IV

THE PSYCHOTHERAPY OF HYSTERIA

(FREUD)

In our 'Preliminary Communication' we reported how, in the course of our investigation into the aetiology of hysterical symptoms, we also came upon a therapeutic method which seemed to us of practical importance. For we found, to our great surprise at first, that each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying effect, and when the patient had described that event in the greatest possible detail and had put the effect into words'. (P. 6.)

We further endeavoured to explain the way in which our psychotherapeutic method works. 'It brings to an end the operative force of the idea which was not abreacted in the first instance, by allowing its strangulated effect to find a way out through speech; and it subjects it to associative correction by introducing it into normal consciousness (under light hypnosis) or by removing it through the physician's suggestion, as is done in somnambulism accompanied by amnesia.' (P. 17.)

I will now try to give a connected account of how far this method carries us, of the respects in which it achieves more than other methods, of the technique by which it works and of the difficulties it meets with. Much of the substance of this is already contained in the case histories printed in the earlier portion of this book, and I shall not be able to avoid repeating myself in the account which follows.

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For my own part, I too may say that I can still hold by what is contained in the 'Preliminary Communication'. None the less I must confess that during the years which have since passed—in which I have been unceasingly concerned with the problems touched upon in it—fresh points of view have forced themselves on my mind. These have led to what is in part at least
a different grouping and interpretation of the factual material known to me at that time. It would be unfair if I were to try to lay too much of the responsibility for this development upon my honoured friend Dr. Josef Breuer. For this reason the considerations which follow stand principally under my own name.

When I attempted to apply to a comparatively large number of patients Breuer’s method of treating hysterical symptoms by an investigation and abreaction of them under hypnosis, I came up against two difficulties, in the course of dealing with which I was led to an alteration both in my technique and in my view of the facts. (1) I found that not everyone could be hypnotized who exhibited undoubted hysterical symptoms and who, it was highly probable, was governed by the same psychical mechanism. (2) I was forced to take up a position on the question of what, after all, essentially characterizes hysteria and what distinguishes it from other neuroses.

I will put off until later my account of how I got over the first of these two difficulties and what I have learnt from it, and I will begin by describing the attitude I adopted in my daily practice towards the second problem. It is very hard to obtain a clear view of a case of neurosis before one has submitted it to a thorough analysis—an analysis which can, in fact, only be brought about by the use of Breuer’s method; but a decision on the diagnosis and the form of therapy to be adopted has to be made before any such thorough knowledge of the case has been arrived at. The only course open to me, therefore, was to select for cathartic treatment such cases as could be provisionally diagnosed as hysteria, which exhibited one or more of the stigmata or characteristic symptoms of hysteria. It then sometimes happened that in spite of the diagnosis of hysteria the therapeutic results turned out to be very scanty and that even analysis brought nothing significant to light. On other occasions again, I tried applying Breuer’s method of treatment to neuroses which no one could have mistaken for hysteria, and I found that in that manner they could be influenced and indeed cleared up. I had this experience, for instance, with obsessional ideas, genuine obsessional ideas of the Westphal type, in cases without a single trait which recalled hysteria.

1 [Westphal (1877) had given a detailed descriptive classification of these.]

Consequently, the psychical mechanism revealed by the ‘Preliminary Communication’ could not be pathognomonic for hysteria. Nor could I resolve, merely for the sake of preserving that mechanism as a criterion of it, to lump all these other neuroses in with hysteria. I eventually found a way out of all these emerging doubts by the plan of treating all the other neuroses in question in the same way as hysteria. I determined to investigate their aetiology and the nature of their psychical mechanism in every case and to let the decision as to whether the diagnosis of hysteria was justified depend upon the outcome of that investigation.

Thus, starting out from Breuer’s method, I found myself engaged in a consideration of the aetiology and mechanism of the neuroses in general. I was fortunate enough to arrive at some serviceable findings in a relatively short time. In the first place I was obliged to recognize that, in so far as one can speak of determining causes which lead to the acquisition of neuroses, their aetiology is to be looked for in sexual factors. There followed the discovery that different sexual factors, in the most general sense, produce different pictures of neurotic disorders. And it then became possible, in the degree to which this relation was confirmed, to venture on using aetiology for the purpose of characterizing the neuroses and of making a sharp distinction between the clinical pictures of the various neuroses. Where the aetiological characteristics coincided regularly with the clinical ones, this was of course justified.

In this manner I found that neurasthenia presented a monotonous clinical picture in which, as my analyses showed, a ‘psychical mechanism’ played no part. There was a sharp distinction between neurasthenia and ‘obsessional neurosis’, the
neurosis of obsessional ideas proper. In this latter one I was able to recognize a complicated psychical mechanism, an aetiology similar to that of hysteria and an extensive possibility of reducing it by psychotherapy. On the other hand, it seemed to me absolutely necessary to detach from neurasthenia a complex of neurotic symptoms which depend on a quite different and indeed at bottom a contrary aetiology. The component symptoms of this complex are united by a characteristic which has already been recognized by Hecker (1893). For they are either symptoms or equivalents and rudiments of manifestations of anxiety; and for this reason I have given to this complex which is to be detached from neurasthenia the name of ‘anxiety neurosis’. I have maintained [Freud 1895b] that it arises from an accumulation of physical tension, which is itself once more of sexual origin. This neurosis, too, has no psychical mechanism, but it invariably influences mental life, so that ‘anxious expectation’, phobias, hyperaesthesia to pains, etc., are among its regular manifestations. This anxiety neurosis, in my sense of the term, no doubt coincides in part with the neurosis which, under the name of ‘hypochondria’, finds a place in not a few descriptions alongside hysteria and neurasthenia. But I cannot regard the delimitation of hypochondria in any of the works in question as being the correct one, and the applicability of its name seems to me to be prejudiced by the fixed connection of that term with the symptom of ‘fear of illness’.

After I had in this way fixed the simple pictures of neurasthenia, anxiety neurosis and obsessional ideas, I went on to consider the cases of neurosis which are commonly included under the diagnosis of hysteria. I reflected that it was not right to stamp a neurosis as a whole as hysterical because a few hysterical signs were prominent in its complex of symptoms. I could well understand this practice, since after all hysteria is the oldest, best-known and most striking of the neuroses under consideration; but it was an abuse, for it put down to the

1 [Cf. above, p. 243.—Freud had already considered the relations between hypochondria, neurasthenia and anxiety neurosis in Part I of his first paper on anxiety neurosis (1895b). Much later, in the course of his closing remarks in a discussion on masturbation (1912f), he suggested that hypochondria should be regarded, together with neurasthenia and anxiety neurosis, as a third ‘actual neurosis’—that is, as having a purely physical aetiology. He took up this idea at much greater length at the beginning of Section II of his paper on narcissism (1914c).]

IV. PSYCHOTHERAPY OF HYSTERIA (FREUD) account of hysteria so many traits of perversion and degeneracy. Whenever a hysterical sign, such as an anaesthesia or a characteristic attack, was found in a complicated case of psychical degeneracy, the whole condition was described as one of ‘hysteria’, so that it is not surprising that the worst and the most contradictory things were found together under this label.

But just as it was certain that this diagnosis was incorrect, it was equally certain that we ought also to separate out the various neuroses; and since we were acquainted with neurasthenia, anxiety neurosis, etc., in a pure form, there was no longer any need to overlook them in the combined picture.

The following view, therefore, seemed to be the more probable one. The neuroses which commonly occur are mostly to be described as ‘mixed’. Neurasthenia and anxiety neuroses are easily found in pure forms as well, especially in young people. Pure forms of hysteria and obsessional neurosis are rare; as a rule these two neuroses are combined with anxiety neurosis.

The reason why mixed neuroses occur so frequently is that their aetiological factors are so often intermixed, sometimes only by chance, sometimes as a result of causal relations between the processes from which the aetiological factors of the neuroses are derived. There is no difficulty in tracing this out and demonstrating it in detail. As regards hysteria, however, it follows that that disorder can scarcely be segregated from the nexus of the sexual neuroses for the purposes of study, that as a rule it represents only a single side, only one aspect, of a complicated case of neurosis, and that it is only in marginal cases that it can be found and treated in isolation. We may perhaps say in a number of instances: *a potiori fit denominatio* [i.e. it has been given its name from its more important feature].

I will now examine the case histories that have been reported here, with a view to seeing whether they speak in favour of my opinion that hysteria is not an independent clinical entity.

Breuer’s patient, Anna O., seems to contradict my opinion and to be an example of a pure hysterical disorder. This case, however, which has been so fruitful for our knowledge of hysteria, was not considered at all by its observer from the point of view of a sexual neurosis, and is now quite useless for this purpose. When I began to analyse the second patient, Frau Emmy von N., the expectation of a sexual neurosis being the
basis of hysteria was fairly remote from my mind. I had come fresh from the school of Charcot, and I regarded the linking of hysteria with the topic of sexuality as a sort of insult—just as the women patients themselves do. When I go through my notes on this case to-day there seems to me no doubt at all that it must be looked on as a case of severe anxiety neurosis accompanied by anxious expectation and phobias—an anxiety neurosis which originated from sexual abstinence and had become combined with hysteria. Case 3, that of Miss Lucy R., can perhaps best be described as a marginal case of pure hysteria. It was a short hysteria which ran an episodic course and had an unmistakable sexual aetiology, such as would correspond to an anxiety neurosis. The patient was an over-mature girl with a need to be loved, whose affections had been too hastily aroused through a misunderstanding. The anxiety neurosis, however, did not become visible, or it escaped me. Case 4, Katharina, was nothing less than a model of what I have described as 'virginal anxiety'. It was a combination of anxiety neurosis and hysteria. The former created the symptoms, while the latter repeated them and operated with them. Incidentally, it was a case typical of a large number of neuroses in young people that are described as ‘hysteria’. Case 5, that of Fräulein Elisabeth von R., was once again not investigated as a sexual neurosis. I was only able to express, without confirming it, a suspicion that a spinal neurasthenia may have been its basis [p. 175, footnote].

