

A PSYCHOANALYTIC STUDY OF A SEVERE CASE OF HYSTERIA

(Concluded)

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AN actual psychoanalysis is always far more complex and persistently difficult than one is led to suppose by the smooth account of the abstract theory.

The present case is no exception. But as one aim of this report is to be as concrete as possible, that is an advantage.

Most serious traumas have been revealed. There remains, however, to show their far-reaching effects; and to show also the nature of the present conflict. The present conflict is one of the most important aspects of the psychoneurosis from the point of view of therapeutics.

Before entering upon the final stage of the analysis, however, it will be well, I think, to recapitulate, in brief, chronologically, the psycho-sexual traumas and childhood habits, the repression of which caused the hysteria.

AGE	TRAUMA
7.....	Masturbated by father and probable beginning of incestuous relations with brother.
10.....	Sexually assaulted and masturbated by two men in woods.
13.....	Sexually assaulted by a neighbor.
18.....	Seduced by lover.
19.....	Mother's confession.
23.....	Solicited by father.

To this must be added the childhood habits which contribute to the present conflict. The patient began to masturbate herself about the same age her father masturbated her. (She said it was just after.) At about this time the

patient also began to have frequent incestuous relations with her brother. And, finally, the patient said the return of the convulsions, for relief of which she came to me, were preceded by her father's coming into her room one day, making sexually expressive movements and offering to pay her money if she would let him do as he liked. She was terribly frightened and drove him out of her room. That night, she said, her convulsions returned, after a remission of two years, following her mother's death.

With these facts in mind we will now conclude the analysis. In this connection the following dream is significant:

"I was going from place to place trying to forget, but I couldn't, as it seemed as if every one knew some way. I got discouraged, so took my life. Then it was as if I traveled a long ways and went through a lot of trouble — I don't know what. At last it seemed I got to the end and asked some one where I was. They said it was heaven. Then I went in search for mother. I found her. I asked her if I had done right; she said yes. Just then it seemed as if some one separated us and put fire between us, and said if I could go by that I could be with her. I wouldn't after that have anything to do with her, but turned and went with this person."

During the same night she had a second dream:

"I dreamed my promise was taken away from me so that I was free to talk as I wished. I was really happy. I woke up then and decided to talk everything out; then I went to sleep and when I woke up again I couldn't speak." This aphonia lasted a day.

The patient said that the previous afternoon she had written out what her mother had told her and was thinking whether she should give it to me or not. At the next interview the following dream was reported: The patient and her mother were swimming together in dirty water. There was fresh, clean water in the distance which she was trying to reach, but her mother kept trying to drag her down. Later in the night she dreamed she was a pure girl.

The vomiting has continued, though not so badly. There have been no auditory hallucinations for two days, but this

morning the patient heard her mother calling her. She has had visual hallucinations of her mother, however, and last night thought she was in heaven with her mother and brother. She tried hard, she said, to get out of it, but the minute she gave up trying she merged back. She said she wanted to go insane. She wanted to die. The afternoon before while in a dream-like state she bit badly her right forefinger. The morning of the interview she bit off part of a needle and accidentally swallowed the blunt end.

At the next interview the patient told the details of her mother's confession. This seemed somewhat to relieve her. The next day, however, the patient came to me with her right arm bandaged: she had bitten herself badly four or five times during the night. This suggested a trait of character which had previously not been suspected. A little questioning revealed considerable capacity for revenge and cruelty, though here, of course, directed against herself. The masochistic significance of this will be much clearer later. The patient told me that when she was about fifteen, in a fit of anger she tore all of her father's shirts to pieces. She said she often wanted to kill him, and had thought how easy it would be to do so with a knife, pistol or poison. One time she cut holes in her father's pockets so he would lose his money. She started to set the house on fire several times. Once she had cotton soaked in oil, and took it to her father's room and lighted it, but then put it out. Just after her mother confessed her sexual sins to her she knocked over a lighted lamp. They thought it was accidental. She said she couldn't make me understand how cruel and revengeful she used to feel, and does now, at times.

At the next interview the patient said she had not bitten herself. She related the three following significant dreams (1) She dreamed she and her brother agreed to take poison together. She took hers, but he did not take his, and she reproached him, because, she said, he was the only one she ever loved, and now he had failed her. She woke thinking she was dying. (2) In the next dream she thought she was going to heaven, climbing a long flight of stairs. Finally she got there and was being shown around by a guide. Then he said she must see hell, and they started downstairs. After

awhile she could not go any further, and began to fall. She woke falling. (3) Dreamed she was masturbating herself. The next day she said she had bitten herself once, but not very badly. On the day following she told me she had wakened about five A.M., biting herself. For an instant she knew that *she was trying to bite her hand off so she couldn't masturbate any more*. She knew, too, in this instant that she had just been masturbating, in her sleep, and had been, more or less frequently, all her life. She knew, too, that that was what came before her eyes when she had the last convulsion; she knew that was why she was so nauseated (she was disgusted with herself); she knew the meaning of the pregnancy dream, and all together, this was too much for her — *she fainted*. She was easily brought to consciousness, however, by a nurse giving her some water.

For the significance of the pregnancy dream we must go back a little.

When I asked her if she knew one of the symptoms of pregnancy, she said, "Yes, vomiting." Then she remembered she had dreamed something about pregnancy, and a baby, during the night, and again when asleep in the morning. The next day she said she had dreamed she had a baby. The next night she dreamed she was with Dick, her lover, and the following night she dreamed again of pregnancy. She now remembered that when she saw her lover for the last time, in her friend's house, he asked her what she was going to do now she was pregnant. He used this as an argument in an attempt to persuade her to let him have his way with her again. She was terribly frightened, and denied that she was pregnant. She said, "It kind of seems as if the dream had something to do with what Dick told me.— I think of one, then I think of the other, and it kind of seems as if they draw together, only I can't get how they would go together — I know what he said made me dream that — I know it is that because my stomach is all upset now thinking about it."

