Freud Teaches Psychotherapy

Breuer and Freud Study Hysteria

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From December 1880 to June 1882, Dr. Josef Breuer (1842-1925), a well-known and highly reputed physician in Vienna, treated Fraulein "Anna O." for what was generally accepted as a classical case of hysteria. The patient was an intelligent girl of twenty-one who had developed a large variety of symptoms in connection with her father's fatal illness, including paralysis of the limbs, disturbances of sight and speech, inability to eat, a distressing nervous cough, and the presence of two distinct states of consciousness— one rather normal and the other "naughty" and troublesome. To Breuer's great astonishment, on one occasion when she related the details of the first appearance of one of her innumerable symptoms, this resulted in its complete disappearance. The patient realized the value of her discovery and continued with the same procedure of relating the details of the first appearance of a symptom, calling this procedure "the talking cure" or "chimney sweeping." For more than a year, Breuer devoted hours every day to this patient, supplementing the chimney sweeping by artificial hypnosis; the chimney sweeping took place in the evening, and artificial hypnosis took place in the morning, a process Breuer named catharsis.

Breuer developed a strong countertransference to this patient and became so engrossed that his wife became jealous, unhappy, and morose. Breuer felt guilty and decided to bring the treatment to an end. He announced this to Anna O., by this time much better, and that same evening he was fetched back to find her in a terrible state, apparently as ill as ever. In addition, the patient, who according to him had appeared to be asexual and never made any allusions to such a forbidden topic throughout the treatment, was now in the throes of an hysterical childbirth, the logical termination of an imagined pregnancy that had been invisibly developing in response to Breuer's treatment. Breuer calmed her by hypnosis and in a state of shock fled the house. He left for Venice the next day with his wife, to spend a second honeymoon, which resulted in the conception of a daughter (who sixty years later committed suicide in New York). The forty-year-old Breuer wanted no more of the chimney sweeping treatment and left the field to Freud.

Jones (1953) relates that Anna O. later became institutionalized and inflamed the heart of the psychiatrist in charge of the institution. She was then taken to live with her mother and later became the first social worker in Germany, founding a periodical as well as institutes

for training students. She never married, remained very religious, and gave her life to women's causes and work for children. One must keep this in mind in assessing the depth of the psychopathology of Anna O., who has sometimes been labeled schizophrenic.

On November 18, 1882, Breuer told Freud about the case; it made a deep impression on him. He discussed it with Charcot but failed to arouse his interest. Anna O. and Freud's experiences with Charcot demonstrated that "whatever the unknown neurological basis of hysteria might be, the symptoms themselves could be both treated and abolished by ideas alone. They had a psychogenic origin. This opened the door to a medical motive for investigating the psychology of patients, with all the ramifying results that the past half century has shown. It put psychology itself on a totally different footing from its previous academic one" (Jones 1953, p. 227).

In *Studies on Hysteria*, one observes the gradual evolution of the method of free association from Breuer's original hypnotic and cathartic procedures. The development of this method was essentially an effort to free the therapist from the need to hypnotize patients, which was often extremely difficult. A crucial demonstration of the

difference between Freud and Breuer occurred during this period when a patient suddenly flung her arms around Freud's neck—"an unexpected *contretemps* fortunately remedied by the entrance of a servant" (p. 242). Rather than retreating, Freud regarded this problem of the erotic transference as one of scientific interest and recognized its great importance in the psychotherapy of hysteria.

We now appreciate situations in which the erotic transference arises unrelated to hysteria and that an erotic transference is not necessarily even undesirable. For example, the oldest patient I have ever treated, a seventy- eight-year-old lady with a depression, unexpectedly and suddenly threw her arms around me at the end of the therapy and told me lovingly how, although she understood very little of the "nonsense" I was saying, my presence made her feel better because I reminded her of her deceased son. This surprising event, coming at the end of the patient's treatment for depression (which had been entirely successful and was carried out over fifteen years ago without the benefit of drugs) was a startling experience for a young psychotherapist. Due to the patient's age there was no counter-transference difficulty; but the event was a striking demonstration of the power of a personal relationship between the patient and the

physician to influence therapeutic improvement. My experience has been that often the true intensity of the erotic transference does not appear, as in Breuer's case, until the termination of the psychotherapy.