I must add, though, that in the meantime pure hysterias have become even rarer in my experience. If it was possible for me to bring together these four cases as hysterias and if in reporting them I was able to overlook the points of view that were of importance as regards sexual neuroses, the reason is that these histories date some distance back, and that I did not at that time as yet submit such cases to a deliberate and searching investigation of their neurotic sexual foundation. And if, instead of these four, I did not report tens of cases whose analysis provides a confirmation of the psychical mechanism of hysterical phenomena put forward by us, this reticence was necessitated by the very circumstance that the analysis revealed these cases as being simultaneously sexual neuroses, although certainly no diagnostician would have refused them the name of hysteria. But an elucidation of these sexual neuroses would overstep the bounds of the present joint publication.

I should not like it to be wrongly thought that I do not wish to allow that hysteria is an independent neurotic affection, that I regard it merely as a psychical manifestation of anxiety neurosis and that I attribute to it 'ideogenic' symptoms only and am transferring the somatic symptoms (such as hysterogenic points and anaesthesias) to anxiety neurosis. Nothing of the sort. In my opinion it is possible to deal with hysteria, freed from any admixture, as something independent; and to do so in every respect except in that of therapeutics. For in therapeutics we are concerned with a practical aim, with getting rid of the pathological state as a whole. And if hysteria generally appears as a component of a mixed neurosis, the situation resembles that in which there is a mixed infection, where preserving life sets a problem which does not coincide with that of combating the operation of one particular pathogenic agent.

It is very important for me to distinguish the part played by hysteria in the picture of the mixed neuroses from that played by neurasthenia, anxiety neurosis and so on, because, once I have made this distinction, I shall be able to express concisely the therapeutic value of the cathartic method. For I am inclined to venture the assertion that that method is—as a matter of theory—very well able to get rid of any hysterical symptom, whereas, as will be easily understood, it is completely powerless against the phenomena of neurasthenia and is only able rarely and in roundabout ways to influence the psychical effects of anxiety neurosis. Its therapeutic effectiveness in any particular case will accordingly depend on whether the hysterical components of the clinical picture do or do not assume a position of practical importance in comparison with the other neurotic components.

There is another obstacle in the way of the effectiveness of the cathartic method, which we have already indicated in the 'Preliminary Communication' [p. 17]. It cannot affect the underlying causes of hysteria: thus it cannot prevent fresh symptoms from taking the place of the ones which had been got rid of. On the whole, then, I must claim a prominent place for our therapeutic method as employed within the framework of a therapy of the neuroses; but I should like to advise against assessing its value or applying it outside this framework. Since,
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however, I cannot in these pages offer a 'therapy of the nerves' of the sort needed by practitioners. What I have just said is equivalent to postponing my account of the subject to a possible later publication. But I am able, I think, to add the following remarks by way of explanation and elucidation.

(1) I do not maintain that I have actually got rid of all the cathartic method. But it is my opinion that the obstacles and have not been due to any question of theory. I am justified in saying that because it is a symptomatic and not a causal one. For a causal therapy is in fact a rule only a prophylactic one; but that agency does therefore necessarily get rid of the cathartic method. It must, however, return to a consideration of the technique. When I come to deal with the difficulties and drawbacks to this source. [See p. 301.]

(2) The cathartic method is not to be regarded as worthless because it is a symptomatic and not a causal one. For a causal therapy is in fact a rule only a prophylactic one; but that agency does therefore necessarily get rid of the cathartic method.

(3) A period of hysterical production, an acute hysterical paroxysm, has been overcome and all that is left over are the cathartic method, the cathartic method suffices for every indication and brings about the desired result. The cathartic method does not claim to alter the constitutional needs, it is content with the effects of the treatment. Here the cathartic method must be regarded as the constitutional one. It is a task of altering the conditions necessary in order to bring about a sexual trauma.

I must content myself with the observational result that give rid of all the troubles to which it is familiar as the constellations of the region of sexual life, owing to the unavoidableness of the patient's condition of usual sexual needs and being about to be asked off it, for the constitution cannot set in the task of altering a condition such as the hysterical one. He must content himself with getting rid of the troubles to which it is familiar as the constitutions must incline the person from it with the constitution of the external circumstances. He will feel satisfied if the patient
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264 analogous case of an acute infectious disease—these and other difficulties will probably make a systematic application of the cathartic method as a rule impossible in any given case. Nevertheless, it remains a matter for serious consideration whether it may not be true that even in an acute hysteria the regular clearing up of the products of the illness exercises a curative influence, by supporting the patient's normal ego which is engaged in the work of defence, and by preserving it from being overwhelmed and falling into a psychosis and even perhaps into a permanent state of confusion.

What the cathartic method is able to accomplish even in acute hysteria, and how it even restricts the fresh production of pathological symptoms in a manner that is of practical importance, is quite clearly revealed by the case history of Anna O., in which Breuer first learnt to employ this psychotherapeutic procedure.

(5) Where it is a question of hysterias which run a chronic course, accompanied by a moderate but constant production of hysterical symptoms, we find the strongest reason for regretting our lack of a therapy which is effective causally, but we also have most ground for the appreciation of the value of the cathartic procedure as a symptomatic therapy. In such cases we have to do with the mischief produced by an aetiology that persists chronically. Everything depends on reinforcing the patient's nervous system in its capacity to resist; and we must reflect that the existence of a hysterical symptom means a weakening of the resistance of that nervous system and represents a factor predisposing to hysteria. As can be seen from the mechanism of monosymptomatic hysteria, a new hysterical symptom is most easily formed in connection with, and on the analogy of, one that is already present. The point at which a symptom has already broken through once (see p. 203) forms a weak spot at which it will break through again the next time. A psychical group that has once been split off plays the part of a 'provoking' crystal from which a crystallization which would otherwise not have occurred will start with the greatest facility [p. 123]. To get rid of the symptoms which are already present, to undo the psychical changes which underlie them, is to give back to patients the whole amount of their capacity for resistance, so that they can successfully withstand the effects of the noxious agency. A very great deal can be done for such patients by means of prolonged supervision and occasional 'chimney-sweeping' (p. 30).

(6) It remains for me to mention the apparent contradiction between the admission that not all hysterical symptoms are psychogenic and the assertion that they can all be got rid of by a psychotherapeutic procedure. The solution lies in the fact that some of these non-psychogenic symptoms (stigmata, for instance) are, it is true, indications of illness, but cannot be described as ailments; and consequently it is not of practical importance if they persist after the successful treatment of the illness. As regards other such symptoms, it seems to be the case that in some roundabout way they are carried off along with the psychogenic symptoms, just as, perhaps, in some roundabout way they are after all dependent on a psychical causation.

I must now consider the difficulties and disadvantages of our therapeutic procedure, so far as they do not become obvious to everyone from the case histories reported above or from the remarks on the technique of the method which follow later. I will enumerate and indicate these difficulties rather than elaborate them.

The procedure is laborious and time-consuming for the physician. It presupposes great interest in psychological happenings, but personal concern for the patients as well. I cannot imagine bringing myself to delve into the psychical mechanism of a hysteria in anyone who struck me as low-minded and repellant, and who, on closer acquaintance, would not be capable of arousing human sympathy; whereas I can keep the treatment of a tabetic or rheumatic patient apart from personal approval of this kind. The demands made on the patient are not less. The procedure is not applicable at all below a certain level of intelligence, and it is made very much more difficult by any trace of feebleness of mind. The complete consent and complete attention of the patients are needed, but above all their confidence, since the analysis invariably leads to the disclosure of the most intimate and secret psychical events. A good number of the patients who would be suitable for this form of treatment abandon the doctor as soon as the suspicion begins to dawn on them of the direction in which the investigation is leading. For patients such as these the doctor has remained a
stranger. With others, who have decided to put themselves in
his hands and place their confidence in him—a step which in
other such situations is only taken voluntarily and never at the
doctor's request—with these other patients, I, say, it is almost
inevitable that their personal relation to him will force itself,
for a time at least, unduly into the foreground. It seems, indeed,
as though an influence of this kind on the part of the doctor is a
sine qua non to a solution of the problem. I do not think any
essential difference is made in this respect whether hypnosis
can be used or whether it has to be by-passed and replaced by
something else. But reason demands that we should emphasize
the fact that these drawbacks, though they are inseparable
from our procedure, cannot be laid at its door. On the contrary,
it is quite clear that they are based on the predetermining
conditions of the neuroses that are to be cured and that they
must attach to any medical activity which involves intense
preoccupation with the patient and leads to a psychical change
in him. I have not been able to attribute any deleterious effects
or danger to the employment of hypnosis, though I made
copious use of it in some of my cases. Where I caused damage,
the reasons lay elsewhere and deeper. If I survey my therapeutic
efforts during the last few years since the communications made
by my honoured teacher and friend Josef Breuer showed me
the use of the cathartic method, I believe that in spite of every-
thing, I have done much more, and more frequent, good than
harm and have accomplished some things which no other
therapeutic procedure could have achieved. It has on the
whole, as the 'Preliminary Communication' put it, brought
'considerable therapeutic advantages' [p. 17].