The next day she remembered that after Dick told her she was pregnant, she often dreamed she was, and would wake terrified and trembling, sick all over. She used to ask her mother, in roundabout ways, to find out, if she could,

how one could tell, but her mother always avoided the subject. The first time she associated vomiting with pregnancy was the summer before she first came to me, when a young married friend of hers was visiting her and was sick and told her why. She added, "It does seem like a wish, and a dream, what Dick said, pregnancy and a baby, all mixed up, and I can't connect it up." The next day everything was clear to her. After dinner she was dozing in a chair when it came over her that what she was dreaming was: *being pregnant*. Then she remembered that after Dick accused her she thought of what had already happened and thought she might as well have a baby anyway, and so began wishing and hoping she would.

Now comes the conscious struggle, the present conflict, so emphasized by Jung. The dream of the next night shows this. The patient saw her mother in the sky and started to rise toward her. As she rose she had to keep dropping things to get higher. The things she seemed to be dropping were the things she had been through and done. Finally, she came to a cloud and had to drop something, but woke trying, for she couldn't seem to let go. Later, she dreamed she was in the woods. There was a great bowl, hewn out of granite. She had a big fire in it and was burning snakes, when suddenly one jumped out and into her mouth. She woke trying to get it out. She was very sick and vomited. *She had been sucking her thumb*. The next night she woke three or four times as she was just about to masturbate — (or just had, she did not know which). She now acknowledged having masturbated a great deal lately. She said she had been sick all the morning, nauseated by her failure. "I'm discouraged, and deep down in my heart I don't want to try," was her final cry. That night she dreamed she was cutting herself up. She cut off her hands, legs, body, etc. "It seemed as if I was two people," she said, "and I was lying on the table, yet I was standing there cutting myself up." She woke as she was chopping her body into bits.

The following night she dreamed of destroying herself. "It seemed as if I came out of myself and tried in a number of ways to get rid of my old self." (1) She tried to cut herself up, but could make no impression on the body;

(2) she tried to set fire to the body with a torch, but it would not burn; (3) then she tried to drown herself, but the body would float, so she got a boat and brought it to shore, and (4) tried to bury it, but could not dig deep enough, or fast enough, because the earth kept filling in. Then she woke.

A few days later, the vomiting being much improved, and no other new symptoms manifesting themselves, the patient was discharged.

I. CONFLICT

All psychoneurotic symptoms . . . must be taken as wish-fulfillments of the unconscious. . . . The symptom is not merely the expression of a realized unconscious wish, but it must be joined by another wish from the foreconscious which is fulfilled by the same symptom; so that the symptom is at least doubly determined, once by each one of the conflicting systems. . . . The determination not derived from the unconscious is, as far as I can see, invariably a stream of thought in reaction against the unconscious wish, *e. g.*, a *self-punishment*.¹

Conflict, then, according to Freud, is the situation out of which arises hysteria. Is this the situation in the present case? That it is can hardly be open to doubt. From the point of view of "self-punishment," the biting becomes clearly understandable. So with the convulsions; beating the head upon the floor, tearing out the hair, etc.,—here is a self-inflicted punishment that satisfies at the same time the overwhelming desire for sexual satisfaction. Here we have concrete material similar to that from which Freud deduced the following formulæ:²

"The hysterical symptom serves as a sexual gratification," and "The hysterical symptom results as a compromise between two opposing affects or impulse incitements, one of which strives to bring to realization a partial impulse, or a component of the sexual constitution, while the other strives to suppress the same." It is from this point of view

¹Freud: *Traumdeutung*, translated by Brill, p. 449.

²Freud: *Selected Papers on Hysteria*, translated by Brill, p. 198.

of conflict that the hysterical paralysis becomes intelligible. The paralysis is the external manifestation of the balance of two opposing impulses. In our patient the two impulses were: (1) The tendency of becoming conscious of the repressed memories and fancies, and satisfying her cravings. (2) The determination to keep these ideas out of mind. These ideas were associatively closely related to the ideas of the voluntary control of the legs. Rather than allow any such painful ideas as those we now know, to come to consciousness, the whole system was violently excluded from the realm of conscious control. One can hardly refrain from conceiving this process as a disconnection of some sort, where the kinesthetic ideas necessary to voluntary motion are rigidly held out of consciousness. Aphonia, too, and hysterical amaurosis, are external manifestations of the same balance of conflicting impulses. To talk at all would mean to tell, to tell would mean to know, therefore, talking is inhibited; to see would mean painful knowledge; seeing, therefore, is inhibited. The hysterical contraction, the clenched fist, too, manifest the conflict.

II. DEFENSE: REPRESSION

It is clear that what the ego-consciousness tries to do in any psychic conflict is to defend itself against mental distress. This defense may be active, passive, or partly one and partly the other. From this point of view, hysterical phenomena become still more fully understandable. In the case under consideration, the unbearable ideas, against which the ego-consciousness tried to defend itself were sexual. They were memory images of sexual traumas which constantly tended to come into consciousness. Freud says it is only "ideas of a sexual content which can be repressed," and the reason he gives is as follows:

"It is known that ideas of a sexual content produce exciting processes in the genitals resembling the actual sexual experience. It may be assumed that this somatic excitement becomes transformed into psychic. As a rule the activity referred to is much stronger at the time of the occurrence than at the recollection of the same. But if the sexual experience takes place during the time of sexual

immaturity and the recollection of the same is awakened during or after maturity, the recollection then acts as disproportionately more exciting than the previous experience, for puberty has in the meantime incomparably increased the reactive capacity of the sexual apparatus."¹

Whether Freud is right or not in generalizing his etiology of hysteria, certainly the case under discussion conforms to that picture. The unbearable ideas against which the patient tried, unsuccessfully, to defend herself were unmistakably sexual. So far as consciousness was concerned, the defense was successful, but it was at a heavy cost otherwise.

