of her normal state would occur earlier on, and the memory would only gradually be awakened in her *condition seconde*.[1]

Her evening hypnosis was thus heavily burdened, for we had to talk off not only her contemporary imaginative products but also the events and "vexations" [2] of 1881. (Fortunately I had already relieved her at the time of the imaginative products of that year.) But in addition to all this the work that had to be done by the patient and her physician was immensely increased by a third group of separate disturbances which had to be disposed of in the

[1] [Cf. The similar phenomenon in the case of Frau Cäcilie, p. 106 *n*.]

[2] [In English in the original.]

same manner. These were the psychical events involved in the period of incubation of the illness between July and December, 1880; it was they that had produced the whole of the hysterical phenomena, and when they were brought to verbal utterance the symptoms disappeared.

When this happened for the first time—when, as a result of an accidental and spontaneous utterance of this kind, during the evening hypnosis, a disturbance which had persisted for a considerable time vanished—I was greatly surprised. It was in the summer during a period of extreme heat, and the patient was suffering very badly from thirst; for, without being able to account for it in any way, she suddenly found it impossible to drink. She would take up the glass of water she longed for, but as soon as it touched her lips she would push it away like someone suffering from hydrophobia. As she did this, she was obviously in an *absence* for a couple of seconds. She lived only on fruit, such as melons, etc., so as to lessen her tormenting thirst. This had lasted for some six weeks, when one day during hypnosis she grumbled about her English lady-companion whom she did not care for, and went on to describe, with every sign of disgust, how she had once gone into that lady's room and how her little dog—horrid creature!—had drunk out of a glass there. The patient had said nothing, as she had wanted to be polite. After giving further energetic expression to the anger she had held back, she asked for something to drink, drank a large quantity of water without any difficulty and woke from her hypnosis with the glass at her lips; and thereupon the disturbance vanished, never to return. A number of extremely obstinate whims were similarly removed after she had described the experiences which had given rise to them. She took a great step forward when the first of her chronic symptoms disappeared in the same way—the contracture of her right leg, which, it is true, had already diminished a great deal. These findings—that in the case of this patient the hysterical phenomena disappeared as soon as the event which had given rise to them was reproduced in her hypnosis—made it possible to arrive at a therapeutic technical procedure which left nothing to be desired in its logical consistency and systematic application. Each individual symptom in this complicated case was taken separately in hand; all the occasions on which it had appeared were described in

reverse order, starting before the time when the patient became bed-ridden and going back to the event which had led to its first appearance. When this had been described the symptom was permanently removed.

In this way her paralytic contractures and anaesthesias, disorders of vision and hearing of every sort, neuralgias, coughing, tremors, etc., and finally her disturbances of speech were "talked away." Amongst the disorders of vision, the following, for instance, were disposed of separately: the convergent squint with diplopia; deviation of both eyes to the right, so that when her hand reached out for something it always went to the left of the object; restriction of the visual field; central amblyopia; macropsia; seeing a death's head instead of her father; inability to read. Only a few scattered phenomena (such, for instance, as the extension of the paralytic contractures to the left side of her body) which had developed while she was confined to bed, were untouched by this process of analysis,[1] and it is probable, indeed, that they had in fact no immediate psychical cause [cf. below, pp. 79–80].

It turned out to be quite impracticable to shorten the work by trying to elicit in her memory straight away the first provoking cause of her symptoms. She was unable to find it, grew confused, and things proceeded even more slowly than if she was allowed quietly and steadily to follow back the thread of memories on which she had embarked. Since the latter method, however, took too long in the evening hypnosis, owing to her being over-strained and distraught by "talking out" the two other sets of experiences—and owing, too, to the reminiscences needing time before they could attain sufficient vividness—we evolved the following procedure. I used to visit her in the morning and hypnotize her. (Very simple methods of doing this were arrived at empirically.) I would next ask her to concentrate her thoughts on the symptom we were treating at the moment and to tell me the occasions on which it had appeared. The patient would proceed to describe in rapid succession and under brief headings the external events concerned and these I would jot down. During her subsequent evening hypnosis she would then, with the help of my notes, give me a fairly detailed account of these circumstances.

[1] [See footnote 2, p. 83.]

An example will show the exhaustive manner in which she accomplished this. It was our regular experience that the patient did not hear when she was spoken to. It was possible to differentiate this passing habit of not hearing as follows:

(*a*) Not hearing when someone came in, while her thoughts were abstracted; 108 separate detailed instances of this, mentioning the persons and circumstances, often with dates. First instance: not hearing her father come in.

(*b*) Not understanding when several people were talking; 27 instances. First instance: her father, once more, and an acquaintance.

(*c*) Not hearing when she was alone and directly addressed; 50 instances. Origin: her father having vainly asked her for some wine.

(*d*) Deafness brought on by being shaken (in a carriage, etc.); 15 instances. Origin: having been shaken angrily by her young brother when he caught her one night listening at the sickroom door.

(*e*) Deafness brought on by fright at a noise; 37 instances. Origin: a choking fit of her father's, caused by swallowing the wrong way.

(*f*) Deafness during deep *absence;* 12 instances.

(*g*) Deafness brought on by listening hard for a long time, so that when she was spoken to she failed to hear; 54 instances.

Of course all these episodes were to a great extent identical in so far as they could be traced back to states of abstraction or *absences* or to fright. But in the patient's memory they were so clearly differentiated, that if she happened to make a mistake in their sequence she would be obliged to correct herself and put them in the right order; if this was not done her report came to a standstill. The events she described were so lacking in interest and significance and were told in such detail that there could be no suspicion of their having been invented. Many of these incidents consisted of purely internal experiences and so could not be verified; others of them (or circumstances attending them) were within the recollection of people in her environment.

This example, too, exhibited a feature that was always observable when a symptom was being "talked away": the particular symptom emerged with greater force while she was discussing it. Thus during the analysis

of her not being able to hear she was so deaf that for part of the time I was obliged to communicate with her in writing.[1] The first provoking cause was habitually a fright of some kind, experienced while she was nursing her father—some oversight on her part, for instance.

The work of remembering was not always an easy matter and sometimes the patient had to make great efforts. On one occasion our whole progress was obstructed for some time because a recollection refused to emerge. It was a question of a particularly terrifying hallucination. While she was nursing her father she had seen him with a death's head. She and the people with her remembered that once, while she still appeared to be in good health, she had paid a visit to one of her relatives. She had opened the door and all at once fallen down unconscious. In order to get over the obstruction to our progress she visited the same place again and, on entering the room, again fell to the ground unconscious. During her subsequent evening hypnosis the obstacle was surmounted. As she came into the room, she had seen her pale face reflected in a mirror hanging opposite the door; but it was not herself that she saw but her father with a death's head.—We often noticed that her dread of a memory, as in the present instance, inhibited its emergence, and this had to be brought about forcibly by the patient or physician.

The following incident, among others, illustrates the high degree of logical consistency of her states. During this period, as has already been explained, the patient was always in her *condition seconde*—that is, in the year 1881—at night. On one occasion she woke up during the night, declaring that she had been taken away from home once again, and became so seriously excited that the whole household was alarmed. The reason was simple. During the previous evening the talking cure had cleared up her disorder of vision, and this applied also to her *condition seconde*. Thus when she woke up in the night she found herself in a strange room, for her family had moved house in the spring of 1881. Disagreeable events of this kind were avoided by my always (at her request)

[1] [This phenomenon is discussed at some length by Freud below (pp. 342 f.), where he describes it as a symptom "joining in the conversation."]

shutting her eyes in the evening and giving her a suggestion that she would not be able to open them till I did so myself on the following morning. The disturbance was only repeated once, when the patient cried in a dream and opened her eyes on waking up from it.