There is one other advantage in the use of this procedure
which I must emphasize. I know of no better way of getting
to understand a severe case of complicated neurosis with a
greater or lesser admixture of hysteria than by submitting it
to an analysis by Breuer's method. The first thing that happens
is the disappearance of whatever exhibits a hysterical mech-
nanism. In the meantime I have learnt in the course of the
analysis to interpret the residual phenomena and to trace their
aetiology; and in this way I have secured a firm basis for
deciding which of the weapons in the therapeutic armoury
against the neuroses is indicated in the case concerned. When

1 [This topic is discussed at greater length below, p. 301 ff.]
could not adopt a causal method of meeting the difficulty. I noticed, however, that in some patients the obstacle lay still further back: they refused even any attempt at hypnosis. The idea then occurred to me one day that the two cases might be identical and that both might signify an unwillingness; that people who were not hypnotizable were people who had a psychical objection to hypnosis, whether their objection was expressed as unwillingness or not. I am not clear in my mind whether I can maintain this view.

The problem was, however, how to by-pass hypnosis and yet obtain the pathogenic recollections. This I succeeded in doing in the following manner.

When, at our first interview, I asked my patients if they remembered what had originally occasioned the symptom concerned, in some cases they said they knew nothing of it, while in others they brought forward something which they described as an obscure recollection and could not pursue further. If, following the example of Bernheim when he awoke in his patient's impressions from their somnambulistic state which had ostensibly been forgotten (cf. p. 109f.), I now became insistent—if I assured them that they did know it, that it would occur to their minds—then, in the first cases, something did actually occur to them, and, in the others, their memory went a step further. After this I became still more insistent; I told the patients to lie down and deliberately close their eyes in order to concentrate—all of which had at least some resemblance to hypnosis. I then found that without any hypnosis new recollections emerged which went further back and which probably related to our topic. Experiences like this made me think that it would in fact be possible for the pathogenic groups of ideas, that were after all certainly present, to be brought to light by mere insistence; and since this insistence involved effort on my part and so suggested the idea that I had to overcome a resistance, the situation led me at once to the theory that by means of my psychical work I had to overcome a psychical force in the patients which was opposed to the pathogenic ideas becoming conscious (being remembered). A new understanding seemed to open before my eyes when it occurred to me that this must no doubt be the same psychical force that had played a part in the generating of the hysterical symptom and that at that time prevented the pathogenic idea from becoming conscious. What

kind of force could one suppose was operative here, and what motive could have put it into operation? I could easily form an opinion on this. For I already had at my disposal a few completed analyses in which I had come to know examples of ideas that were pathogenic, and had been forgotten and put out of consciousness. From these I recognized a universal characteristic of such ideas: they were all of a distressing nature, calculated to arouse the affects of shame, of self-reproach and of psychical pain, and the feeling of being harmed; they were all of a kind that one would prefer not to have experienced, that one would rather forget. From all this there arose, as it were automatically, the thought of defence. It has indeed been generally admitted by psychologists that the acceptance of a new idea (acceptance in the sense of believing or of recognizing as real) is dependent on the nature and trend of the ideas already united in the ego, and they have invented special technical names for this process of censorship to which the new arrival must submit. The patient's ego had been approached by an idea which proved to be incompatible, which provoked on the part of the ego a repelling force of which the purpose was defence against this incompatible idea. This defence was in fact successful. The idea in question was forced out of consciousness and out of memory. The psychical trace of it was apparently lost to view. Nevertheless that trace must be there. If I endeavoured to direct the patient's attention to it, I became aware, in the form of resistance, of the same force as had shown itself in the form of repulsion when the symptom was generated. If, now, I could make it appear probable that the idea had become pathogenic precisely as a result of its expulsion and repression, the chain would seem complete. In several of the discussions on our case histories, and in a short paper on 'The Neuro-Psychoses of Defence' (1894a), I have attempted to sketch out the psychological hypotheses by the help of which this causal connection—the fact of conversion—can be demonstrated.

Thus a psychical force, aversion on the part of the ego, had originally driven the pathogenic idea out of association and was now opposing its return to memory. The hysterical

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1 [This appears to be Freud's first published use of the term.]
2 ['Jetzt,' This word is found only in the first edition. It is omitted, probably by accident, in all the later editions.]
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Of course aware that a pressure on the forehead like this could be replaced by any other signal or by some other exercise of physical influence on the patient; but since the patient is lying in front of me, pressure on his forehead, or taking his head between my two hands, seems to be the most convenient way of applying suggestion for the purpose I have in view. It would be possible for me to say by way of explaining the efficacy of this device that it corresponded to a ‘momentarily intensified hypnosis’; but the mechanism of hypnosis is so puzzling to me that I would rather not make use of it as an explanation. I am rather of opinion that the advantage of the procedure lies in the fact that by means of it I dissociate the patient’s attention from his conscious searching and reflecting— from everything, in short, on which he can employ his will—in the same sort of way in which this is effected by staring into a crystal ball, and so on. The conclusion which I draw from the fact that what I am looking for always appears under the pressure of my hand is as follows. The pathogenic idea which has ostensibly been forgotten is always lying ready ‘close at hand’ and can be reached by associations that are easily accessible. It is merely a question of getting some obstacle out of the way. This obstacle seems once again to be the subject’s will, and different people can learn with different degrees of ease to free themselves from their intentional thinking and to adopt an attitude of completely objective observation towards the psychical processes taking place in them.

What emerges under the pressure of my hand is not always a ‘forgotten’ recollection; it is only in the rarest cases that the actual pathogenic recollections lie so easily to hand on the surface. It is much more frequent for an idea to emerge which is an intermediate link in the chain of associations between the idea from which we start and the pathogenic idea which we are in search of; or it may be an idea which forms the starting point of a new series of thoughts and recollections at the end of this procedure. 

1 [The part played in the technique of hypnotism by distracting conscious attention was discussed by Freud much later, in Chapter X of his Group Psychology (1921e), Standard Ed., 18, 126. Further references to the use of the same mechanism in telepathy and in joking are enumerated in a footnote to that passage.]

2 [The difficulty felt by some people in adopting this non-critical attitude was discussed by Freud at some length in Chapter II of The Interpretation of Dreams (1900a), Standard Ed., 4, 101-3.]

Patient’s ‘not knowing’ was in fact a ‘not wanting to know’—a not wanting which might be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming by his psychical work this resistance to association. He does this in the first place by ‘insisting’, by making use of psychical compulsion to direct the patients’ attention to the ideational traces of which he is in search. His efforts, however, are not exhausted by this, but, as I shall show, they take on other forms in the course of an analysis and call in other psychical forces to assist them.

I must dwell on the question of insistence a little longer. Simple assurances such as ‘of course you know it’, ‘tell me all the same’, ‘you’ll think of it in a moment’ do not carry us very far. Even with patients in a state of ‘concentration’ the thread breaks off after a few sentences. It should not be forgotten, however, that it is always a question here of a quantitative comparison, of a struggle between motive forces of different degrees of strength or intensity. Insistence on the part of a strange doctor who is unfamiliar with what is happening is not powerful enough to deal with the resistance to association in a serious case of hysteria. We must think of stronger means.

In these circumstances I make use in the first instance of a small technical device. I inform the patient that, a moment later, I shall apply pressure to his forehead, and I assure him that, all the time the pressure lasts, he will see before him a recollection in the form of a picture or will have it in his thoughts in the form of an idea occurring to him; and I pledge him to communicate this picture or idea to me, whatever it may be. He is not to keep it to himself because he may happen to think it is not what is wanted, not the right thing, or because it would be too disagreeable for him to say it. There is no criticism of it, no reticence, either for emotional reasons or because it is judged unimportant. Only in this manner can we find what we are in search of, but in this manner we shall find it infallibly. Having said this, I press for a few seconds on the forehead of the patient as he lies in front of me; I then leave go and ask quietly, as though there were no question of a disappointment: ‘What did you see?’ or ‘What occurred to you?’

This procedure has taught me much, and has also invariably achieved its aim. To-day I can no longer do without it. I am
of which the pathogenic idea will be found. It is true that where
this happens my pressure has not revealed the pathogenic idea—
which would in any case be incomprehensible, torn from its con-
text and without being led up to—but it has pointed the
way to it and has shown the direction in which further inves-
tigation is to be made. The idea that is first provoked by the
pressure may in such cases be a familiar recollection which has
never been repressed. If on our way to the pathogenic idea the
thread is broken off once more, it only needs a repetition of the
procedure, of the pressure, to give us fresh bearings and a fresh
starting-point.

On yet other occasions the pressure of the hand provokes
a memory which is familiar in itself to the patient, but the
appearance of which astonishes him because he has forgotten
its relation to the idea from which we started. This relation is
then confirmed in the further course of the analysis. All these
consequences of the pressure give one a deceptive impression
of there being a superior intelligence outside the patient’s
consciousness which keeps a large amount of psychological material
arranged for particular purposes and has fixed a planned order
for its return to consciousness. I suspect, however, that this
unconscious second intelligence is no more than an appearance.

In every fairly complicated analysis the work is carried on
by the repeated, indeed continuous, use of this procedure
of pressure on the forehead. Sometimes this procedure, starting
from where the patient’s waking retrospection breaks off, points
the further path through memories of which he has remained
aware; sometimes it draws attention to connections which have
been forgotten; sometimes it calls up and arranges recollections
which have been withdrawn from association for many years but
which can still be recognized as recollections; and sometimes,
finally, as the climax of its achievement in the way of repro-
ductive thinking, it causes thoughts to emerge which the patient
will never recognize as his own, which he never remembers,
although he admits that the context calls for them inexorably,
and while he becomes convinced that it is precisely these ideas
that are leading to the conclusion of the analysis and the removal
of his symptoms.