The way the ego defends itself against the admission of the unbearable idea is by repression. This power of repression is reflexly automatic, like the contracting of the pupil at a flash of light. It is this power that induces Freud to characterize consciousness as a perceptive organ.² Just as the eye may refuse to see, so may consciousness refuse to know. And, like the eye, it can do this in two ways — (1) close; (2) turn away. Hysterical fainting and blindness are illustrations of the former, and turning one's attention to symbolical physiological processes and actions illustrates the latter. Like the eye, too, consciousness acts automatically as well as voluntarily. This was illustrated innumerable times during the analysis when the patient tried to see but could not. She described the process as like a cloud coming, or a veil, before her mind. At other times her mind snapped shut like a camera shutter. This "closure" also applied to the throat and to the hand. That repression can be so completely successful as to exclude totally from consciousness such moving memories as have been uncovered by the psychoanalysis seems highly incredible. The only convincing proof that I know of, that such is the fact, lies in personal experience. When Galileo invented the telescope, nobody believed he saw what he said he saw until they looked themselves. So with repressions; their proof lies in looking, psychoanalytically. Logically, one might expect a close correspondence between the severity of the symptoms

¹*Selected Papers on Hysteria*, translated by Brill, p. 159.

²Freud: *Traumdeutung*, translated by Brill, p. 488.

and the seriousness of the psychosexual traumas. That a repression may be deep enough to cause a febrile condition seems established by the hysterical fever in this patient, lasting over a month. What connection this may have with the heat centers can, of course, be only conjectured. According to Freud, "it is just this transformation of affect that constitutes the nature of what we designate as 'repression.'"¹ The affect is thus dislocated from its proper idea. Then the idea, transformed from a strong one into a weak one, can be repressed. But the affect is not thereby destroyed. It is like the electric charge in the Leyden jar, ready to manifest itself with explosive violence when the resistance is lowered. Physiologically, resistance is inhibition. From this point of view the hysteric shows an unusual capacity for inhibition. "Inhibition is a *vera causa*, of that there can be no doubt," says James: "The pneumo-gastric nerve inhibits the heart, the splanchnic inhibits the intestinal movements, and the superior laryngeal those of inspiration. The nerve irritations which may inhibit the contraction of arterioles are innumerable, and reflex actions are often repressed by the simultaneous excitement of other sensory nerves."² And as James says in another place, the very essence of consciousness is dynamic. Thus, impulse and inhibition go hand in hand in making up our mental life. Reasoning from the known to the unknown, Freud deduced "repression" from observed "resistance."

"It is on this idea of *resistance* that I based my theory of the psychic processes of hystericals. It had been found that in order to cure the patient it was necessary that this force should be overcome. Now, with the mechanism of the cure as a starting point, quite a definite theory could be constructed. These same forces, which in the present situation as resistances opposed the emergence of the forgotten ideas into consciousness, must themselves have caused the forgetting, and repressed from consciousness the pathogenic experiences. I called this hypothetical process 'repression' (*Verdrängung*), and considered that it was

¹Freud: *Traumdeutung*, translated by Brill, p. 479.

²Wm. James: *Principles of Psychology*, Vol. I, p. 67.

proved by the undeniable existence of resistance."¹ We shall take up the question of resistance again. Let us now turn to the psychological result of repression, the splitting of consciousness.

III. DISSOCIATION

What at first was, perhaps, only partially successful, *i. e.*, the repression of an unbearable idea, may become finally so completely successful that the mind becomes actually separated into independent parts.

"This division of the mind into independent fragments, which are not co-ordinated together to attain some common end, is termed 'Dissociation of Consciousness,' " says Bernard Hart.²

As Freud says, the patient naturally does not intend to split his consciousness he intends only to rid himself of distress, but what he actually accomplishes is dissociation. In our patient the various symptoms are interpreted as the end products of the activity of such split-off psychic groups. From this point of view the "St. Vitus Dance" is quite intelligible, when the patient tells us that it started by her running around and around the supper-table, falling down, and getting up; it is but the reproduction of the run in the woods when chased and assaulted. Here the psychic group, or complex, to use Jung's term, gained almost complete control of the motor mechanism and used it for its own expression. We have already seen how the other symptoms may be understood as the end-product of the innervation of such split-off psychic groups. This suggests that such splitting as takes place is like horizontal stratification. From this point of view the various symptoms in the case under discussion are of some significance as suggesting degrees of psychic depth, and extent of dissociation.

Fainting	Aphonia
"St. Vitus Dance"	Amaurosis
Convulsions	Fever
Vomiting	Hallucinations (visual and auditory)
Paraplegia	Self-mutilation by biting and cutting
Contracture	Chorea

¹Freud: *Origin and Development of Psychoanalysis*. Lectures and Addresses at Clark University, 1909, p. 13.

²*The Psychology of Insanity*, p. 42.