Since this laborious analysis for her symptoms dealt with the summer months of 1880, which was the preparatory period of her illness, I obtained complete insight into the incubation and pathogenesis of this case of hysteria, and I will now describe them briefly.

In July, 1880, while he was in the country, her father fell seriously ill of a sub-pleural abscess. Anna shared the duties of nursing him with her mother. She once woke up during the night in great anxiety about the patient, who was in a high fever; and she was under the strain of expecting the arrival of a surgeon from Vienna who was to operate. Her mother had gone away for a short time and Anna was sitting at the bedside with her right arm over the back of her chair. She fell into a waking dream and saw a black snake coming towards the sick man from the wall to bite him. (It is most likely that there were in fact snakes in the field behind the house and that these had previously given the girl a fright; they would thus have provided the material for her hallucination.) She tried to keep the snake off, but it was as though she was paralyzed. Her right arm, over the back of the chair, had gone to sleep and had become anaesthetic and paretic; and when she looked at it the fingers turned into little snakes with death's heads (the nails). (It seems probable that she had tried to use her paralyzed right arm to drive off the snake and that its anaesthesia and paralysis had consequently become associated with the hallucination of the snake.) When the snake vanished, in her terror she tried to pray. But language failed her: she could find no tongue in which to speak, till at last she thought of some children's verses in English[1] and then found herself able to think and pray in that language. The whistle of the train that was bringing the doctor whom she expected broke the spell.

Next day, in the course of a game, she threw a quoit

[1] [In the "Preliminary Communication" (p. 39) what she thought of is described as a prayer. This, of course, involves no contradiction.]

into some bushes; and when she went to pick it out, a bent branch revived her hallucination of the snake, and simultaneously her right arm became rigidly extended. Thenceforward the same thing invariably occurred whenever the hallucination was recalled by some object with a more or less snake-like appearance. This hallucination, however, as well as the contracture only appeared during the short *absences* which became more and more frequent from that night onwards. (The contracture did not become stabilized until December, when the patient broke down completely and took to her bed permanently.) As a result of some particular event which I cannot find recorded in my notes and which I no longer recall, the contracture of the right leg was added to that of the right arm.

Her tendency to auto-hypnotic *absences* was from now on established. On the morning after the night I have described, while she was waiting for the surgeon's arrival, she fell into such a fit of abstraction that he finally arrived in the room without her having heard his approach. Her persistent anxiety interfered with her eating and gradually led to intense feelings of nausea. Apart from this, indeed, each of her hysterical symptoms arose during an affect. It is not quite certain whether in every case a momentary state of *absence* was involved, but this seems probable in view of the fact that in her waking state the patient was totally unaware of what had been going on.

Some of her symptoms, however, seem not to have emerged in her *absences* but merely in an affect during her waking life; but if so, they recurred in just the same way. Thus we were able to trace back all of her different disturbances of vision to different, more or less clearly determining causes. For instance, on one occasion, when she was sitting by her father's bedside with tears in her eyes, he suddenly asked her what time it was. She could not see clearly; she made a great effort, and brought her watch near to her eyes. The face of the watch now seemed very big—thus accounting for her macropsia and convergent squint. Or again, she tried hard to suppress her tears so that the sick man should not see them.

A dispute, in the course of which she suppressed a rejoinder, caused a spasm of the glottis, and this was repeated on every similar occasion.

She lost the power of speech (*a*) as a result of fear, after her first hallucination at night, (*b*) after having suppressed a remark another time (by active inhibition), (*c*) after having been unjustly blamed for something and (*d*) on every analogous occasion (when she felt mortified). She began coughing for the first time when once, as she was sitting at her father's bedside, she heard the sound of dance music coming from a neighboring house, felt a sudden wish to be there, and was overcome with self-reproaches. Thereafter, throughout the whole length of her illness she reacted to any markedly rhythmical music with a *tussis nervosa*.

I cannot feel much regret that the incompleteness of my notes makes it impossible for me to enumerate all the occasions on which her various hysterical symptoms appeared. She herself told me them in every single case, with the one exception I have mentioned [p. 70, also below, pp. 79–80]; and, as I have already said, each symptom disappeared after she had described its first occurrence.

In this way, too, the whole illness was brought to a close. The patient herself had formed a strong determination that the whole treatment should be finished by the anniversary of the day on which she was moved into the country [June 7 (p. 62)]. At the beginning of June, accordingly, she entered into the "talking cure" with the greatest energy. On the last day—by the help of re-arranging the room so as to resemble her father's sickroom—she reproduced the terrifying hallucination which I have described above and which constituted the root of her whole illness. During the original scene she had only been able to think and pray in English; but immediately after its reproduction she was able to speak German. She was moreover free from the innumerable disturbances which she had previously exhibited.[1] After this she left Vienna

[1] [At this point (so Freud once told the present editor, with his finger on an open copy of the book) there is a hiatus in the text. What he had in mind and went on to describe was the occurrence which marked the end of Anna O.'s treatment. He made short allusions to it at the beginning of his "History of the Psycho-Analytic Movement" (1914*d*), where he spoke of it as, from Breuer's point of view, an "untoward event," and in Chapter II of his *Autobiographical Study* (1925*d*). The whole story is told by Ernest Jones in his life of Freud (1953, 1, 246 ff.), and it is

and traveled for a while; but it was a considerable time before she regained her mental balance entirely. Since then she has enjoyed complete health.

Although I have suppressed a large number of quite interesting details, this case history of Anna O. has grown bulkier than would seem to be required for a hysterical illness that was not in itself of an unusual character. It was, however, impossible to describe the case without entering into details, and its features seem to me of sufficient importance to excuse this extensive report. In just the same way, the eggs of the echinoderm are important in embryology, not because the sea-urchin is a particularly interesting animal but because the protoplasm of its eggs is transparent and because what we observe in them thus throws light on the probable course of events in eggs whose protoplasm is opaque.[1] The interest of the present case seems to me above all to reside in the extreme clarity and intelligibility of its pathogenesis.

There were two psychical characteristics present in the girl while she was still completely healthy which acted as predisposing causes for her subsequent hysterical illness:

(1) Her monotonous family life and the absence of adequate intellectual occupation left her with an unemployed surplus of mental liveliness and energy, and this found an outlet in the constant activity of her imagination.

(2) This led to a habit of day-dreaming (her "private theater"), which laid the foundations for a dissociation of her mental personality. Nevertheless a dissociation of this degree is still within the bounds of normality. Reveries and reflections during a more or less mechanical occupation do not in themselves imply a pathological splitting of

enough to say here that, when the treatment had apparently reached a successful end, the patient suddenly made manifest to Breuer the presence of a strong unanalyzed positive transference of an unmistakably sexual nature. It was this occurrence, Freud believed, that caused Breuer to hold back the publication of the case history for so many years and that led ultimately to his abandonment of all further collaboration in Freud's researches.

[1] [This same analogy was similarly used by Freud many years later (Freud, 1913*h*, *Standard Ed.*, 13, 193).]

consciousness, since if they are interrupted—if, for instance, the subject is spoken to—the normal unity of consciousness is restored; nor, presumably, is any amnesia present. In the case of Anna O., however, this habit prepared the ground upon which the affect of anxiety and dread was able to establish itself in the way I have described, when once that affect had transformed the patient's habitual day-dreaming into a hallucinatory *absence*. It is remarkable how completely the earliest manifestation of her illness in its beginnings already exhibited its main characteristics, which afterwards remained unchanged for almost two years. These comprised the existence of a second state of consciousness which first emerged as a temporary *absence* and later became organized into a *"double conscience"*, an inhibition of speech, determined by the affect of anxiety, which found a chance discharge in the English verses; later on, paraphasia and loss of her mother-tongue, which was replaced by excellent English; and lastly the accidental paralysis of her right arm, due to pressure, which later developed into a contractural paresis and anaesthesia on her right side. The mechanism by which this latter affection came into being agreed entirely with Charcot's theory of traumatic hysteria—a slight trauma occurring during a state of hypnosis.