I will try to enumerate a few instances of the excellent results
brought about by this technical procedure.

IV. PSYCHOTHERAPY OF HYSTERIA (FREUD)

I treated a girl suffering from an intolerable *tussis nervosa*
which had dragged on for six years. It was obviously due to her
man from every common catarrh, but must nevertheless have
had strong psychic motives. All other kinds of therapy had
long proved ineffectual against it. I therefore tried to remove the
symptom by means of psychical analysis. All she knew was that
her nervous cough began when, at the age of fourteen, she was
boarding with an aunt. She maintained that she knew nothing
of any mental agitations at that time and did not believe that
there was any motive for her complaint. Under the pressure of
my hand she first of all remembered a big dog. She then
recognized the picture in her memory: it was a dog of her
aunt’s which became attached to her, followed her about
everywhere, and so on. And it now occurred to her, without
further prompting, that this dog died, that the children gave
it a solemn burial and that her cough started on the way back
from the funeral. I asked why, but had once more to call in the
help of a pressure. The thought then came to her: ‘Now I am
quite alone in the world. No one here loves me. This creature
was my only friend, and now I have lost him.’ She continued
her story. ‘The cough disappeared when I left my aunt’s, but
it came on again eighteen months later.’ ‘Why was that?’ ‘I
don’t know.’ I pressed again. She recalled the news of her
uncle’s death, when the cough started again, and also recalled
having a similar train of thought. Her uncle seems to have been
the only member of the family who had shown any feeling for
her, who had loved her. Here, then, was the pathogenic idea.
No one loved her, they preferred everyone else to her, she did
not deserve to be loved, and so on. But there was something
attaching to the idea of ‘love’ which there was a strong resis-
tance to her telling me. The analysis broke off before this was
cleared up.

Some time ago I was asked to relieve an elderly lady of her
attacks of anxiety, though judging by her traits of character
she was scarcely suitable for treatment of this kind. Since her
menopause she had become excessively pious, and she used to
receive me at each visit armed with a small ivory crucifix con-
cealed in her hand, as though I were the Evil One. Her anxiety
attacks, which were of a hysterical character, went back to her
early girlhood and, according to her, originated from the use
of a preparation of iodine intended to reduce a moderate
swelling of her thyroid gland. I naturally rejected this derivation and tried to find another instead of it which would harmonize better with my views on the aetiology of the neuroses. I asked her first for an impression from her youth which stood in a causal relation to her anxiety attacks, and, under the pressure of my hand, a memory emerged of her 'reading what is known as an 'edifying' book, in which there occurred a mention, in a sufficiently pious strain, of the sexual processes. The passage in question made an impression on the girl which was quite the reverse of the author's intention: she burst into tears and flung the book away. This was before her first anxiety attack. A second pressure on the patient's forehead conjured up a further reminiscence—the recollection of a tutor of her brothers who had manifested a great admiration for her and towards whom she herself had had feelings of some warmth. This recollection culminated in the reproduction of an evening in her parents' house when they had all sat round the table with the young man and had enjoyed themselves immensely in an entertaining conversation. During the night following that evening she was woken up by her first anxiety attack which, it is safe to say, had more to do with a repudiation of a sensual impulse than with any contemporary doses of iodine.—What prospect should I have had by any other method of revealing such a connection, against her own views and assertions, in this recalcitrant patient who was so prejudiced against me and every form of mundane therapy?

Another example concerns a young, happily-married woman. As long ago as in her early girlhood she used for some time to be found every morning in a stuporous condition, with her limbs rigid, her mouth open and her tongue protruding; and now once again she was suffering, on waking, from attacks which were similar though not so severe. Since deep hypnosis turned out not to be obtainable, I began to investigate while she was in a state of concentration. At my first pressure I assured her that she would see something that was directly related to the causes of her condition in her childhood. She was quiet and co-operative. She saw once more the house in which she had spent her early girlhood, her own room, the position of her bed, her grandmother, who had lived with them at that time, and one of her governesses of whom she had been very fond. A number of small scenes, all of them unimportant, which took place in these rooms and between these people followed one after the other; they were concluded by the departure of the governess, who left in order to get married. I could make nothing at all of these reminiscences; I could not establish any relation between them and the aetiology of the attacks. Various circumstances showed, however, that they belonged to the same period at which the attacks first appeared. But before I was able to proceed with the analysis I had occasion to talk to a colleague who in former years had been the family doctor of my patient's parents. He gave me the following information. At the time at which he was treating the girl, who was approaching maturity and very well developed physically, for her first attacks, he was struck by the excessive affectionateness of the relation between her and the governess who was at that time in the house. He became suspicious and induced the grandmother to keep an eye on this relationship. After a short time the old lady was able to report to him that the governess was in the habit of visiting the child in bed at night and that after such nights the child was invariably found next morning in an attack. They did not hesitate after this to arrange for the silent removal of this corruptor of youth. The children and even the mother were encouraged to believe that the governess had left in order to get married.—My therapy, which was immediately successful, consisted in giving the young woman the information I had received.

The revelations which one obtains through the procedure of pressing occasionally appear in a very remarkable form and in circumstances which make the assumption of there being an unconscious intelligence even more tempting. Thus I remember a lady who had suffered for many years from obsessions and phobias and who referred me to her childhood for the genesis of her illness but was also quite unable to say what might be to blame for it. She was frank and intelligent and she put up only a remarkably small conscious resistance. (I may remark in parenthesis that the psychical mechanism of obsessions has a very great deal of internal kinship with hysterical symptoms and that the technique of analysis is the same for both of them.) When I asked this lady whether she had seen anything or had any recollection under the pressure of my hand, she replied: 'Neither the one nor the other, but a word has suddenly occurred to me.' 'A single word?' 'Yes, but it sounds too silly.
‘Say it all the same,’ ‘Concierge,’ ‘Nothing else?’ ‘No.’ I pressed a second time and once more an isolated word shot through her mind: ‘Night-gown.’ I saw now that this was a new sort of method of answering, and by pressing repeatedly I brought out what seemed to be a meaningless series of words: ‘Concierge’—‘night-gown’—‘bed’—‘town’—‘farm-cart.’ ‘What does all this mean?’ I asked. She reflected for a moment and the following thought occurred to her: ‘It must be the story that has just come into my head. When I was ten years old and my next elder sister was twelve, she went raving mad one night and had to be tied down and taken into the town on a farm-cart. I remember perfectly that it was the concierge who overpowered her and afterwards went with her to the asylum as well.’ We pursued this method of investigation and our oracle produced another series of words, which, though we were not able to interpret all of them, made it possible to continue this story and lead on from it to another one. Soon, moreover, the meaning of this reminiscence became clear. Her sister’s illness had made such a deep impression on her because the two of them shared a secret; they slept in one room and on a particular night they had both been subjected to sexual assaults by a certain man. The mention of this sexual trauma in the patient’s childhood revealed not only the origin of her first obsessions but also the trauma which subsequently produced the pathogenic effects.

The peculiarity of this case lay only in the emergence of isolated key-words which we had to work into sentences; for the appearance of disconnectedness and irrelevance which characterized the words emitted in this oracular fashion applies equally to the complete ideas and scenes which are normally produced under my pressure. When these are followed up, it invariably turns out that the apparently disconnected reminiscences are closely linked in thought and that they lead quite straight to the pathogenic factor we are looking for. For this reason I am glad to recall a case of analysis in which my confidence in the products of pressure were first put to a hard test but afterwards brilliantly justified.

A very intelligent and apparently happy young married woman had consulted me about an obstinate pain in her abdomen which was resistant to treatment. I recognized that the pain was situated in the abdominal wall and must be referred to palpable muscular indurations, and I ordered local treatment. Some months later I saw the patient again and she said to me: ‘The pain I had then passed off after the treatment you recommended, and it stayed away for a long time; but now it has come back in a nervous form. I know that is so, because I no longer have it, as I used to, when I make certain movements, but only at particular times—for instance, when I wake up in the morning and when I am agitated in certain ways.’

The lady’s diagnosis was quite correct. It was now a question of finding out the cause of the pain, and she could not help me about this while she was in an uninfluenced state. When I asked her, in concentration and under the pressure of my hand, whether anything occurred to her or whether she saw anything, she decided in favour of seeing and began to describe her visual pictures. She saw something like a sun with rays, which I naturally took to be a phosphene, produced by pressure on the eyes. I expected that something more serviceable would follow. But she went on: ‘Stars of a curious pale blue light, like moonlight’ and so on, all of which I took to be no more than flickering, flashes and bright specks before her eyes. I was already prepared to regard this experiment as a failure and I was wondering how I could make an inconspicuous retreat from the affair, when my attention was attracted by one of the phenomena which she described. She saw a large black cross, leaning over, which had round its edges the same shimmer of light with which all her other pictures had shone, and on whose cross-beam a small flame flickered. Clearly there could no longer be any question of a phosphene here. I now listened carefully. Quantities of pictures appeared bathed in the same light, curious signs looking rather like Sanskrit; figures like triangles, among them a large triangle; the cross once more. . . .