A law of repressed complexes, dissociated from consciousness, seems to be that complexes of like quality fuse. In this case the fusion is very clear. Each sexual experience joins the previous ones, so to speak, and fusing with them is kept beneath the surface of consciousness. Emerging into consciousness, the various complexes appear at first like superposed views, where parts of one and parts of others stand out in apparently hopeless confusion. Psychoanalysis does exactly what the word implies, analyzes the fused complexes into their experiential elements. The reason for this fusion may, perhaps, be formulated as follows: The nucleus of the complex is an affect. This affect has a great many experiences and thoughts associated with it. The stronger the affect, the more it can hold to itself, as the stronger a magnet, the more filings it can attract and hold. If now, following Freud, we regard consciousness as a perceptive organ, it is clear that the stronger the affect is and the more it implies, the more confusing will be the first view that consciousness may attempt to take. Consciousness, so far as it is directed towards the past, and perceives this past as memories, strips the remembered experiences of temporal quality and sees them all at once. But memory, like any other function proper to consciousness, is limited in the amount it can handle at any one moment, and, hence, if there is a great deal to remember, all of which is of high affectivity, the first attempts at such functioning will seem necessarily confused and confusing. The affectivity appropriate to the particular memory sought would act on the organ perceiving it as the heat of the sun, say, acts on the artificial organs, or instruments, such as telescopes, bolometers, etc., directed towards observing its characteristics. Following the figure a little further, the appropriate affectivity interferes with a clear memory image as the brightness of the sun interferes with direct vision. Thus, glimpses only are at first possible; hence the confusion.

IV. MANIFESTATIONS OF REPRESSED COMPLEXES

A. Conversion

In patients provided with a suitable mechanism the repressed complex manifests itself by bodily acts involuntarily initiated. This constitutes the hysterical symptom. Hence, reading backward, one has to interpret the symptom as a symbolical act signifying the complex striving for full expression. It is as if the split-off psychic group had gained temporary possession of the motor mechanism of the individual. Inasmuch as the movements seen are the end results of unconscious psychic processes, they are often quite unintelligible. Sometimes, in simple cases, they are almost obvious; for instance, the clenched fist of the angry person. In the subject of the present study the patient showed a rich assortment of conversions. The "St. Vitus Dance," convulsions, aphonia, vomiting, contracture and paralysis, amaurosis, biting, etc., all are protean processes manifesting the existence of the suppressed memories. Through this conversion the psyche relieves itself of unbearable emotional distress. It is like an explosion. Pressure has risen until a part of the resistance has given way before it. After the explosion there is great relief in the lowered and restored emotional equilibrium. After five convulsions during the day the patient would sleep quietly and peacefully during the night. From this point of view the emotional pressure of the repressed complexes would seem to be cumulative. Experiences and thoughts, instead of passing off lightly through superficial conscious associative thinking, would sink in, so to speak, until it was as if the whole being of the person were saturated with a highly dynamic and explosive substance. In self-defense against this explosive manifestation of her thoughts and experiences the patient, one might say, split off the conscious level of her mind from all association whatever with anything below the surface: hence, the paralysis. It is interesting to note that while the legs were paralyzed, the hand was contracted. If one may be permitted a rather fanciful flight of the imagination, one might imagine that by the contraction of the hand the patient narrowed her consciousness at the corres-

ponding higher level, and thus kept out all memories of anything associated with her body at any lower level. This has a certain anatomical correspondence as well as ideational.

Similarly with the aphonia and the amaurosis, one can think of contractile processes, or narrowing of consciousness for purposes of defense. The psyche, or ego-consciousness, showed that it would do almost anything in the way of self-delimitation rather than face itself as a whole.

As we saw above, when we were discussing conflicts, the manifestation of the repressed complex in the hysterical symptom is of the nature of a compromise. The primary psychic system expresses itself, but only by means which will pass the censorship of the secondary psychic system. This is one reason the symptom is so baffling to reason, so unintelligible. It is like an intersection point. A point is the intersection of an infinite number of lines. So a symptom may be a compromise between an innumerable number of conflicts. And just because it is so symbolical is it hard properly to interpret. For this reason, probably, in the past, the symptom was regarded purely physiologically and as non-intelligible. The doctrine of symbols seems to have been one of the worst stumbling-blocks to a more general acceptance of the Freudian psychology. One reason is, I think, the too intellectual way of taking symbols. In our patient, beating her head upon the floor, tearing out her hair, was not an intellectually chosen conversion symbolizing self-punishment, but it was the concrete living through of an action which gave, at once, sexual satisfaction and self-punishment. To rave, and beat one's head, and tear one's hair is concrete self-abuse, symbolically, self-punishment. Thus the patient fools herself, and incidentally, learned doctors. The attempt at biting her hand off for the *purpose* of preventing further masturbation was observed by the patient and intelligently understood, so far as this conscious purpose went. But what she failed to see was that the act was also an enhancing of sexual excitement and its attendant satisfaction through masturbation. In the realm of symbolization anything may mean anything else, and the specific symbolism depends on the concrete case. Pelletier has said that "symbolical thinking is the lowest

form of thought."¹ This is what one might expect would be the case with isolated psychic processes. But it is not the symbolical character of hysterical thought that classes it so low, for all thinking is symbolical, but it is the unsocial character of the thought, the independent isolation from socially sanctioned meanings. The greatest endeavor of the hysteric is to avoid self-conscious thinking, and the very essence of self-consciousness is dependent on social relations, hence the unintelligibility of the end-product of uninterpreted unconscious thought. The end-product of all thought is an action of some sort or other. The hysteric chooses the grossest forms for this expression and thus conceals the more refined and higher meanings. This regression to more elemental forms of expression is very unpleasant to the trained thinker who has labored strenuously for long years to escape just that crude, gross, and infantile form of thinking and acting. But the highly trained thinker errs egregiously if he thinks the highest form of thinking and its expression differs in any essential way from the lowest. The difference is one of degree of refinement and subtlety of meaning.