But whereas the paralysis experimentally provoked by Charcot in his patients became stabilized immediately, and whereas the paralysis caused in sufferers from traumatic neuroses by a severe traumatic shock sets in at once, the nervous system of this girl put up a successful resistance for four months. Her contracture, as well as the other disturbances which accompanied it, set in only during the short *absences* in her *condition seconde* and left her during her normal state in full control of her body and possession of her senses; so that nothing was noticed either by herself or by those around her, though it is true that the attention of the latter was centered upon the patient's sick father and was consequently diverted from her.

Since, however, her *absences* with their total amnesia and accompanying hysterical phenomena grew more and more frequent from the time of her first hallucinatory auto-hypnosis, the opportunities multiplied for the formation of new symptoms of the same kind, and those that

had already been formed became more strongly entrenched by frequent repetition. In addition to this, it gradually came about that any sudden distressing affect would have the same result as an *absence* (though, indeed, it is possible that such affects actually *caused* a temporary *absence* in every case); chance coincidences set up pathological associations and sensory or motor disturbances, which thenceforward appeared along with the affect. But hitherto this only occurred for fleeting moments. Before the patient took permanently to her bed she had already developed the whole assemblage of ıysterical phenomena, without anyone's knowing it. It was only after the patient had broken down completely owing to exhaustion brought about by lack of nourishment, nsomnia and constant anxiety, and only after she had begun to pass more time in her *condition seconde* than n her normal state, that the hysterical phenomena exended to the latter as well and changed from intermittent cute symptoms into chronic ones.

The question now arises how far the patient's statements re to be trusted and whether the occasions and mode of rigin of the phenomena were really as she represented ıem. So far as the more important and fundamental vents are concerned, the trustworthiness of her account eems to me to be beyond question. As regards the sympoms disappearing after being "talked away," I cannot use is as evidence; it may very well be explained by suggeson. But I always found the patient entirely truthful and ustworthy. The things she told me were intimately bound with what was most sacred to her. Whatever could be ecked by other people was fully confirmed. Even the ost highly gifted girl would be incapable of concocting a sue of data with such a degree of internal consistency was exhibited in the history of this case. It cannot be puted, however, that precisely her consistency may have l her (in perfectly good faith) to assign to some of her nptoms a precipitating cause which they did not in fact ssess. But this suspicion, too, I consider unjustified. The y insignificance of so many of those causes, the irranal character of so many of the connections involved, ue in favor of their reality. The patient could not underndhow it was that dance music made her cough; such onstruction is too meaningless to have been deliberate. seemed very likely to me, incidentally, that each of her

twinges of conscience brought on one of her regular spasms of the glottis and that the motor impulses which she felt—for she was very fond of dancing—transformed the spasm into a *tussis nervosa*.) Accordingly, in my view the patient's statements were entirely trustworthy and corresponded to the facts.

And now we must consider how far it is justifiable to suppose that hysteria is produced in an analogous way in other patients, and that the process is similar where no such clearly distinct *condition seconde* has become organized. I may advance in support of this view the fact that in the present case, too, the story of the development of the illness would have remained completely unknown alike to the patient and the physician if it had not been for her peculiarity of remembering things in hypnosis, as I have described, and of relating what she remembered. While she was in her waking state she knew nothing of all this. Thus it is impossible to arrive at what is happening in other cases from an examination of the patients while in a waking state, for with the best will in the world they can give one no information. And I have already pointed out how little those surrounding the present patient were able to observe of what was going on. Accordingly, it would only be possible to discover the state of affairs in other patients by means of some such procedure as was provided in the case of Anna O. by her auto-hypnoses. Provisionally we can only express the view that trains of events similar to those here described occur more commonly than our ignorance of the pathogenic mechanism concerned has led us to suppose.

When the patient had become confined to her bed, and her consciousness was constantly oscillating between her normal and her "secondary" state, the whole host of hysterical symptoms, which had arisen separately and had hitherto been latent, became manifest, as we have already seen, as chronic symptoms. There was now added to these a new group of phenomena which seemed to have had a different origin: the paralytic contractures of her left extremities and the paresis of the muscles raising her head. I distinguish them from the other phenomena because when once they had disappeared they never returned, even in the briefest or mildest form or during the concluding and recuperative phase, when all the other symptoms became active again after having been in abeyance for

some time. In the same way, they never came up in the hypnotic analyses and were not traced back to emotional or imaginative sources. I am therefore inclined to think that their appearance was not due to the same psychical process as was that of the other symptoms, but is to be attributed to a secondary extension of that unknown condition which constitutes the somatic foundation of hysterical phenomena.

Throughout the entire illness her two states of consciousness persisted side by side: the primary one in which she was quite normal psychically, and the secondary one which may well be likened to a dream in view of its wealth of imaginative products and hallucinations, its large gaps of memory and the lack of inhibition and control in its associations. In this secondary state the patient was in a condition of alienation. The fact that the patient's mental condition was entirely dependent on the intrusion of this secondary state into the normal one seems to throw considerable light on at least one class of hysterical psychosis. Every one of her hypnoses in the evening afforded evidence that the patient was entirely clear and well-ordered in her mind and normal as regards her feeling and volition so long as none of the products of her secondary state was acting as a stimulus "in the unconscious".[1] The extremely marked psychosis which appeared whenever there was any considerable interval in this unburdening process showed the degree to which those products influenced the psychical events of her "normal"

[1] [This seems to be the first published occurrence of the term "*das Unbewusste*" ("the unconscious") in what was to be its psycho-analytic sense. It had, of course, often been used previously by other writers, particularly by philosophers (e.g. Hartmann, 1869). The fact that Breuer puts it in quotation marks may possibly indicate that he is attributing it to Freud. The term is used by Freud himself below, e.g. on p. 112 *n.* The adjectival form "*unbewusst*" ("unconscious") had been used some years earlier in an unpublished draft drawn up in November, 1892, jointly by Breuer and Freud (Freud, 1940*d*). Freud had used the term "*le subconscient*" in a French paper on motor paralyses (1893*c*) and uses "*unterbewusst*" ("subconscious") in the present work (p. 266 *n.*), as does Breuer very much more frequently (e.g. p. 266). Later, of course, Freud objected to the employment of this latter term. (Cf., for instance, the end of Section I of his paper on "The Unconscious," 1915*e*.)]

state. It is hard to avoid expressing the situation by saying that the patient was split into two personalities of which one was mentally normal and the other insane. The sharp division between the two states in the present patient only exhibits more clearly, in my opinion, what has given rise to a number of unexplained problems in many other hysterical patients. It was especially noticeable in Anna O. how much the products of her "bad self," as she herself called it, affected her moral habit of mind. If these products had not been continually disposed of, we should have been faced by a hysteric of the malicious type—refractory, lazy, disagreeable and ill-natured; but, as it was, after the removal of those stimuli her true character, which was the opposite of all these, always reappeared at once.

Nevertheless, though her two states were thus sharply separated, not only did the secondary state intrude into the first one, but—and this was at all events frequently true, and even when she was in a very bad condition—a clear-sighted and calm observer sat, as she put it, in a corner of her brain and looked on at all the mad business. This persistence of clear thinking while the psychosis was actually going on found expression in a very curious way. At a time when, after the hysterical phenomena had ceased, the patient was passing through a temporary depression, she brought up a number of childish fears and self-reproaches, and among them the idea that she had not been ill at all and that the whole business had been simulated. Similar observations, as we know, have frequently been made. When a disorder of this kind has cleared up and the two states of consciousness have once more become merged into one, the patients, looking back to the past, see themselves as the single undivided personality which was aware of all the nonsense; they think they could have prevented it if they had wanted to, and thus they feel as though they had done all the mischief deliberately.—It should be added that this normal thinking which persisted during the secondary state must have fluctuated enormously in its amount and must very often have been completely absent.