This time I suspected an allegorical meaning and asked what the cross could be. ‘It probably means pain,’ she replied. I objected that by ‘cross’ one usually meant a moral burden. What lay concealed behind the pain? She could not say, and went on with her visions: a sun with golden rays. And this she was also able to interpret. ‘It’s God, the primaeval force.’ Then came a gigantic lizard which regarded her enquiringly but not alarmingly. Then a heap of snakes. Then once more a sun, but with mild, silver rays; and in front of her, between her and this source of light, a grating which hid the centre of
the sun from her. I had known for some time that what I had to do with were allegories and at once asked the meaning of this last picture. She answered without hesitation: 'The sun is perfection, the ideal, and the grating represents my weaknesses and faults which stand between me and the ideal.' 'Are you reproaching yourself, then? Are you dissatisfied with yourself?' 'Yes indeed.' 'Since when?' 'Since I have been a member of the Theosophical Society and have been reading its publications. I always had a low opinion of myself.' 'What has made the strongest impression on you recently?' 'A translation from the Sanskrit which is just now coming out in installments.' A minute later I was being initiated into her mental struggles and her self-reproaches, and was hearing about a small episode which gave rise to a self-reproach—an occasion on which what had previously been an organic pain now for the first time appeared as the consequence of the conversion of an excitement. The pictures which I had first taken for phosphenes were symbols of trains of thought influenced by the occult and were perhaps actually emblems from the title-pages of occult books.

Hitherto I have been so warm in my praises of the achievements of pressure as an auxiliary procedure, and I have the whole time so greatly neglected the aspect of defence or resistance, that I may no doubt have created an impression that this little device has put us in a position to master the psychical obstacles to a cathartic treatment. But to believe this would be to make a serious mistake. Gains of this kind, so far as I can see, are not to be looked for in treatment. Here, as elsewhere, a large change requires a large amount of work. The procedure by pressure is no more than a trick for temporarily taking unawares an ego which is eager for defence. In all fairly serious cases the ego recalls its aims once more and proceeds with its resistance.

I must mention the different forms in which this resistance appears. One is that, as a rule, the pressure procedure fails on the first or second occasion. The patient then declares, very disappointedly: 'I expected something would occur to me, but all I thought was how tensely I was expecting it. Nothing came.' The fact of the patient putting himself on his guard like this does not yet amount to an obstacle. We can say in reply: 'It's precisely because you were too curious; it will work
hear a patient speak so disparagingly of something that has occurred to him. For it is an indication that defence has been successful if the pathogenic ideas seem, when they re-emerge, to have so little importance. From this we can infer what in the process of defence consisted: it consisted in turning a strong idea into a weak one, in robbing it of its affect.

A pathogenic recollection is thus recognizable, among other things, by the fact that the patient describes it as unimportant and nevertheless only utters it under resistance. There are cases, too, in which the patient tries to disown it even after its return. ‘Something has occurred to me now, but you obviously put it into my head.’ Or, ‘I know what you expect me to answer. Of course you believe I’ve thought this or that.’ A particularly clever method of disavowal lies in saying: ‘Something has occurred to me now, it’s true, but it seems to me as if I’d put it in deliberately. It doesn’t seem to be a reproduced thought at all.’ In all such cases, I remain unshakably firm. I avoid entering into any of these distinctions but explain to the patient that they are only forms of his resistance and pretexts raised by it against reproducing this particular memory, which we must recognize in spite of all this.

When memories return in the form of pictures our task is in general easier than when they return as thoughts. Hysterical patients, who are as a rule of a ‘visual’ type, do not make such difficulties for the analyst as those with obsessions.

Once a picture has emerged from the patient’s memory, we may hear him say that it becomes fragmentary and obscure in proportion as he proceeds with his description of it. The patient is, as it were, getting rid of it by turning it into words. We go on to examine the memory picture itself in order to discover the direction in which our work is to proceed. ‘Look at the picture once more. Has it disappeared?’ ‘Most of it, yes, but I still see this detail.’ ‘Then this residue must still mean something. Either you will see something new in addition to it, or something will occur to you in connection with it.’ When this work has been accomplished, the patient’s field of vision is once more free and we can conjure up another picture. On other occasions, however, a picture of this kind will remain obstinately before the patient’s inward eye, in spite of his having described it; and this is an indication to me that he still has something important to tell me about the topic of the picture. As soon as
elements of the picture were missing—its relation to himself or to the main contents of his thoughts—and that is why it remained unintelligible.

I will give one or two examples of the way in which a censoring of this kind operates when pathogenic recollections first emerge. For instance, the patient sees the upper part of a woman's body with the dress not properly fastened—out of carelessness, it seems. It is not until much later that he fits a head to this torso and thus reveals a particular person and his relation to her. Or he brings up a reminiscence from his childhood of two boys. What they look like is quite obscure to him, but they are said to have been guilty of some misdeed. It is not until many months later and after the analysis has made great advances that he sees this reminiscence once more and recognizes himself in one of the children and his brother in the other.

What means have we at our disposal for overcoming this continual resistance? Few, but they include almost all those by which one man can ordinarily exert a psychological influence on another. In the first place, we must reflect that a psychological resistance, especially one that has been in force for a long time, can only be resolved slowly and by degrees, and we must wait patiently. In the next place, we may reckon on the intellectual interest which the patient begins to feel after working for a short time. By explaining things to him, by giving him information about the marvellous world of psychological processes into which we ourselves only gained insight by such analyses, we make him himself into a collaborator; induce him to regard himself with the objective interest of an investigator, and thus push back his resistance, resting as it does on an affective basis. But lastly—and this remains the strongest lever—we must endeavour, after we have discovered the motives for his defence, to deprive them of their value or even to replace them by more powerful ones. This no doubt is where it ceases to be possible to state psychotherapeutic activity in formulas. One works to the best of one's power, as an elucidator (where ignorance has given rise to fear), as a teacher, as the representative of a freer or superior view of the world, as a father confessor who gives absolution, as it were, by a continuance of his sympathy and respect after the confession has been made. One tries to give the patient human assistance, so far as this is allowed by the capacity of one's own personality and by the amount of sympathy that one can feel for the particular case. It is an essential precondition for such psychological activity that we should have more or less divined the nature of the case and the motives of the defence operating in it, and fortunately the technique of insistence and pressure takes us as far as this. The more such riddles we have already solved, the easier we may find it to guess a new one and the sooner we shall be able to start on the truly curative psychological work. For it is well to recognize this clearly: the patient only gets free from the hysterical symptom by reproducing the pathogenic impressions that caused it and by giving utterance to them with an expression of affect, and thus the therapeutic task consists solely in inducing him to do so; when once this task has been accomplished there is nothing left for the physician to correct or to remove. Whatever may be required for this purpose in the way of counter-suggestions has already been expended during the struggle against the resistance. The situation may be compared with the unlocking of a locked door, after which opening it by turning the handle offers no further difficulty.

Besides the intellectual motives which we mobilize to overcome the resistance, there is an affective factor, the personal influence of the physician, which we can seldom do without, and in a number of cases the latter alone is in a position to remove the resistance. The situation here is no different from what it is elsewhere in medicine and there is no therapeutic procedure of which one may say that it can do entirely without the co-operation of this personal factor.

In view of what I have said in the preceding section about the difficulties of my technique, which I have unsparingly exposed (I brought them together, incidentally, from the severest cases; things often turn out very much more conveniently)—in view of all this, then, everyone will no doubt feel inclined to ask whether it would not be more expedient, instead of putting up with all these troubles, to make a more energetic use of hypnosis or to restrict the use of the cathartic method to patients who can be put under deep hypnosis. As regards the latter proposal I should have to answer that in that
case the number of suitable patients, so far as my skill is concerned, would dwindle far too much; and I would meet the first piece of advice with the suspicion that the forcible imposition of hypnosis might not spare us much resistance. My experiences on this point, oddly enough, have not been numerous, and I cannot, therefore, go beyond a suspicion. But where I have carried out a cathartic treatment under hypnosis instead of under concentration, I did not find that this diminished the work I had to do. Not long ago I completed a treatment of this kind in the course of which I caused a hysterical paralysis of the legs to clear up. The patient passed into a state which was very different physically from waking and which was characterized physically by the fact that it was impossible for her to open her eyes or get up till I had called out to her: 'Now wake up!' None the less I have never come across greater resistance than in this case. I attached no importance to these physical signs, and towards the end of the treatment, which lasted ten months, they had ceased to be noticeable. But in spite of this the patient's state while we were working lost none of its psychological characteristics—the capacity she possessed for remembering unconscious material and her quite special relation to the figure of the physician. On the other hand, I have given an example in the case history of Frau Emmy von N. of a cathartic treatment in the deepest somnambulism in which resistance played scarcely any part. But it is also true that I learnt from that lady nothing whose telling might have called for any special overcoming of objections, nothing that she could not have told me even in a waking state, supposing we had been acquainted for some time and she had thought fairly highly of me. I never reached the true causes of her illness, which were no doubt identical with the causes of her relapse after my treatment (for this was my first attempt with this method); and the only occasion on which I happened to ask her for a reminiscence which involved an erotic element [p. 79] I found her just as reluctant and untrustworthy in what she told me as I did later with any of my non-somnambulistic patients. I have already spoken in that lady's case history of the resistance which she put up even during somnambulism to other requests and suggestions of mine. I have become altogether sceptical about the value of hypnosis in facilitating cathartic

1 ['Psychical' in the first edition only; omitted in all the later editions.]

In what I have hitherto said the idea of resistance has forced its way into the foreground. I have shown how, in the course of our therapeutic work, we have been led to the view that hysteria originates through the repression of an incompatible idea from a motive of defence. On this view, the repressed idea would persist as a memory trace that is weak (has little intensity), while the affect that is torn from it would be used for a somatic innervation. (That is, the excitation is 'converted'.) It would seem, then, that it is precisely through its repression that the idea becomes the cause of morbid symptoms—that is to say, becomes pathogenic. A hysteria exhibiting this psychological mechanism may be given the name of 'defence hysteria'.