B. Dreams

There are two varieties of symbols that interest us here: (1) The symbolical action. (2) The symbolical thought. We have been considering the symbolical action, now let us consider symbolical thought. The most significant examples of this second variety of symbolization are dreams. As Freud has shown, the *via regia* to the unconscious lies through dreams. If now we turn to the dreams of our patient, we can see exemplified all of Freud's laws about dreams. That the dream is a wish-fulfilment is obvious in the present case, now that we know what the patient's repressed complexes are. That the dream is a compromise psychic formation, expressive of the censorship of the higher secondary psychic process, which we call the ego or self-conscious ethical pretensions of the dreamer, is also clear in this case. Thus, the similarity of the dream to the hysterical symptom is, perhaps, more apparent. Besides being a compromised, and hence

¹Quoted by Jung: *Psychology of Dementia Praecox*.

concealed, manifestation of the wishes of the dreamer, the dream is also a more or less confused memory of childhood experiences. This is abundantly proved by the dreams of our patient. The running and stumbling dream; the dream of hiding with her brother; the "troubled" dream, these, and many others, show that one source of their material lies in childhood. The four laws of dream formation — (1) condensation; (2) displacement, (3) dramatization, and (4) secondary elaboration, are all manifested in the dreams of the patient. It is significant that the clue to the repressed brother complex was gained by a report of what the patient had called out at night during sleep. The patient herself had no consciousness of the significance of her words, nor any memory of having said them. This talking in her sleep seems to mean that the psychical processes underlying it had not reached the level of a dream formation. This, of course, does not rule out what might have been the case, *i. e.*, that the consciousness associated with the words, "Why did you do it?" was dissociated from the higher psychic processes and so lapsed into the unconscious with waking.

Two dreams of the patient's seem to be especially significant as corroborating Freud's observations: I mean the dream of biting off the hand, and the dream of a snake jumping into her mouth. The "biting" dream was one where dream and reality seemed to merge. Here the four laws are clear, and especially the difference between the manifest and latent content of dreams. A desire for masturbation was the motive power of this dream, or the latent content, while the biting was the manifest content, elaborated secondarily into an ethical purpose. The snake dream similarly was reality and dream mixed, and clearly the snake in her mouth was symbolical of her thumb, for she was sucking her thumb just before, or at the time. Sucking was an infantile habit prolonged into late childhood, for she used to suck her skin till it produced sores, and unlike most children she was very fond of snakes and played with them and made pets of them.

The connection between night dreams and day dreams was very close in our patient. Especially significant, perhaps, was the dream of pregnancy. Here the dream was not

even remembered until the patient began to seek the significance of vomiting, and found it a symptom of pregnancy. Then came the sudden illumination wherein she saw the subject of one of her most insistent day dreams.

V. ANALYSIS

The patient being not very highly intelligent, of an extremely sluggish mentality, the technique of the treatment was largely an analysis of her dreams. Analysis by free association methods was extremely difficult, because of the enormous resistances developed at every step. It was assumed, from the beginning, that Freud's theory of dreams was correct, and, so far as this patient is concerned, at least, the assumption was proved to be sound. The most striking thing about this analysis was the impossible-to-be-exaggerated resistance. Resistance, of course, was to be expected, but such resistance! It seemed almost unintelligible. But certainly without the resistance the repression is unintelligible. The work of the analysis was almost wholly one of urging. It was more like drilling into rock and blasting than like any intellectual endeavor. Some idea of the labor involved may be gained by the time it took. One deduction which it seems possible to make in this case is that the patient has remarkable powers of concentration. This is certainly one element of intellectual power. If she could have put forth a tithe of the mental effort necessary to the repressions to more useful work she might have amounted to a great deal.

The question of method is indeed most important. Simple questioning started the analysis. The most objective, superficial answers were, of course, at first given. This abstract objectivity applied as well to the feelings and symptoms as to assumed environment and external causes. It was not until the fifth interview that any mention of sex matters was made at all, and only then was a question ventured following a significant remark of the patient's: "I didn't know anything about badness between man and wife." I asked, "What do you know about badness between man and wife?" This question opened up the way to much information as to the father and the patient's relation to him.

In working with a patient my method always is, so far as practicable, to follow up actual suggestions made by the patient. It is not what the patient "ought" to think or feel, that is sought, but what is actually felt and thought.

The next significant move that was made, in the matter of method, was putting my hands over the eyes of the patient in order to force her to look at the images that came before her mind. This brings up a second point in technique. Where resistances manifest themselves, there effort should be made to overcome them. The resistance in this case consisted in the patient's absolutely refusing to keep her eyes shut more than a moment at a time. It was obvious that just as soon as she shut her eyes she saw something that was distressing. To look at this image long enough to describe it was essential, and it was for that purpose that I forcibly held her eyes shut. This was a modification of the method first used by Freud, where he pressed the temples of his patients and told them that at the moment of pressure they would see something and think of something which they must tell and which would be important for the analysis. Freud has since abandoned this detail of technical procedure. With the exception of this one patient I have always followed Freud's later procedure. In this case, however, the resistances developed were so strong, I simply lost patience. Whether it was an error in method, or not, I am unable to decide. The immediate practical result was two-fold: First, I did succeed in getting by the first great resistance; and second, the symptoms were transformed: the convulsions changed into paralysis. With the paralysis I secured more of a lever to give power to my urgent arguments. The patient seemed not to mind having convulsions, but did mind very much being paralyzed, and so tried much more heartily to enter into co-operation with my attempts to discover hidden complexes and to analyze them. When I asked her if she couldn't look and see what was going on in the depths of her mind, she said, "I couldn't before, but to get the use of my legs, I will."

In this connection the ineffectiveness of simple, naïve questioning is apparent. In a simple question it is the analyst's will-to-know against the patient's will-not-to-

know. What does a patient care for the analyst's disappointment in comparison to her own distress? Obviously, little. Here lies the point of failure of many tentative psychoanalyses.

The next most important point in technique lies in the use of the "*Übertragung*," or "transference." After that was well established my desires did have a motive power in her mind. When my patience at her continued resistance would break down and I would scold her, she always manifested much feeling, and the next day, never the day of the scolding, she would let down a little the bars of her repression and we would get on a bit further. In connection with the transference, whenever it manifested itself very strongly in dreams, I explained it to the patient and did not despair until it seemed that she thoroughly understood its significance. Of course, without transference no such progress as was made would have been at all possible.