I have already described the astonishing fact that from beginning to end of the illness all the stimuli arising from the secondary state, together with their consequences, were permanently removed by being given verbal utterance in hypnosis, and I have only to add an assurance that

this was not an invention of mine which I imposed on the patient by suggestion. It took me completely by surprise, and not until symptoms had been got rid of in this way in a whole series of instances did I develop a therapeutic technique out of it.

The final cure of the hysteria deserves a few more words. It was accompanied, as I have already said, by considerable disturbances and a deterioration in the patient's mental condition. I had a very strong impression that the numerous products of her secondary state which had been quiescent were now forcing their way into consciousness; and though in the first instance they were being remembered only in her secondary state, they were nevertheless burdening and disturbing her normal one. It remains to be seen whether it may not be that the same origin is to be traced in other cases in which a chronic hysteria terminates in a psychosis.[1]

[1] [A very full summary and discussion of this case history occupies the greater part of the first of Freud's *Five Lectures* (1910*a*).]

CASE 2

Frau Emmy von N., Age 40, from Livonia (Freud)

On May 1, 1889,[1] I took on the case of a lady of about forty years of age, whose symptoms and personality interested me so greatly that I devoted a large part of my time to her and determined to do all I could for her recovery. She was a hysteric and could be put into a state of somnambulism with the greatest ease; and when I became aware of this I decided that I would make use of Breuer's technique of investigation under hypnosis, which I had come to know from the account he had given me of the successful treatment of his first patient. This was my first attempt at handling that therapeutic method [pp. 142 *n.* and 329]. I was still far from having mastered it; in fact I did not carry the analysis[2] of the symptoms far enough, nor pursue it systematically enough. I shall perhaps be able best to give a picture of the patient's condition and my medical procedure by reproducing the notes which I made each evening during the first three weeks of the treatment. Wherever later experience has brought me a better understanding, I shall embody it in footnotes and interpolated comments.

May 1, 1889.—This lady, when I first saw her, was lying on a sofa with her head resting on a leather cushion. She still looked young and had finely cut features, full of character. Her face bore a strained and painful expression, her eyebrows were drawn together and her eyes cast down; there was a heavy frown on her forehead and the

[1] [The chronology of this case history is self-contradictory as it stands and there is a distinct possibility that the treatment began in 1888, not in 1889. The dates which are given in all the German editions have been retained in the present translation, but they are evidently in need of correction. The question is fully discussed in Appendix A (p. 353).]

[2] [Freud had already used the term "analysis" (as well as "psychical analysis," "psychological analysis" and "hypnotic analysis") in his first paper on "The Neuro-Psychoses of Defense" (1894*a*). He only later introduced the word "psychoanalysis" in a paper on the aetiology of the neuroses, written in French (1896*a*).]

CASE 3

Miss Lucy R., age 30 (Freud)

At the end of the year 1892 a colleague of my acquaintance referred a young lady to me who was being treated by him for chronically recurrent suppurative rhinitis. It subsequently turned out that the obstinate persistence of her trouble was due to caries of the ethmoid bone. Latterly she had complained of some new symptoms which the well-informed physician was no longer able to attribute to a local affection. She had entirely lost her sense of smell and was almost continuously pursued by one or two subjective olfactory sensations. She found these most distressing. She was, moreover, in low spirits and fatigued, and she complained of heaviness in the head, diminished appetite and loss of efficiency.

The young lady, who was living as a governess in the house of the managing director of a factory in Outer Vienna, came to visit me from time to time in my consulting hours. She was an Englishwoman. She had a delicate constitution, with a poor pigmentation, but was in good health apart from her nasal affection. Her first statements confirmed what the physician had told me. She was suffering from depression and fatigue and was tormented by subjective sensations of smell. As regards hysterical symptoms, she showed a fairly definite general analgesia, with no loss of tactile sensibility, and a rough examination (with the hand) revealed no restriction of the visual field. The interior of her nose was completely analgesic and without reflexes; she was sensitive to tactile pressure there, but the perception proper to it as a sense-organ was absent, alike for specific stimuli and for others (e.g. ammonia or acetic acid). The purulent nasal catarrh was just then in a phase of improvement.

In our first attempts at making the illness intelligible it was necessary to interpret the subjective olfactory sensa-ions, since they were recurrent hallucinations, as chronic ysterical symptoms. Her depression might perhaps be the ffect attaching to the trauma, and it should be possible to ind an experience in which these smells, which had now ecome subjective, had been objective. This experience ust have been the trauma which the recurring sensations

of smell symbolized in memory. It might be more correct to regard the recurrent olfactory hallucinations, together with the depression which accompanied them, as equivalents of a hysterical *attack*. The nature of recurrent hallucinations makes them unsuitable in point of fact for playing the part of *chronic* symptoms. But this question did not really arise in a case like this which showed only a rudimentary development. It was essential, however, that the subjective sensations of smell should have had a specialized origin of a sort which would admit of their being derived from some quite particular real object.

This expectation was promptly fulfilled. When I asked her what the smell was by which she was most constantly troubled she answered: "A smell of burnt pudding." Thus I only needed to assume that a smell of burnt pudding had actually occurred in the experience which had operated as a trauma. It is very unusual, no doubt, for olfactory sensations to be chosen as mnemic symbols of traumas, but it was not difficult to account for this choice. The patient was suffering from suppurative rhinitis and consequently her attention was especially focused on her nose and nasal sensations. What I knew of the circumstances of the patient's life was limited to the fact that the two children whom she was looking after had no mother; she had died some years earlier of an acute illness.

I therefore decided to make the smell of burnt pudding the starting-point of the analysis. I will describe the course of this analysis as it might have taken place under favorable conditions. In fact, what should have been a single session spread over several. This was because the patient could only visit me in my consulting hours, when I could only devote a short time to her. Moreover, a single discussion of this sort used to extend over more than a week, since her duties would not allow her to make the long journey from the factory to my house very often. We used therefore to break our conversation off short and take up the thread at the same place next time.

Miss Lucy R. did not fall into a state of somnambulism when I tried to hypnotize her. I therefore did without somnambulism and conducted her whole analysis while she was in a state which may in fact have differed very little from a normal one.

I shall have to go into this point of my technical

procedure in greater detail. When, in 1889, I visited the Nancy clinics, I heard Dr. Liébeault, the *doyen* of hypnotism, say: "If only we had the means of putting every patient into a state of somnambulism, hypnotic therapy would be the most powerful of all." In Bernheim's clinic it almost seemed as though such an art really existed and as though it might be possible to learn it from Bernheim. But as soon as I tried to practice this art on my own patients, I discovered that *my* powers at least were subject to severe limits, and that if somnambulism were not brought about in a patient at the first three attempts I had no means of inducing it. The percentage of cases amenable to somnambulism was very much lower in my experience than what Bernheim reported.