Now both of us, Breuer and I, have repeatedly spoken of two other kinds of hysteria, for which we have introduced the terms 'hypnoid hysteria' and 'retention hysteria'. It was hypnoid hysteria which was the first of all to enter our field of study. I could not, indeed, find a better example of it than Breuer's first case, which stands at the head of our case histories. Breuer has put forward for such cases of hypnoid hysteria a psychological mechanism which is substantially different from that of defence by conversion. In his view what happens in hypnoid hysteria is that an idea becomes pathogenic because it has been received during a special psychological state and has from the first remained outside the ego. No psychological force has therefore been required in order to keep it apart from the ego and no resistance need be aroused if we introduce it into the ego with the help of mental activity during somnambulism. And

1 [Some remarks on the length of the period during which Freud made use of the techniques of 'pressure' and hypnosis respectively will be found above in a footnote on p. 110 f.]

2 [The last nine words are omitted in the German collected editions, G.S., 1925 and G.W., 1952, in which the case of Anna O. is not included.]
will be about inherent difficulties for which we cannot hold the
patients responsible and which must be partly the same in a
hypnoid or retention hysteria as in the defence hysterias which
I have before my eyes as a model. I approach this last part of
my exposition with the expectation that the psychical char-
acteristics which will be revealed in it may one day acquire a
certain value as raw material for the dynamics of ideation.

The first and most powerful impression made upon one dur-
ing such an analysis is certainly that the pathogenic psychical
material which has ostensibly been forgotten, which is not
at the ego’s disposal and which plays no part in association and
memory, nevertheless in some fashion lies ready to hand and in
correct and proper order. It is only a question of removing the
resistances that bar the way to the material. In other respects
this material is known,¹ in the same way in which we are able
to know anything; the correct connections between the separate
ideas and between them and the non-pathogenic ones, which
are frequently remembered, are in existence; they have been
completed at some time and are stored up in the memory. The
pathogenic psychical material appears to be the property of
an intelligence which is not necessarily inferior to that of the
normal ego. The appearance of a second personality is often
presented in the most deceptive manner.

Whether this impression is justified, or whether in thinking
this we are not dating back to the period of the illness an
arrangement of the psychical material which in fact was made
after recovery—these are questions which I should prefer not
to discuss as yet, and not in these pages. The observations made
during such analyses can in any case be most conveniently and
clearly described if we regard them from the position that we
are able to assume after recovery for the purpose of surveying
the case as a whole.

As a rule, indeed, the situation is not as simple as we have
represented it in particular cases—for instance, where there is
one symptom only, which has arisen from one major trauma.
We do not usually find a single hysterical symptom, but a
number of them, partly independent of one another and partly
linked together. We must not expect to meet with a single

¹ ['Gewusst' ('known') in the first edition only. In all later German
editions 'bewusst' ('conscious') which seems to make much less good
sense.]
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traumatic memory and a single pathogenic idea as its nucleus; we must be prepared for successions of partial traumas and concatenations of pathogenic trains of thought. A monosymptomatic traumatic hysteria is, as it were, an elementary organism, a unicellular creature, as compared with the complicated structure of such comparatively severe\textsuperscript{1} neuroses as we usually meet with.

The psychological material in such cases of hysteria presents itself as a structure in several dimensions which is stratified in at least three different ways. (I hope I shall presently be able to justify this pictorial mode of expression.) To begin with there is a nucleus consisting in memories of events or trains of thought in which the traumatic factor has culminated or the pathogenic idea has found its purest manifestation. Round this nucleus we find what is often an incredibly profuse amount of other mnemonic material which has to be worked through in the analysis and which is, as we have said, arranged in a threefold order.

In the first place there is an unmistakable linear chronological order which obtains within each separate theme. As an example of this I will merely quote the arrangement of the material in Breuer's analysis of Anna O. Let us take the theme of becoming deaf, of not hearing. This was differentiated according to seven sets of determinants, and under each of these seven headings ten to over a hundred individual memories were collected in chronological series (p. 36). It was as though we were examining a dossier that had been kept in good order. The analysis of my patient Emmy von N. contained similar files of memories though they were not so fully enumerated and described. These files form a quite general feature of every analysis and their contents always emerge in a chronological order which is as infallibly trustworthy as the succession of days of the week or names of the month in a mentally normal person. They make the work of analysis more difficult by the peculiarity that, in reproducing the memories, they reverse the order in which these originated. The freshest and newest experience in the file appears first, as an outer cover, and last of all comes the experience with which the series in fact began.

I have described such groupings of similar memories into

\textsuperscript{1} ['Schweren' ('comparatively severe') in the first and second editions only; 'schwere' ('severe') in all later editions.]

collections arranged in linear sequences (like a file of documents, a packet, etc.) as constituting 'themes'. These themes exhibit a second kind of arrangement. Each of them is—I cannot express it in any other way—stratified concentrically round the pathogenic nucleus. It is not hard to say what produces this stratification, what diminishing or increasing magnitude is the basis of this arrangement. The contents of each particular stratum are characterized by an equal degree of resistance, and that degree increases in proportion as the strata are nearer to the nucleus. Thus there are zones within which there is an equal degree of modification of consciousness, and the different themes extend across these zones. The most peripheral strata contain the memories (or files), which, belonging to different themes, are easily remembered and have always been clearly conscious. The deeper we go the more difficult it becomes for the emerging memories to be recognized, till near the nucleus we come upon memories which the patient disavows even in reproducing them.

It is this peculiarity of the concentric stratification of the pathogenic psychological material which, as we shall hear, lends to the course of these analyses their characteristic features. A third kind of arrangement has still to be mentioned—the most important, but the one about which it is least easy to make any general statement. What I have in mind is an arrangement according to thought-content, the linkage made by a logical thread which reaches as far as the nucleus and tends to take an irregular and twisting path, different in every case. This arrangement has a dynamic character, in contrast to the morphological one of the two stratifications mentioned previously. While these two would be represented in a spatial diagram by a continuous line, curved or straight, the course of the logical chain would have to be indicated by a broken line which would pass along the most roundabout paths from the surface to the deepest layers and back, and yet would in general advance from the periphery to the central nucleus, touching at every intermediate halting-place—a line resembling the zig-zag line in the solution of a Knight's Move problem, which cuts across the squares in the diagram of the chess-board.

I must dwell for a moment longer on this last simile in order to emphasize a point in which it does not do justice to the

\textit{s.f. II—X}
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Nor does the treatment consist in extirpating something—psychotherapy is not able to do this for the present—but in causing the resistance to melt and in thus enabling the circulation to make its way into a region that has hitherto been cut off.

(I am making use here of a number of similes, all of which have only a very limited resemblance to my subject and which, moreover, are incompatible with one another. I am aware that this is so, and I am in no danger of over-estimating their value. But my purpose in using them is to throw light from different directions on a highly complicated topic which has never yet been represented. I shall therefore venture to continue in the following pages to introduce similes in the same manner, though I know this is not free from objection.)

If it were possible, after the case had been completely cleared up, to demonstrate the pathogenic material to a third person in what we now know is its complicated and multi-dimensional organization, we should rightly be asked how a camel like this got through the eye of the needle. For there is some justification for speaking of the 'defile' of consciousness. The term gains meaning and liveliness for—a physician who carries out an analysis like this. Only a single memory at a time can enter ego-consciousness. A patient who is occupied in working through such a memory sees nothing of what is pushing after it and forgets what has already pushed its way through. If there are difficulties in the way of mastering this single pathogenic memory—as, for instance, if the patient does not relax his resistance against it, if he tries to repress or mutilate it—then the defile is, so to speak, blocked. The work is at a standstill, nothing more can appear, and the single memory which is in process of breaking through remains in front of the patient until he has taken it up into the breadth of his ego. The whole spatially-extended mass of psychogenetic material is in this way drawn through a narrow cleft and thus arrives in consciousness cut up, as it were, into pieces or strips. It is the psychotherapist's business to put these together once more into the organization which he presumes to have existed. Anyone who has a craving for further similes may think at this point of a Chinese puzzle.

If we are faced with starting such an analysis, in which we have reason to expect an organization of pathogenic material like this, we shall be assisted by what experience has taught

1 'Überbestimm.' See footnote, p. 212.
us, namely that it is quite hopeless to try to penetrate directly to the nucleus of the pathogenic organization. Even if we ourselves could guess it, the patient would not know what to do with the explanation offered to him and would not be psychologically changed by it.

There is nothing for it but to keep at first to the periphery of the psychical structure. We begin by getting the patient to tell us what he knows and remembers, while we are at the same time already directing his attention and overcoming his slighter resistances by the use of the pressure procedure. Whenever we have opened a new path by thus pressing on his forehead, we may expect him to advance some distance without fresh resistance.

After we have worked in this way for some time, the patient begins as a rule to co-operate with us. A great number of reminiscences now occur to him, without our having to question him or set him tasks. What we have done is to make a path to an inner stratum within which the patient now has spontaneously at his disposal material that has an equal degree of resistance attaching to it. It is best to allow him for a time to reproduce such material without being influenced. It is true that he himself is not in a position to uncover important connections, but he may be left to clear up material lying within the same stratum. The things that he brings up in this way often seem disconnected, but they offer material which will be given point when a connection is discovered later on.

Here we have in general to guard against two things. If we interfere with the patient in his reproduction of the ideas that pour in on him, we may 'bury' things that have to be freed later with a great deal of trouble. On the other hand we must not over-estimate the patient's unconscious 'intelligence' and leave the direction of the whole work to it. If I wanted to give a diagrammatic picture of our mode of operation, I might perhaps say that we ourselves undertake the opening up of inner strata, advancing radially, whereas the patient looks after the peripheral extension of the work.