Free association was also used. In this particular case, however, it *seemed* the least successful method used. I say "seemed" because I do not know how much it may have helped the analysis in ways I could not determine. The reason, it seems to me, why free association was of so little value here was because, after the first, there was no doubt as to what some of the repressed complexes were, and the only thing to do was to break down the barriers raised against them by the fore-conscious. To speak in mining terms, a very short preliminary time of prospecting was sufficient to show where the lead was, and what remained was only the drudgery of digging.

It is a great mistake to imagine that "free association" is the essence of psychoanalysis. Free association is only one of the methods used to get at the unconscious. If there is any one thing in an analysis more essential than any other, it is, perhaps, the insistent, vigorous urging the patient on when he stops. It is the refusing to take the patient's surface statement that there is nothing there when he is asked what is in his mind; and it is demanding that he tell *something* about what is going on mentally. This is psychic work for the analyst. It is impossible to give any adequate "acquaintance with" or first-hand idea as to the

feeling of this psychic effort, but it is very real. Next to this tireless persistence in pursuing a topic once it is started, perhaps the most important thing about the analysis is the *choosing significant* leads to follow. Besides all the normal uncertainty that necessarily goes with the infinite number of possible paths one might take, there is the most diabolical subtlety of concealment, artful dissimulation, and cunning falsification. Through all this maze of equivocation one must thread his way to the *actual present conflict*: no easy task.

In the present case the greatest difficulty the analysis had to overcome was an absolutely unabating resistance to free-associations. Instead of freely giving a lot of associations from which clues might be gained, every advance was made against the greatest resistance. This is extremely discouraging and irritating to the analyst. It is as if a patient should try to conceal every symptom and do everything possible to lead the physician astray. There is nothing so irritating; and success is absolutely dependent on the self-control of the analyst. Scientists in other fields have learned to pay absolute respect to the nature and laws of the material they are studying, and they conquer their own feelings by being impersonal. This is quite as necessary here; but it is more difficult, because the *personal* and *scientific* points of view are so inextricably mixed; yet it is necessary to change from one to the other at a moment's notice. Probably this necessity for the expenditure of personal effort against the most irritating of all resistances, personal resistance, and yet with absolute self-possession and without resentment, will prove the greatest obstacle to a general practice of psychoanalysis. To adopt and hold an impersonal attitude to another person while entering into the most intimate psychical relations possible with that person, makes demands that few will be willing to grant. A pitfall fatal to a successful psychoanalysis is a premature moral judgment. If one condemns a patient on moral grounds, he thereby ends any further possible help by him through psychoanalysis. The only moral judgment that is of any help to the patient is his own moral judgment of himself, made inevitable by his fully conscious perception of his own psy-

chic past, present and future. All hysterics tell untruths; some hysterics lie; it is necessary to discriminate. It is hard, however, to do this, and preserve at the same time an impersonal attitude. One is apt to go too far and become purely abstract.

There is an advantage about free-association which makes it very important not to neglect it, and that is that by its use new relations and new connections are revealed which would never otherwise have been suspected. These relations are revealed by the revelation of new facts, new, that is, to the investigator. To get free associations from the patient is not so simple as it sounds. The analyst has to overcome a good many tendencies of his own to interfere. Free association seems so aimless, so endless, so utterly without form and void, that the temptation to take things in one's own hands and direct the mental processes is almost overpowering. One usually does this directing by questions, and here is apparent the limitation: one can question only so far as one already knows; one cannot ask a question about something utterly unknown. If the analyst gives free rein to his own associations and asks any question that may come into his own imagination he can cover a wide field, but here, it is his own psyche which gets disclosed by his questions, and not the patient's, because (1) it is highly improbable that the two fields coincide, and (2) it is very easy for the patient to deny categorically any implications suggested by the question. On the other hand, if it is the patient who gives loose rein to his own thoughts, in a free-association, the analyst can almost always observe when a repression is interfering with the free flow of ideas, and while he cannot know the content of this repressed idea, he can know that an idea has been withheld and urge its disclosure. Thus, there is a conflict in the analyzer's own breast between his desire to direct and his willingness to listen. Hence, it is evident that a successful use of the psychoanalytic method of free-association depends on a judicious alternation of observing and of directing. Neither the urging nor the observing must be overdone. If one urges too much he but increases the obstinacy of the patient. Neither should the analyst merely observe, because if he do this alone he loses

his way in the infinitude of details. Three things he should be on the watch for: (1) repressions; (2) ideas without adequate affect, and (3) affects inadequately accounted for by the ideas associated with them.

The inadequacy of any abstract purely intellectual formulation of the pathogenic nucleus to produce a therapeutic effect is clearly shown in this case. The patient herself was intellectually convinced of what she was after, but not until her resistance was overcome and the actual release of the complex from its repression did any therapeutic effect take place. Therapy consists in breaking down resistances, and releasing repressed complexes, not in "knowing" what the complexes are, and "telling."

Following Jung, some association experiments were made. They were not of great advantage, however, for, while they did demonstrate the existence of complexes, and, in some cases, suggested what they were, they added nothing new, and were of no noticeable help in overcoming the resistances. As cross-sections, so to speak, of the patient's emotionality, they were, however, of significance. The most probable association time of the first association test, determined according to Jung's method, was 6.4 seconds. That of the second test (same stimulus words used) taken two months later, was 3.6 seconds. This indicates something of the effect of the psychoanalysis in reducing the overwhelming emotionality of the patient. The association test is like a microscopic cross-section, and for what such cross-sections can show is of the greatest value; but for tracing the tortuous twistings and turnings of the path leading to the submerged complexes it is too inflexible: here, "free" associations are alone adequate. For therapeutic purposes it is also of little value because it does not help the patient to overcome his resistances, it only shows that they are there. Nevertheless, I am inclined to believe that the method is of great value in establishing fixed points of departure and suggesting questions to be asked as well as showing resistances to be overcome.