I was accordingly faced with the choice of either abandoning the cathartic method in most of the cases which might have been suitable for it, or of venturing on the experiment of employing that method without somnambulism and where the hypnotic influence was light or even where its existence was doubtful. It seemed to me a matter of indifference what degree of hypnosis—according to one or other of the scales that have been proposed for measuring it—was reached by this nonsomnambulistic state; for, as we know, each of the various forms taken by suggestibility is in any case independent of the others, and the bringing about of catalepsy, automatic movements, and so on, does not work either for or against what I required for my purposes, namely that the awakening of forgotten memories should be made easier. Moreover, I soon dropped the practice of making tests to show the degree of hypnosis reached, since in quite a number of cases this roused the patients' resistance and shook their confidence in me, which I needed for carrying out the more important psychical work. Furthermore, I soon began to tire of issuing assurances and commands such as: "You are going to sleep! . . . sleep!" and of hearing the patient, as so often happened when the degree of hypnosis was light, remonstrate with me: "But, doctor, I'm *not* asleep," and of then having to make highly ticklish distinctions: "I don't mean ordinary sleep; I mean hypnosis. As you see, you are hypnotized, you can't open your eyes," etc., "and in any case, there's no need for you to go to sleep," and so on. I feel sure that many other physicians who practice psychotherapy can get out of such difficulties with more skill than I can. If so,

they may adopt some procedure other than mine. It seems to me, however, that if one can reckon with such frequency on finding oneself in an embarrassing situation through the use of a particular word, one would be wise to avoid both the word and the embarrassment. When, therefore, my first attempt did not lead either to somnambulism or to a degree of hypnosis involving marked physical changes, I ostensibly dropped hypnosis, and only asked for "concentration"; and I ordered the patient to lie down and deliberately shut his eyes as a means of achieving this "concentration." It is possible that in this way I obtained with only a slight effort the deepest degree of hypnosis that could be reached in the particular case.

But in doing without somnambulism I might be depriving myself of a precondition without which the cathartic method seemed unusable. For that method clearly rested on the patients in their changed state of consciousness having access to memories and being able to recognize connections which appeared not to be present in their normal state of consciousness. If the somnambulistic extension of memory were absent there could also be no possibility of establishing any determining causes which the patient could present to the physician as something unknown to him (the patient); and, of course, it is precisely the pathogenic memories which, as we have already said in our "Preliminary Communication" [p. 44] are "absent from the patients' memory, when they are in a normal psychical state, or are only present in a highly summary form."

I was saved from this new embarrassment by remembering that I had myself seen Bernheim producing evidence that the memories of events during somnambulism are only *apparently* forgotten in the waking state and can be revived by a mild word of command and a pressure with the hand intended to indicate a different state of consciousness. He had, for instance, given a woman in a state of somnambulism a negative hallucination to the effect that he was no longer present, and had then endeavored to draw her attention to himself in a great variety of ways, including some of the decidedly aggressive kind. He did not succeed. After she had been woken up he asked her to tell him what he had done to her while she thought he was not there. She replied in surprise that she knew nothing of it. But he did not accept this. He insisted that she could

remember everything and laid his hand on her forehead to help her to recall it. And lo and behold! she ended by describing everything that she had ostensibly not perceived during her somnambulism and ostensibly not remembered in her waking state.

This astonishing and instructive experiment served as my model. I decided to start from the assumption that my patients knew everything that was of any pathogenic significance and that it was only a question of obliging them to communicate it. Thus when I reached a point at which, after asking a patient some question such as: "How long have you had this symptom?" or: "What was its origin?" I was met with the answer: "I really don't know," I proceeded as follows. I placed my hand on the patient's forehead or took her head between my hands and said: "You will think of it under the pressure of my hand. At the moment at which I relax my pressure you will see something in front of you or something will come into your head. Catch hold of it. It will be what we are looking for.—Well, what have you seen or what has occurred to you?"

On the first occasions on which I made use of this procedure (it was not with Miss Lucy R.)[1] I myself was

[1] [Freud's first use of the "pressure technique" seems to have been with Fräulein Elisabeth von R. (see below, p. 185), though his statement there is not completely unambiguous. Further accounts of this procedure, in addition to those in the text above and in the passage just referred to, will be found on pp. 193 ff. and 315 ff. There is a slight apparent inconsistency in these accounts. In the present one, the patient is told that she will see something or have some idea "at the moment at which I relax my pressure;" on p. 185, she is told that this will occur "at the moment of the pressure;" and on p. 315 that it will occur "all the time the pressure lasts." It is not known exactly when Freud abandoned this pressure technique. He had certainly done so before 1904, since in his contribution of that date to Loewenfeld's book on obsessions he explicitly remarks that he avoids touching his patients in any way (1904*a*, *Standard, Ed.*, 7, 250). But it seems likely that he had already given up the practice before 1900, for he makes no mention of it in the short account of his procedure given near the beginning of Chapter II of *The Interpretation of Dreams* (1900*a*), *Standard Ed.*, 4, 101. Incidentally, in this latter passage Freud still recommends that the patient should keep his eyes shut during analysis. This last remnant (apart from lying down) of the original hypnotic procedure

surprised to find that it yielded me the precise results that I needed. And I can safely say that it has scarcely ever left me in the lurch since then. It has always pointed the way which the analysis should take and has enabled me to carry through every such analysis to an end without the use of somnambulism. Eventually I grew so confident that, if patients answered, "I see nothing" or "nothing has occurred to me," I could dismiss this as an impossibility and could assure them that they had certainly become aware of what was wanted but had refused to believe that that was so and had rejected it. I told them I was ready to repeated the procedure as often as they liked and they would see the same thing every time. I turned out to be invariably right. The patients had not learned to relax their critical faculty. They had rejected the memory that had come up or the idea that had occurred to them, on the ground that it was unserviceable and an irrelevant interruption; and after they had told it to me it always proved to be what was wanted. Occasionally, when, after three or four pressures, I had at last extracted the information, the patient would reply: "As a matter of fact I knew that the first time, but it was just what I didn't want to say," or: "I hoped that would not be it."

This business of enlarging what was supposed to be a restricted consciousness was laborious—far more so, at least, than an investigation during somnambulism. But it nevertheless made me independent of somnambulism, and gave me insight into the motives which often determine the "forgetting" of memories. I can affirm that this forgetting is often intentional and desired; and its success is never more than *apparent*.

I found it even more surprising perhaps that it was possible by the same procedure to bring back numbers and

was also explicitly disrecommended in the sentence already quoted from his contribution to Loewenfeld (1904*a*).—We have fairly exact information upon the period of Freud's use of hypnotism proper. In a letter to Fliess of December 28, 1887 (Freud, 1950*a*, Letter 2) he wrote: "During the last few weeks I have taken up hypnosis." And in a lecture given before the Vienna "Medizinisches Doktorencollegium" on December 12, 1904 (Freud, 1905*a*, *Standard Ed.*, 7, 260) he declared: "I have not used hypnosis for therapeutic purposes for some eight years (except for a few special experiments)." His use of hypnotism therefore fell approximately between the years 1887 and 1896.]

dates which, on the face of it, had long since been forgotten, and so to reveal how unexpectedly accurate memory can be.

The fact that in looking for numbers and dates our choice is so limited enables us to call to our help a proposition familiar to us from the theory of aphasia, namely that recognizing something is a lighter task for memory than thinking of it spontaneously.[1] Thus, if a patient is unable to remember the year or month or day when a particular event occurred, we can repeat to him the dates of the possibly relevant years, the names of the twelve months and the thirty-one numbers of the days of the month, assuring him that when we come to the right number or the right name his eyes will open of their own accord or that he will feel which is the right one. In the great majority of cases the patient will in fact decide on a particular date. Quite often (as in the case of Frau Cäcilie M.) it is possible to prove from documents belonging to the period in question that the date has been recognized correctly; while in other cases and on other occasions the indisputable accuracy of the date thus chosen can be inferred from the context of the facts remembered. For instance, after a patient had had her attention drawn to the date which had been arrived at by this "counting over" method, she said: "Why, that's my father's birthday!" and added: "Of course! It was because it was his birthday that I was expecting the event we were talking about."

Here I can only touch upon the theme in passing. The conclusion I drew from all these observations was that experiences which have played an important pathogenic part, and all their subsidiary concomitants, are accurately retained in the patient's memory even when they seem to be forgotten—when he is unable to call them to mind.[2]

[1] [Freud had written his book on aphasia (1891*b*) not long before.]