Advances are brought about, as we know, by overcoming resistance in the manner already indicated. But before this, we have as a rule another task to perform. We must get hold of a piece of the logical thread, by whose guidance alone we may hope to penetrate to the interior. We cannot expect that the free communications made by the patient, the material from the most superficial strata, will make it easy for the analyst to recognize at what points the path leads into the depths or where he is to find the starting-points of the connections of thought of which he is in search. On the contrary. This is precisely what is carefully concealed; the account given by the patient sounds as if it were complete and self-contained. It is at first as though we were standing before a wall which shuts out every prospect and prevents us from having any idea whether there is anything behind it, and if so, what.

But if we examine with a critical eye the account that the patient has given us without much trouble or resistance, we shall quite infallibly discover gaps and imperfections in it. At one point the train of thought will be visibly interrupted and patched up by the patient as best he may, with a turn of speech or an inadequate explanation; at another point we come upon a motive which would have to be described as a feeble one in a normal person. The patient will not recognize these deficiencies when his attention is drawn to them. But the physician will be right in looking behind the weak spots for an approach to the material in the deeper layers and in hoping that he will discover precisely there the connecting threads for which he is seeking with the pressure procedure. Accordingly, we say to the patient: 'You are mistaken; what you are putting forward can have nothing to do with the present subject. We must expect to come upon something else here, and this will occur to you under the pressure of my hand.'

For we may make the same demands for logical connection and sufficient motivation in a train of thought, even if it extends into the unconscious, from a hysterical patient as we should from a normal individual. It is not within the power of a neurosis to relax these relations. If the chains of ideas in neurotic and particularly in hysterical patients produce a different impression, if in them the relative intensity of different ideas seems inexplicable by psychological determinants alone, we have already found out the reason for this and can attribute it to the existence of hidden unconscious motives. We may thus suspect the presence of such secret motives wherever a breach of this kind in a train of thought is apparent or when the force ascribed by the patient to his motives goes far beyond the normal.

1 [In the first edition only, 'a quite inadequate'.]
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In carrying out this work we must of course keep free from the theoretical prejudice that we are dealing with the abnormal brains of "dégoûtés" and "ùséquilibres," who are at liberty, owing to a stigma, to throw overboard the common psychological laws that govern the connection of ideas and in whom one chance idea may become exaggeratedly intense for no motive and another may remain indestructible for no psychological reason. Experience shows that the contrary is true of hysteria. Once we have discovered the concealed motives, which have often remained unconscious, and have taken them into account, nothing that is puzzling or contrary to rule remains in hysterical connections of thought, any more than in normal ones.

In this way, then, by detecting lacunas in the patient's first description, lacunas which are often covered by 'false connections' [see below, p. 302], we get hold of a piece of the logical thread at the periphery, and from this point on we clear a further path by the pressure technique.

In doing this, we very seldom succeed in making our way right into the interior along one and the same thread. As a rule it breaks off half-way: the pressure fails and either produces no result or one that cannot be clarified or carried further in spite of every effort. We soon learn, when this happens, to avoid the mistakes into which we might fall. The patient's facial expression must decide whether we have really come to an end, or whether this is an instance which requires no psychical elucidation, or whether what has brought the work to a standstill is excessive resistance. In the last case, if we cannot promptly overcome the resistance we may assume that we have followed the thread into a stratum which is for the time being still impenetrable. We drop it and take up another thread, which we may perhaps follow equally far. When we have arrived at this stratum along all the threads and have discovered the entanglements on account of which the separate threads could not be followed any further in isolation, we can think of attacking the resistance before us afresh.

It is easy to imagine how complicated a work of this kind can become. We force our way into the internal strata, overcoming resistences all the time; we get to know the themes accumulated in one of these strata and the threads running through it, and we experiment how far we can advance with our present means and the knowledge we have acquired; we obtain preliminary information about the contents of the next strata by means of the pressure technique; we drop threads and pick them up again; we follow them as far as nodal points; we are constantly making up arrears; and every time that we pursue a file of memories we are led to some side-path, which nevertheless eventually joins up again. By this method we at last reach a point at which we can stop working in strata and can penetrate by a main path straight to the nucleus of the pathogenic organization. With this the struggle is won, though not yet ended. We must go back and take up the other threads and exhaust the material. But now the patient helps us energetically. His resistance is for the most part broken.

In these later stages of the work it is of use if we can guess the way in which things are connected up and tell the patient before we have uncovered it. If we have guessed right, the course of the analysis will be accelerated; but even a wrong hypothesis helps us on, by compelling the patient to take sides and by enticing him into energetic denials which betray his undoubted better knowledge.

We learn with astonishment from this that we are not in a position to force anything on the patient about the things of which he is ostensibly ignorant or to influence the products of the analysis by arousing an expectation. I have never once succeeded, by foretelling something, in altering or falsifying the reproduction of memories or the connection of events; for if I had, it would inevitably have been betrayed in the end by some contradiction in the material. If something turned out as I had foretold, it was invariably proved by a great number of unimpeachable reminiscences that I had done no more than guess right. We need not be afraid, therefore, of telling the patient what we think his next connection of thought is going to be. It will do no harm.

Another observation, which is constantly repeated, relates to the patient's spontaneous reproductions. It may be asserted that every single reminiscence which emerges during an analysis of this kind has significance. An intrusion of irrelevant mnemonic images (which happen in some way or other to be associated with the important ones) in fact never occurs. An exception which does not contradict this rule may be postulated for memories which, unimportant in themselves, are nevertheless

1 ['Degenerate' and 'unbalanced' persons. The view then currently held by French psychopathologists.]
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indispensable as a bridge, in the sense that the association between two important memories can only be made through them.

The length of time during which a memory remains in the narrow defile in front of the patient’s consciousness is, as has already been explained [p. 291], in direct proportion to its importance. A picture which refuses to disappear is one which still calls for consideration, a thought which cannot be dismissed is one that needs to be pursued further. Moreover, a recollection never returns a second time once it has been dealt with; an image that has been ‘talked away’ is not seen again. If nevertheless this happens we can confidently assume that the second time the image will be accompanied by a new set of thoughts, or the idea will have new implications. In other words, they have not been completely dealt with. Again, it frequently happens that an image or thought will re-appear in different degrees of intensity, first as a hint and later with complete clarity. This, however, does not contradict what I have just asserted.

Among the tasks presented by analysis is that of getting rid of symptoms which are capable of increasing in intensity or of returning: pains, symptoms (such as vomiting) which are due to stimuli, sensations or contractures. While we are working at one of these symptoms we come across the interesting and not undesired phenomenon of ‘joining in the conversation’. The problematical symptom re-appears, or appears with greater intensity, as soon as we reach the region of the pathogenic organization which contains the symptom’s aetiology, and thenceforward it accompanies the work with characteristic oscillations which are instructive to the physician. The intensity of the symptom (let us take for instance a desire to vomit) increases the deeper we penetrate into one of the relevant pathogenic memories; it reaches its climax shortly before the patient gives utterance to that memory; and when he has finished doing so it suddenly diminishes or even vanishes completely for a time. If, owing to resistance, the patient delays his telling for a long time, the tension of the sensation—of the desire to vomit—becomes unbearable, and if we cannot force him to speak he actually begins to vomit. In this way we obtain

1 [An example of this will be found in the case history of Fraulein Elisabeth von R. (p. 148). It is also mentioned by Breuer on p. 37.]

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a plastic impression of the fact that ‘vomiting’ takes the place of a psychical act (in this instance, the act of utterance), exactly as the conversion theory of hysteria maintains.

This oscillation in intensity on the part of the hysterical symptom is then repeated every time we approach a fresh memory which is pathogenic in respect of it. The symptom, we might say, is on the agenda all the time. If we are obliged temporarily to drop the thread to which this symptom is attached, the symptom, too, retires into obscurity, to emerge once more at a later period of the analysis. This performance goes on until the working-over of the pathogenic material disposes of the symptom once and for all.

In all this, strictly speaking, the hysterical symptom is not behaving in any way differently from the memory-picture or the reproduced thought which we conjure up under the pressure of our hand. In both cases we find the same obsessively obstinate recurrence in the patient’s memory, which has to be disposed of. The difference lies only in the apparently spontaneous emergence of the hysterical symptoms, while, as we very well remember, we ourselves provoked the scenes and ideas. In fact, however, there is an uninterrupted series, extending from the unmodified mnemic residues of affective experiences and acts of thought to the hysterical symptoms, which are the mnemic symbols of those experiences and thoughts.

The phenomenon of hysterical symptoms joining in the conversation during the analysis involves a practical drawback, to which we ought to be able to reconcile the patient. It is quite impossible to effect an analysis of a symptom at a single stretch or to distribute the intervals in our work so that they fit in precisely with pauses in the process of dealing with the symptom. On the contrary, interruptions which are imperatively prescribed by incidental circumstances in the treatment, such as the lateness of the hour, often occur at the most inconvenient points, just as one may be approaching a decision or just as a new topic emerges. Every newspaper reader suffers from the same drawback in reading the daily instalment of his serial story, when, immediately after the heroine’s decisive speech or after the shot has rung out, he comes upon the words: ‘To be continued.’ In our own case the topic that has been raised but not dealt with, the symptom that has become temporarily intensified and has not yet been explained, persists in the patient’s
mind and may perhaps be more troublesome to him than it has otherwise been. He will simply have to make the best of this; there is no other way of arranging things. There are patients who, in the course of an analysis, simply cannot get free of a topic that has once been raised and who are obsessed by it in the interval between two treatments; since by themselves they cannot take any steps towards getting rid of it, they suffer more, to begin with, than they did before the treatment. But even such patients learn in the end to wait for the doctor and to shift all the interest that they feel in getting rid of the pathogenic material on to the hours of treatment, after which they begin to feel freer in the intervals.