A point of much importance in psychoanalytic technique, is the emotional attitude of the analyst. Sympathy must be unflinching, and the greatest respect for personal

peculiarities and bizarre, irritating mental abnormalities. The hysteric is as sensitive to variations of emotional attitude as the most delicate galvanometer is to variations in the magnetic field. The method demands the greatest self-control, and the clearest self-consciousness of fundamental attitudes. In this connection Spinoza's axioms, in his Ethics, are worthy of the fullest acceptance. Concretely, I accepted the patient's own estimate of her morality and agreed with her as to her ethical standards and pretensions. I consciously refrained from holding "her" responsible for any of the things she disclosed. This, I assume, was not an unmixed good, for it may have added to her unconscious resistances by making her still more unwilling to tell me anything that she thought would tend to lower my opinion of her. In this connection it has been my practice always to assume an attitude of complete confidence in the patient's power to act according to his ideals. The question as to whether the ideals are or are not good ones is another matter. The patient can live up to his ideals, *if he wants to, enough*. Thus, the question is essentially ethical, and the act moral. Hence it follows, in my opinion, that therapeutically it is self-contradictory to advise a course of action which is already condemned by the ideals of the hysteric. It is in this conflict of ideals with desires that the disease gets its origin, according to the repression theories. The desires, in themselves, cannot be changed, therefore, the only thing to do is to clarify the conflict by making it conscious, and to change the ideals, if possible, or desirable. So far as my experience goes, the hysteric always has the highest of ideals, only there is a wide chasm between his ideals and his acts, and he is blind to his own limitations and absolutely unaware as to just where the conflict really lies. This follows, of course, from his repressions, and the consequent narrow conception of wherein virtue consists. It is the function of the analysis to show, and, so far as possible, convince the patient, that virtue consists in virtuous acts, and not in barren purity of thought. Here, as Freud has said, the possibility of expressing the therapeutic procedure in formulæ closes. "One does as well as he can as an explainer where ignorance has produced timorousness, as a teacher, as a

representative of a freer and superior world-conception, and as confessor, who through the continuance of his sympathy and his respect, imparts, so to say, absolution after the confession. One endeavors to do something humane for the patient in so far as the range of one's own personality and the measure of sympathy which one can set apart for the case allows."¹

I have hardly more than hinted, so far, of one very important aspect of an analysis, I mean the so-called "*Übertragung*," or "transference." The manifestation of personal sympathy and interest, the willingness to listen and not condemn, often arouses in the patient a feeling of attraction which rapidly grows into strong affection. This affection is in turn a help and a hindrance. It is a help in so far as because of it the patient makes a greater endeavor to assist the analyst in his search; and it is a hindrance in so far as it is in turn a reason for further repression. It is a hindrance also in so far as because of it the analyst develops unrecognized resistances in his own psyche and thereby fails to see the significance of some of the patient's attitudes, actions and inhibitions. The immediate effect of a repressed complex in the psyche of the analyst is fear: fear to follow certain leads, and consequent blindness. This blocks all further progress, until the fear has been met, recognized, and overcome.

As Freud has shown² there is a "positive," or friendly transference, and a "negative," or antagonistic transference. In so far as the patient feels antagonism towards the analyst will it interfere with the work. Further, the friendly aspect of the transference goes from conscious sympathy, friendship and trust to unconscious origin in sexual attraction, and thus, so far as the "positive" transference is *unconscious* it is connected with the repressed complexes and so interferes with their release. One aspect of the personal relation between analyst and patient makes it utterly impossible to do anything in the way of an analysis accurately, much less to help therapeutically, and that is an attitude of scorn, or dislike, on the part of the analyst. Psychoneurotics are

¹Freud: *Selected Papers on Hysteria*, translated by Brill, p. 100.

²*Zur Dynamik der Übertragung*: Zentralblatt für Psychoanalyse, Jahrgang I, Heft 4. Jan., 1912, s. 171.

hypersensitive and notice attitudes unknown even to the one who has them. But this is obvious to any one who has even the slightest idea of a psychoneurotic. On account of the transference it is impossible for a psychoanalysis to be made by several analysts at once. In so far as the transference is positive, the feelings of the patient for one conflict with the feelings for the other. And in so far as there is negative transference, the patient tries to play one physician against the other. Thus enter the problems of jealousy and hate, insurmountable problems when added to the ones already there inherent in the situation. There is, too, the "*Gegenübertragung*," the reaction feeling of the analyst; and the reports of the patient as to what the other analysts may have said create currents and counter currents so complex and interfering as to render their analysis and control quite hopeless. It is like the famous problem of the three bodies. On account of fixation, and the negative transference, parents and relations may be the greatest interference to a successful analysis. In the present case, if the mother had been alive it would have been impossible to have carried out the analysis to anything like a successful termination. As it was, the mother-image, to use Jung's felicitous phrase, was all but successful in opposing every step of advance. This was partially due to the fixation of the *libido*, preventing a proper transference. In similar fashion, though negatively, the feeling for the father, the father-image, was at the bottom of a feeling of hate which in its turn actively interfered with the transference. Thus, the "*conditio sine qua non*" of an analysis, the transference, was actively interfered with. It is only by virtue of the transference that the resistances can be overcome; if the resistances are increased by anything they become impregnable. As Freud has shown, this is the reason the paranoiac is beyond help. The paranoiac regards the analyst with the same negative transference, or hate, which he has for all others. This absolutely prohibits the transference and thus any therapeutics is rendered impossible. The greatest obstruction to a proper transference is, of course, the father-image, the mother-image, or spouse, brother, sister, or lover-image or complex. This is true when either one or all

are dead or far removed, but it is doubly true, with all apologies to the absolutists, where one or more of the family are living and in close relationship to the patient. In the present case the mother was dead, but father and brother actively conspired to prevent a complete transference. Father and brother served as fixation points for the *libido*, and thus encouraged repression. With a complete conscious transference begins the first upward step leading to constructive sublimation. This begins the cure. With the flight of the psyche from its infantile attitude towards the parents, independence begins and personal growth commences. It is necessary, of course, that the *libido* is not allowed to become again fixed, this time on the analyst, but is transferred to more general, perhaps non-sexual, objects, such as is the aim of the highest, broadest and best education. Thus, it is obvious that the analyst must be to the highest degree conscious as to the nature of the transference, its extent and intensity, and have a completely conscious self-control and self-possession.