[2] As an example of the technique which I have described above of carrying out investigations in non-somnambulistic states—that is, where there is no extension of consciousness—I will describe an instance which I happen to have analysed in the course of the last few days. I was treating a woman of thirty-eight, suffering from anxiety neurosis (agoraphobia, attacks of fear of death, etc.). Like so many such patients, she had a disinclination to admitting that she had acquired these troubles in her married life and would have liked to push them back into her early youth.

After this long but unavoidable digression I will return to the case of Miss Lucy R. As I have said, then, my attempts at hypnosis with her did not produce somnambulism. She simply lay quietly in a state open to some mild degree of influence, with her eyes closed all the time, her features somewhat rigid, and without moving hand or foot.

Thus she told me that she was seventeen when she had had a first attack of dizziness, with anxiety and feelings of faintness, in the street in her small native town, and that these attacks had recurred from time to time, till a few years ago they had given place to her present disorder. I suspected that these first attacks of dizziness, in which the anxiety faded more and more into the background, were hysterical and I made up my mind to embark on an analysis of them. To begin with she only knew that this first attack came over her while she was out shopping in the principal street. "What were you going to buy?"—"Different things, I believe; they were for a ball I had been invited to."—"When was this ball to take place?"—"Two days later, I think."—"Something must have happened to agitate you a few days before, something that made an impression on you."—"I can't think of anything. After all, it was twenty-one years ago."—"That makes no difference; you will remember all the same. I shall press on your head, and when I relax the pressure, you will think of something or see something, and you must tell me what that is." I went through this procedure; but she remained silent. "Well, has nothing occurred to you?"—"I have thought of something, but it can't have any connection with this."—"Tell it to me anyway."—"I thought of a friend of mine, a girl, who is dead. But she died when I was eighteen—a year later, that is."—"We shall see. Let's stick to this point. What about this friend of yours?"—"Her death was a great shock to me, as I used to see a lot of her. A few weeks earlier another girl had died, and that had made a great stir in the town. So after all, I must have been seventeen at the time."—"There, you see, I told you we could rely on the things that come into your head under the pressure of my hand. Now, can you remember what you were thinking about when you felt dizzy in the street?"—"I wasn't thinking of anything; I only felt dizzy."—"That's not possible. States like that never happen without being accompanied by some idea. I shall press once more and the thought you had will come back to you. . . . Well, what has occurred to you?"—"The idea that I am the third."—"What does that mean?"—"When I got the attack of dizziness I must have thought: 'Now I am dying, like the other two girls.' "—"That was the idea, then. As you were having the attack you thought of your friend. So her death must have made a great impression on you."—"Yes, it did. I can remember now that when I heard of her death I felt it was dreadful to be going to a

I asked her if she could remember the occasion on which she first had the smell of burnt pudding. "Oh yes, I know exactly. It was about two months ago, two days before my birthday. I was with the children in the schoolroom and was playing at cooking with them" (they were two little

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ball, while she was dead. But I was looking forward so much to the ball and was so busy with preparations for it; I didn't want to think of what had happened at all." (We may observe here a deliberate repression from consciousness, which rendered the patient's memory of her friend pathogenic.)

The attack was now to some extent explained. But I still required to know of some precipitating factor which had provoked the memory at that particular time. I formed what happened to be a lucky conjecture. "Do you remember the exact street you were walking along just then?"—"Certainly. It was the principal street, with its old houses. I can see them now."—"And where was it that your friend lived?"—"In a house in the same street. I had just passed it, and I had the attack a couple of houses further on."—"So when you went by the house it reminded you of your dead friend, and you were once more overcome by the contrast which you did not want to think of."

I was still not satisfied. There might, I thought, be something else at work as well that had aroused or reinforced the hysterical disposition of a girl who had till then been normal. My suspicions turned to her monthly periods as an appropriate factor, and I asked: "Do you know at what time in the month your period came on?" The question was not a welcome one. "Do you expect me to know that, too? I can only tell you that I had them very seldom then and very irregularly. When I was seventeen I only had one once."—"Very well, then, we will find out when this once was by counting over." I did the counting over, and she decided definitely on one particular month and hesitated between two days immediately preceding the date of a fixed holiday. "Does that fit in somehow with the date of the ball?" She answered sheepishly: "The ball was on the holiday. And now I remember, too, what an impression it made on me that my only period that year should have had to come on just before the ball. It was my first ball."

There is no difficulty now in reconstructing the interconnection between the events, and we can now see into the mechanism of this hysterical attack. It is true that the achievement of this result had been a laborious business. It required complete confidence in my technique on my side, and the occurrence to the patient of a few key ideas, before it was possible to re-awaken, after an interval of twenty-one years, these details of a forgotten experience in a skeptical person who was, in fact, in a waking state. But once all this had been gone through, the whole thing fitted together.

girls). "A letter was brought in that had just been left by the postman. I saw from the postmark and the handwriting that it was from my mother in Glasgow and wanted to open it and read it; but the children rushed at me, tore the letter out of my hands and cried: 'No, you shan't read it now! It must be for your birthday; we'll keep it for you!' While the children were having this game with me there was suddenly a strong smell. They had forgotten the pudding they were cooking and it was getting burnt. Ever since this I have been pursued by the smell. It is there all the time and becomes stronger when I am agitated."

"Do you see this scene clearly before your eyes?"—"As large as life, just as I experienced it."—"What could there be about it that was so agitating?"—"I was moved because the children were so affectionate to me."—"Weren't they always?"—"Yes—but just when I got the letter from my mother."—"I don't understand why there is a contrast between the children's affection and your mother's letter, for that's what you seem to be suggesting."—"I was intending to go back to my mother's, and the thought of leaving the dear children made me feel so sad."—"What's wrong with your mother? Has she been feeling lonely and sent for you? Or was she ill at the time, and were you expecting news of her?"—"No; she isn't very strong, but she's not exactly ill, and she has a companion with her."—"Then why must you leave the children?"—"I couldn't bear it any longer in the house. The housekeeper, the cook and the French governess seem to have thought that I was putting myself above my station. They joined in a little intrigue against me and said all sorts of things against me to the children's grandfather, and I didn't get as much support as I had expected from the two gentlemen when I complained to them. So I gave notice to the Director" (the children's father). "He answered in a very friendly way that I had better think the matter over for a couple of weeks before I finally gave him my decision. I was in this state of uncertainty at the time, and thought I should be leaving the house; but I have stayed on."—"Was there something particular, apart from their fondness for you, which attached you to the children?"—"Yes. Their mother was a distant relation of my mother's, and I had promised her on her death-bed that I would devote myself with all my power to the children, that I would not leave them and

that I would take their mother's place with them. In giving notice I had broken this promise."

This seemed to complete the analysis of the patient's subjective sensation of smell. It had turned out in fact to have been an objective sensation originally, and one which was intimately associated with an experience—a little scene—in which opposing affects had been in conflict with each other: her regret at leaving the children and the slights which were nevertheless urging her to make up her mind to do so. Her mother's letter had not unnaturally reminded her of her reasons for this decision, since it was her intention to join her mother on leaving here. The conflict between her affects had elevated the moment of the letter's arrival into a trauma, and the sensation of smell that was associated with this trauma persisted as its symbol. It was still necessary to explain why, out of all the sense-perceptions afforded by the scene, she had chosen this smell as a symbol. I was already prepared, however, to use the chronic affection of her nose as a help in explaining the point. In response to a direct question she told me that just at that time she had once more been suffering from such a heavy cold in the nose that she could hardly smell anything. Nevertheless, while she was in her state of agitation she perceived the smell of the burnt pudding, which broke through the organically determined loss of her sense of smell.