The general condition of patients during an analysis of this kind also deserves notice. For a time it is uninfluenced by the treatment and continues to be an expression of the factors that were operative earlier. But after this there comes a moment when the treatment takes hold of the patient; it grips his interest, and thenceforward his general condition becomes more and more dependent on the state of the work. Every time something new is elucidated or an important stage in the process of the analysis is reached, the patient, too, feels relieved and enjoys a foretaste, as it were, of his approaching liberation. Every time the work halts and confusion threatens, the psychical burden by which he is oppressed increases; his feeling of unhappiness and his incapacity for work grow more intense. But neither of these things happens for more than a short time. For the analysis proceeds, disdaining to boast because the patient feels well for the time being and going on its way regardless of his periods of gloom. We feel glad, in general, when we have replaced the spontaneous oscillations in his condition by oscillations which we ourselves have provoked and which we understand, just as we are glad when we see the spontaneous succession of symptoms replaced by an order of the day which corresponds to the state of the analysis.

To begin with, the work becomes more obscure and difficult, as a rule, the deeper we penetrate into the stratified psychical

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1 ['Es' ('he') in the first and second editions. 'Es' ('it', evidently a misprint) in the third edition. This was changed to 'Mann' ('one') in the 1924 edition, perhaps in order to make sense of the 'es'; but the meaning was now somewhat changed from the original one.]
analysis to keep my estimate of the reminiscence that comes up independent of the patient's acknowledgement of it. I shall never be tired of repeating that we are bound to accept whatever our procedure brings to light. If there is anything in it that is not genuine or correct, the context will later on tell us to reject it. But I may say in passing that I have scarcely ever had occasion to disavow subsequently a reminiscence that has been provisionally accepted. Whatever has emerged has, in spite of the most deceptive appearance of being a glaring contradiction, nevertheless turned out to be correct.

The ideas which are derived from the greatest depth and which form the nucleus of the pathogenic organization are also those which are acknowledged as memories by the patient with greatest difficulty. Even when everything is finished and the patients have been overborne by the force of logic and have been convinced by the therapeutic effect accompanying the emergence of precisely these ideas—when, I say, the patients themselves accept the fact that they thought this or that, they often add: 'But I can't remember having thought it.' It is easy to come to terms with them by telling them that the thoughts were unconscious. But how is this state of affairs to be fitted into our own psychological views? Are we to disregard this withholding of recognition on the part of patients, when, now that the work is finished, there is no longer any motive for their doing so? Or are we to suppose that we are really dealing with thoughts which never came about, which merely had a possibility of existing, so that the treatment would lie in the accomplishment of a psychical act which did not take place at the time? It is clearly impossible to say anything about this—that is, about the state which the pathogenic material was in before the analysis—until we have arrived at a thorough clarification of our basic psychological views, especially on the nature of consciousness. It remains, I think, a fact deserving serious consideration that in our analyses we can follow a train of thought from the conscious into the unconscious (i.e. into something that is absolutely not recognized as a memory), that we can trace it from there for some distance through consciousness once more and that we can see it terminate in the unconscious again, without this alternation of 'psychical illumination' making any change in the train of thought itself, in its logical consistency and in the interconnection between its various parts.

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Once this train of thought was before me as a whole I should not be able to guess which part of it was recognized by the patient as a memory and which was not. I only, as it were, see the peaks of the train of thought dipping down into the unconscious—the reverse of what has been asserted of our normal psychical processes.

I have finally to discuss yet another topic, which plays an undesirably large part in the carrying out of cathartic analyses such as these. I have already [p. 281] admitted the possibility of the pressure technique failing, of its not eliciting any reminiscence in spite of every assurance and insistence. If this happens, I said, there are two possibilities: either, at the point at which we are investigating, there is really nothing more to be found—and this we can recognize from the complete calmness of the patient's facial expression; or we have come up against a resistance which can only be overcome later, we are faced by a new stratum into which we cannot yet penetrate—and this, once more, we can infer from the patient's facial expression, which is tense and gives evidence of mental effort [p. 294]. But there is yet a third possibility which bears witness equally to an obstacle, but an external obstacle, and not one inherent in the material. This happens when the patient's relation to the physician is disturbed, and it is the worst obstacle that we can come across. We can, however, reckon on meeting it in every comparatively serious analysis.

I have already [p. 266] indicated the important part played by the figure of the physician in creating motives to defeat the psychical force of resistance. In not a few cases, especially with women and where it is a question of elucidating erotic trains of thought, the patient's co-operation becomes a personal sacrifice, which must be compensated by some substitute for love. The trouble taken by the physician and his friendliness have to suffice for such a substitute. If, now, this relation of the patient to the physician is disturbed, her co-operativeness fails, too; when the physician tries to investigate the next pathological idea, the patient is held up by an intervening consciousness of the complaints against the physician that have been accumulating in her. In my experience this obstacle arises in three principal cases.

(1) If there is a personal estrangement—if, for instance, the
IV. PSYCHOTHERAPY OF HYSTERIA (FREUD) might boldly take the initiative and give her a kiss. On one occasion, at the end of a session, a similar wish came up in her about me. She was horrified at it, spent a sleepless night, and at the next session, though she did not refuse to be treated, was quite useless for work. After I had discovered the obstacle and removed it, the work proceeded further; and lo and behold! the wish that had so much frightened the patient made its appearance as the next of her pathogenic recollections and the one which was demanded by the immediate logical context. What had happened therefore was this. The content of the wish had appeared first of all in the patient's consciousness without any memories of the surrounding circumstances which would have assigned it to a past time. The wish which was present was then, owing to the compulsion to associate which was dominant in her consciousness, linked to my person, with which the patient was legitimately concerned; and as the result of this misalliance—which I describe as a 'false connection'—the same affect was provoked which had forced the patient long before to repudiate this forbidden wish. Since I have discovered this, I have been able, whenever I have been similarly involved personally, to presume that a transference and a false connection have once more taken place. Strangely enough, the patient is deceived afresh every time this is repeated.

It is impossible to carry any analysis to a conclusion unless we know how to meet the resistance arising in these three ways. But we can find a way of doing so if we make up our minds that this new symptom that has been produced on the old model must be treated in the same way as the old symptoms. Our first task is to make the 'obstacle' conscious to the patient. In one of my patients, for instance, the pressure procedure suddenly failed. I had reason to suppose that there was an unconscious idea of the kind mentioned under (2) above, and I dealt with it at the first attempt by taking her by surprise. I told her that some obstacle must have arisen to continuing the 'treatment,' but that the pressure procedure had at least the power to show her what this obstacle was; I pressed on her head, and she said in astonishment: 'I see you sitting on the chair here; but that's nonsense. What can it mean?' I was then able to enlighten her. With another patient the 'obstacle' used not to appear directly as a result of my pressure, but I was always able to discover it if I took the patient back to the moment at which it had
originated. The pressure procedure never failed to bring this moment back for us. When the obstacle had been discovered and demonstrated the first difficulty was cleared out of the way. But a greater one remained. It lay in inducing the patient to produce information where apparently personal relations were concerned and where the third person coincided with the figure of the physician.

To begin with I was greatly annoyed at this increase in my psychological work, till I came to see that the whole process followed a law; and I then noticed, too, that transference of this kind brought about no great addition to what I had to do. For the patient the work remained the same; she had to overcome the distressing affect aroused by having been able to entertain such a wish even for a moment; and it seemed to make no difference to the success of the treatment whether she made this psychical repudiation the theme of her work in the historical instance or in the recent one connected with me. The patients, too, gradually learnt to realize that in these transferences on to the figure of the physician it was a question of a compulsion and an illusion which melted away with the conclusion of the analysis. I believe, however, that if I had neglected to make the nature of the 'obstacle' clear to them I should simply have given them a new hysterical symptom—though, it is true, a milder one—in exchange for another which had been generated spontaneously.

I have now given enough indications, I think, of the way in which these analyses have been carried out and of the observations that I have made in the course of them. What I have said may perhaps make some things seem more complicated than they are. Many problems answer themselves when we find ourselves engaged in such work. I did not enumerate the difficulties of the work in order to create an impression that, in view of the demands a cathartic analysis makes on physician and patient alike, it is only worth while undertaking one in the rarest cases. I allow my medical activities to be governed by the contrary assumption, though I cannot, it is true, lay down the most definite indications for the application of the therapeutic method described in these pages without entering into an examination of the more important and comprehensive topic of the treatment of the neuroses in general. I have often in my own mind compared cathartic psychotherapy with surgical intervention. I have described my treatments as psychotherapeutic operations; and I have brought out their analogy with the opening up of a cavity filled with pus, the scraping out of a carious region, etc. An analogy of this kind finds its justification not so much in the removal of what is pathological as in the establishment of conditions that are more likely to lead the course of the process in the direction of recovery.

When I have promised my patients help or improvement by means of a cathartic treatment I have often been faced by this objection: 'Why, you tell me yourself that my illness is probably connected with my circumstances and the events of my life. You cannot alter these in any way. How do you propose to help me, then?' And I have been able to make this reply: 'No doubt fate would find it easier than I do to relieve you of your illness. But you will be able to convince yourself that much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life\textsuperscript{1} that has been restored to health you will be better armed against that unhappiness.'

\textsuperscript{1} [The German editions previous to 1925 read 'nervous system'.]