VI. THERAPEUSIS

Assuming from the beginning that this was a true case of repression, it was also assumed that release would mean recovery. This, so far, has been only partially so, but the evidence seems to show that the reason for this is that the release has been only partial. From the first it is clear that this is so. The release of the memory of the childhood assaults did, temporarily, result in recovery. But a relapse occurred. Then deeper, and still deeper and more distressing memories were gradually laid bare, and to a careless or prejudiced view there seemed to be no corresponding relief. A little reflection shows, however, that even here there was real relief. If one grades symptoms as to degrees of severity, one must acknowledge that a temporary paralysis is less severe than continually recurrent convulsions as violent as those the patient had. To be sure there was a recurrence of the convulsions during treatment, but only twice, and since the second one, what seemed to be the very core of the causal complex has been revealed, and there has been no return. The final return of a symptom corresponds,

indeed, to Freud's observation. It is a last flare-up of a dying flame. Some of the other symptoms that have manifested themselves have been of very short duration. The amaurosis came and went while the brother complex was being probed, and has not returned since. The aphonia, similarly, came and went, with very little real distress. The biting was only two or three times, and was so quickly understood that its continuance was prevented. The cutting occurred only once and was scarcely more than a scratch. The fever was of importance from a medical point of view, but only because of its obscure origin. The hallucinations were more serious symptoms, but they practically soon subsided so much as hardly to warrant their being called hallucinations. They became more like vivid memory-images.

We have now to consider two very important points in psychoanalytic therapeutics: (1) The treatment of repressed complexes. (2) The handling of present conflicts.

If the hysteria is due, as maintained by the repression theory, to repressed memories of long past experiences, and there are no serious present conflicts, the release of the complexes will cure the hysteria. But if there are serious present conflicts, as well as repressed complexes, these present conflicts have to be met and overcome before a complete cure can be effected. In the case under consideration, the core of the complex, which apparently caused the convulsions, was masturbation, paternal solicitation and manustupration and incestuous relations with brother. Since this became known the patient has had no return of convulsions, but what seems to have taken their place is an occasional fainting. That there should be any symptoms at all indicates either incomplete catharsis or an unconquered present conflict. That the latter is largely the case is shown by the struggle to stop masturbation. This is a present conflict of intense severity. The habit was, apparently, started by the father, and has been the habit of her life. Such habits are not easily stopped. Other present conflicts relate to father and brother. It is no easy thing to renounce one's father, even a father like the patient's. But that, at last, has been accomplished. The brother, however, is still loved, though further aggressions have been prohibited by the

patient. When the present conflict is completely won complete recovery will supervene.

VII. ETHICAL

One cannot help but be struck by the ethical implications of hysteria. Hysteria is essentially a disease of personality. Janet's famous definition expresses this point of view: "Hysteria is a form of mental depression characterized by the retraction of the field of personal consciousness and a tendency to the dissociation and emancipation of the system of ideas and functions that constitute personality."¹

In Palmer's classic work, "The Nature of Goodness," the first of the four fundamental characteristics which he finds necessary to personality, is self-consciousness.² Self-consciousness, however, is exactly the thing the hysteric refuses longest to face. It follows logically that if hysteria is a disease of personality, the first step in its cure is a moral one, made in the direction of personality. The first object of psychoanalysis is self-consciousness. Psychoanalysis is a method whereby one may gain self-consciousness. But merely to gain self-consciousness is not necessarily sufficient to restore personality. Hence, psychoanalysis cannot restrict itself, if it seeks successful therapy, to bringing about self-consciousness alone. It must go on to more strictly ethical endeavors, to nurturing, to encouraging, to helping in every way possible, the new-born person. Next to self-consciousness the most important characteristic of personality, it seems to me,—and here again I am following Palmer,—is self-direction. Here, in my opinion, lies the fatal error of suggestion and hypnotism as a treatment of personality. It does not leave the patient free to develop, but tries to force him, utilizing more or less unconsciously, the power of the *Übertragung*, abnormally intensified. Psychoanalysis does not attempt to dominate another personality, but it lends an encouraging hand to the new-born soul making its first free steps in an attempt to direct itself. Ultimate emancipation of the patient from personal dependence on any one person is the aim of psychoanalysis.

¹*The Major Symptoms of Hysteria*, p. 332.

²*The Nature of Goodness*: G. H. Palmer, p. 58.

A third thing that is necessary in the treatment of diseased personality is that there should be given every possible opportunity for self-development. Without such opportunity, a psychoanalysis is fruitless, for the patient. Any attitude of the analyst that fails to respect these three fundamental characteristics of personality, not only interferes with the therapy, but prevents also scientific progress in the finding of fundamental facts in the psychic history of the patient. The reason for this is obvious. The patient's own psychic resistances against becoming self-conscious have to be overcome before the actual disturbing facts are found. If to his actual resistances, are also added resistances aroused by resentment against the analyst's lack of personal respect, the resistances become too great to be overcome, and one can only guess what the real trouble is. The final word in psychoanalysis is reverence for personality. Only with such respect, knowledge, and reverence of personality, is psychoanalysis possible.