But I was not satisfied with the explanation thus arrived at. It all sounded highly plausible, but there was something that I missed, some adequate reason why these agitations and this conflict of affects should have led to hysteria rather than anything else. Why had not the whole thing remained on the level of normal psychical life? In other words, what was the justification for the conversion which occurred? Why did she not always call to mind the scene itself, instead of the associated sensation which she singled out as a symbol of the recollection? Such questions might be over-curious and superfluous if we were dealing with a hysteric of long standing in whom the mechanism of conversion was habitual. But it was not until this trauma, or at any rate this small tale of trouble, that the girl had acquired hysteria.

Now I already knew from the analysis of similar cases that before hysteria can be acquired for the first time one essential condition must be fulfilled: an idea must be *in-*

tentionally repressed from consciousness [1] and excluded from associative modification. In my view this intentional repression is also the basis for the conversion, whether total or partial, of the sum of excitation. The sum of excitation, being cut off from psychical association, finds its way all the more easily along the wrong path to a somatic innervation. The basis for repression itself can only be a feeling of unpleasure, the incompatibility between the single idea that is to be repressed and the dominant mass of ideas constituting the ego. The repressed idea takes its revenge, however, by becoming pathogenic.

I accordingly inferred from Miss Lucy R.'s having succumbed to hysterical conversion at the moment in question that among the determinants of the trauma there must have been one which she had sought intentionally to leave in obscurity and had made efforts to forget. If her fondness for the children and her sensitiveness on the subject of the other members of the household were taken together, only one conclusion could be reached. I was bold enough to inform my patient of this interpretation. I said to her: "I cannot think that these are all the reasons for your feelings about the children. I believe that really you are in love with your employer, the Director, though perhaps without being aware of it yourself, and that you have a secret hope of taking their mother's place in actual fact. And then we must remember the sensitiveness you now feel towards the servants, after having lived with them peacefully for years. You're afraid of their having some inkling of your hopes and making fun of you."

She answered in her usual laconic fashion: "Yes, I think that's true."—"But if you knew you loved your employer why didn't you tell me?"—"I didn't know—or rather I didn't want to know. I wanted to drive it out of my head and not think of it again; and I believe latterly I have succeeded." [2] "Why was it that you were unwilling to

[1] [See footnote p. 45.]

[2] I have never managed to give a better description than this of the strange state of mind in which one knows and does not know a thing at the same time. It is clearly impossible to understand it unless one has been in such a state oneself. I myself have had a very remarkable experience of this sort, which is still clearly before me. If I try to recollect what went on in my mind at the time I can get hold of very little. What happened was that I saw something which did not fit in at all with my expectation;

admit this inclination? Were you ashamed of lovi
man?"—"Oh no, I'm not unreasonably prudish. We'r
responsible for our feelings, anyhow. It was distressin
me only because he is my employer and I am in
service and live in his house. I don't feel the same comp
independence towards him that I could towards any
else. And then I am only a poor girl and he is such a
man of good family. People would laugh at me if they h
any idea of it."

She now showed no resistance to throwing light on
origin of this inclination. She told me that for the first
years she had lived happily in the house, carrying out h
duties and free from any unfulfillable wishes. One d
however, her employer, a serious, overworked man who
behavior towards her had always been reserved, began
discussion with her on the lines along which childr
should be brought up. He unbent more and was mo
cordial than usual and told her how much he depended o
her for looking after his orphaned children; and as he sa
this he looked at her meaningly. . . . Her love for him ha
begun at that moment, and she even allowed herself
dwell on the gratifying hopes which she had based on th
talk. But when there was no further development, an
when she had waited in vain for a second hour's intima
exchange of views, she decided to banish the whole busine
from her mind. She entirely agreed with me that the loo
she had caught during their conversation had probabl
sprung from his thoughts about his wife, and she recognized
quite clearly that there was no prospect of her feelings for
him meeting with any return.

I expected that this discussion would bring about a
fundamental change in her condition. But for the time
being this did not occur. She continued to be in low spirits
and depressed. She felt somewhat refreshed in the morn-
ings by a course of hydropathic treatment which I
prescribed for her at the same time. The smell of burnt

yet I did not allow what I saw to disturb my fixed plan in the
least, though the perception should have put a stop to it. I was
unconscious of any contradiction in this; nor was I aware of my
feelings of repulsion, which must nevertheless undoubtedly have
been responsible for the perception producing no psychical effect.
I was afflicted by that blindness of the seeing eye which is so
astonishing in the attitude of mothers to their daughters, hus-
bands to their wives and rulers to their favorites.

dding did not disappear completely, though it became
s frequent and weaker. It only came on, she said, when
was very much agitated. The persistence of this
nemic symbol led me to suspect that, in addition to the
in scene, it had taken over the representation of the
any minor traumas subsidiary to that scene. We there-
ore looked about for anything else that might have to do
ith the scene of the burnt pudding; we went into the
ubject of the domestic friction, the grandfather's be-
havior, and so on, and as we did so the burnt smell
faded more and more. During this time, too, the treat-
ment was interrupted for a considerable while, owing to a
fresh attack of her nasal disorder, and this now led to the
discovery of the caries of the ethmoid [p. 144].

On her return she reported that at Christmas she had re-
ceived a great many presents from the two gentlemen of
the house and even from the servants, as though they were
all anxious to make it up with her and to wipe out her
memory of the conflicts of the last few months. But these
signs of goodwill had not made any impression on her.

When I enquired once more about the smell of burnt
pudding, she informed me that it had quite disappeared but
that she was being bothered by another, similar smell,
resembling cigar-smoke. It had been there earlier as well,
she thought, but had, as it were, been covered by the
smell of the pudding. Now it had emerged by itself.

I was not very well satisfied with the results of the treat-
ment. What had happened was precisely what is always
brought up against purely symptomatic treatment: I had
removed one symptom only for its place to be taken by
another. Nevertheless, I did not hesitate to set about the
task of getting rid of this new mnemic symbol by analysis.

But this time she did not know where the subjective
olfactory sensation came from—on what important occa-
sion it had been an objective one. "People smoke every
day in our house," she said, "and I really don't know
whether the smell I notice refers to some special occasion."
I then insisted that she should try to remember under the
pressure of my hand. I have already mentioned that
her memories had the quality of plastic vividness, that
she was a "visual" type. And in fact, at my insistence, a
picture gradually emerged before her, hesitatingly and
piecemeal to begin with. It was the dining-room in her
house, where she was waiting with the children for the two

gentlemen to return to luncheon from the factory. "Now we are all sitting round the table, the gentlemen, the French governess, the housekeeper, the children and myself. But that's like what happens every day."—"Go on looking at the picture; it will develop and become more specialized."—"Yes, there is a guest. It's the chief accountant. He's an old man and he is as fond of the children as though they were his own grandchildren. But he comes to lunch so often that there's nothing special in that either." —"Be patient and just keep looking at the picture; something's sure to happen."—"Nothing's happening. We're getting up from the table; the children say their good-byes, and they go upstairs with us as usual to the second floor." —"And then?"—"It *is* a special occasion, after all. I recognize the scene now. As the children say good-bye, the accountant tries to kiss them. My employer flares up and actually shouts at him: 'Don't kiss the children!' I feel a stab at my heart; and as the gentlemen are already smoking, the cigar-smoke sticks in my memory."

This, then, was a second and deeper-lying scene which, like the first, operated as a trauma and left a mnemic symbol behind it. But to what did this scene owe its effectiveness? "Which of the two scenes was the earlier," I asked, "this one or the one with the burnt pudding?"—"The scene I have just told you about was the earlier, by almost two months."—"Then why did you feel this stab when the children's father stopped the old man? His reprimand wasn't aimed at you."—"It wasn't right of him to shout at an old man who was a valued friend of his and, what's more, a guest. He could have said it quietly."—"So it was only the violent way he put it that hurt you? Did you feel embarrassed on his account? Or perhaps you thought: 'If he can be so violent about such a small thing with an old friend and guest, how much more so might he be with me if I were his wife.' "—"No, that's not it."—"But it had to do with his violence, hadn't it?"—"Yes, about the children being kissed. He has never liked that."

And now, under the pressure of my hand, the memory of a third and still earlier scene emerged, which was the really operative trauma and which had given the scene with the chief accountant its traumatic effectiveness. It had happened a few months earlier still that a lady who was an acquaintance of her employer's came to visit them, and on her departure kissed the two children on the mouth. Their

father, who was present, managed to restrain himself from saying anything to the lady, but after she had gone, his fury burst upon the head of the unlucky governess. He said he held her responsible if anyone kissed the children on the mouth, that it was her duty not to permit it and that she was guilty of a dereliction of duty if she allowed it; if it ever happened again he would entrust his children's upbringing to other hands. This had happened at a time when she still thought he loved her, and was expecting a repetition of their first friendly talk. The scene had crushed her hopes. She had said to herself: "If he can fly out at me like this and make such threats over such a trivial matter, and one for which, moreover, I am not in the least responsible, I must have made a mistake. He can never have had any warm feelings for me, or they would have taught him to treat me with more consideration."—It was obviously the recollection of this distressing scene which had come to her when the chief accountant had tried to kiss the children and had been reprimanded by their father.

After this last analysis, when, two days later, Miss Lucy visited me once more, I could not help asking her what had happened to make her so happy. She was as though transfigured. She was smiling and carried her head high. I thought for a moment that after all I had been wrong about the situation, and that the children's governess had become the Director's fiancée. But she dispelled my notion. "Nothing has happened. It's just that you don't know me. You have only seen me ill and depressed. I'm always cheerful as a rule. When I woke yesterday morning the weight was no longer on my mind, and since then I have felt well."—"And what do you think of your prospects in the house?"—"I am quite clear on the subject. I know I have none, and I shan't make myself unhappy over it."—"And will you get on all right with the servants now?"—"I think my own oversensitiveness was responsible for most of that."—"And are you still in love with your employer?"—"Yes, I certainly am, but that makes no difference. After all, I can have thoughts and feelings to myself."

I then examined her nose and found that its sensitivity to pain and reflex excitability had been almost completely restored. She was also able to distinguish between smells, though with uncertainty and only if they were strong. I must leave it an open question, however, how far her nasal

disorder may have played a part in the impairment of her sense of smell.

This treatment lasted in all for nine weeks. Four months later I met the patient by chance in one of our summer resorts. She was in good spirits and assured me that her recovery had been maintained.

DISCUSSION

I am not inclined to under-estimate the importance of the case that I have here described, even though the patient was suffering only from a slight and mild hysteria and though only a few symptoms were involved. On the contrary it seems to me an instructive fact that even an illness such as this, so unproductive when regarded as a neurosis, called for so many psychical determinants. Indeed, when I consider this case history more closely, I am tempted to regard it as a model instance of one particular type of hysteria, namely the form of this illness which can be acquired even by a person of sound heredity, as a result of appropriate experiences. It should be understood that I do not mean by this a hysteria which is independent of *any* pre-existing disposition. It is probable that no such hysteria exists. But we do not recognize a disposition of this sort in a subject until he has actually become a hysteric; for previously there was no evidence of its existence. A neuropathic disposition, as generally understood, is something different. It is already marked out before the onset of the illness by the amount of the subject's hereditary taint or the sum of his individual psychical abnormalities. So far as my information goes, there was no trace in Miss Lucy R. of either of these factors. Her hysteria can therefore be described as an acquired one, and it presupposed nothing more than the possession of what is probably a very widespread proclivity—the proclivity to acquire hysteria. We have as yet scarcely a notion of what the features of this proclivity may be. In cases of this kind, however, the main emphasis falls upon the nature of the trauma, though taken in conjunction, of course, with the subject's reaction to it. It turns out to be a *sine qua non* for the acquisition of hysteria that an incompatibility should develop between the ego and some idea presented to it. I

hope to be able to show elsewhere[1] how different neurotic disturbances arise from the different methods adopted by the 'ego' in order to escape from this incompatibility. The hysterical method of defense—for which, as we have seen, the possession of a particular proclivity is necessary—lies in the conversion of the excitation into a somatic innervation; and the advantage of this is that the incompatible idea is repressed from the ego's consciousness. In exchange, that consciousness now contains the physical reminiscence which has arisen through conversion (in our case, the patient's subjective sensations of smell) and suffers from the affect which is more or less clearly attached to precisely that reminiscence. The situation which has thus been brought about is now not susceptible to further change; for the incompatibility which would have called for a removal of the affect no longer exists, thanks to the repression and conversion. Thus the mechanism which produces hysteria represents on the one hand an act of moral cowardice and on the other a defensive measure which is at the disposal of the ego. Often enough we have to admit that fending off increasing excitations by the generation of hysteria is, in the circumstances, the most expedient thing to do; more frequently, of course, we shall conclude that a greater amount of moral courage would have been of advantage to the person concerned.

The actual traumatic moment, then, is the one at which the incompatibility forces itself upon the ego and at which the latter decides on the repudiation of the incompatible idea. That idea is not annihilated by a repudiation of this kind, but merely repressed into the unconscious.[2] When this process occurs for the first time there comes into being a nucleus and center of crystallization for the formation of a psychical group divorced from the ego—a group around which everything which would imply an acceptance of the incompatible idea subsequently collects. The splitting of consciousness in these cases of acquired hysteria is accordingly a deliberate and intentional

[1] [Freud sketched out the distinction between the mechanisms used in hysteria, obsessions and paranoia in a communication to Fliess of January 1, 1896 (Freud, 1950*a*, Draft K); in the following May he published these findings in his second paper on "The Neuro-Psychoses of Defense" (1896*b*).]

[2] [See footnote, p. 80 above.]

one. At least it is often *introduced* by an act of volition; for the actual outcome is something different from what the subject intended. What he wanted was to do away with an idea, as though it had never appeared, but all he succeeds in doing is to isolate it psychically.

In the history of our present patient the traumatic moment was the moment of her employer's outburst against her about his children being kissed by the lady. For a time, however, that scene had no manifest effect. (It may be that her oversensitiveness and low spirits began from it, but I cannot say.) Her hysterical symptoms did not start until later, at moments which may be described as "auxiliary." [1] The characteristic feature of such an auxiliary moment is, I believe, that the two divided psychical groups temporarily converge in it, as they do in the extended consciousness which occurs in somnambulism. In Miss Lucy R.'s case the first of the auxiliary moments, at which conversion took place, was the scene at table when the chief accountant tried to kiss the children. Here the traumatic memory was playing a part: she did not behave as though she had got rid of everything connected with her devotion to her employer. (In the history of other cases these different moments coincide; conversion occurs as an immediate effect of the trauma.)

The second auxiliary moment repeated the mechanism of the first one fairly exactly. A powerful impression temporarily reunited the patient's consciousness, and conversion once more took the path which had been opened out on the first occasion. It is interesting to notice that the second symptom to develop masked the first, so that the first was not clearly perceived until the second had been cleared out of the way. It also seems to me worth while remarking upon the reversed course which had to be followed by the analysis as well. I have had the same experience in a whole number of cases; the symptoms that had arisen later masked the earlier ones, and the key to the whole situation lay only in the last symptom to be reached by the analysis.

The therapeutic process in this case consisted in compelling the psychical group that had been split off to unite

[1] [Freud had already discussed such "auxiliary" traumatic moments in Section I of his first paper on "The Neuro-Psychoses of Defense" (1894*a*).]

once more with the ego-consciousness. Strangely enough, success did not run *pari passu* with the amount of work done. It was only when the last piece of work had been completed that recovery suddenly took place.