Freud's efforts to proceed with cases such as Fraulein Elisabeth von R. were encouraged, even though she could not be hypnotized, by the French neurologist Bernheim's remark that things experienced in hypnosis were only *apparently* forgotten afterwards and that they could at any time be brought into recollection if only the physician insisted forcibly enough that the patient knew them. Freud's genius made the extrapolation that this should be equally true for the forgotten memories in hysteria. Fraulein Elisabeth von R. was the first patient treated by his "concentration technique," which later became the method of psychoanalysis. At this point it consisted of much urging, forehead-pressing, and questioning. On one historic occasion, the patient reproved Freud for interrupting her flow of thought by his questions. Again Freud's genius showed itself; by being willing to *listen to the patient* and follow the lead given by her, he made another step toward free association.

It is hard to comprehend today the difficulties involved for this

turn-of- the-century Viennese physician, who occupied a totally respected and authoritative position, in allowing himself to be led toward his discoveries by his neurotic patients. *It was the beginning recognition of the requirement for patience and meticulous attention to detail needed for the successful practice of psychotherapy, as well as a demonstration of the importance of being able to refrain from an authoritative medical stance with one's patients, when the therapy requires such restraint.*

In the summer of 1894, Freud's cooperation with Breuer came to an end, for personal reasons and over Breuer's disagreement with Freud as to whether sexual disturbances in childhood were essential factors in the etiology of neuroses. Although Freud's first book, *On Aphasia*, was dedicated to Breuer, the relationship cooled until there was nothing left of twenty years of cooperation, friendship, and mutual interest (Balogh 1971). As the relationship with Breuer disintegrated, the relationship with Fliess gained a corresponding intensity.

When Breuer, who was fourteen years older than Freud, died in 1925, Freud wrote a warm obituary acknowledging him as "a man of rich and universal gifts" even though, according to Roazen (1975), the

friendship in later years had developed, at least on Freud's part, into an intense loathing. It is difficult to evaluate the validity of this report. Part of Freud's problem with Breuer was due to Freud's personality, for Freud often felt that those who were not wholly with him in his theories were against him, and he did not hide his feelings.

This attitude gains significance for the psychotherapist as we gradually realize that Freud's basic orientation as a psychotherapist was that of a passionate investigator and teacher. Roazen (1975) puts it very strongly:

> To Freud, patients were "students" for whom the analyst was a 'guide.' The analytic process was itself an educative activity; psychoanalysis sought to educate the ego. . . . Freud thought that in all analyses points would arise at which the analyst had to act as a model for his patients and sometimes directly as a teacher. But he cautioned against indiscriminate instruction: 'The patient should be educated to liberate and fulfill his own nature, not to resemble ourselves' (p. 18).

Freud's strength as a writer and a psychologist rested on his ability to appeal to the hearts of all men. Examine yourself, said Freud; look within your own depths, and see whether what is true for me is

true for you too. This kind of challenge tends to make strong allies but many outspoken enemies.

Studies on Hysteria (Freud 1895D;2:21ff) is a neglected gold mine for the psychotherapist. I cannot imagine a more appropriate starting point for those who wish to learn about psychotherapy or to deepen their historical and technical understanding of the process of psychotherapy. This book should be mandatory reading for all students of intensive psychotherapy. It literally enables us to observe Freud developing his techniques and is loaded with clinical insights of current value. It contains some model case histories, is easy to read, and is beautifully written. In addition, this work is usually regarded as the historical starting point of psychoanalysis. The term "psychoanalysis" was first used by Freud in a paper published in French, in March 1896.

Breuer's patient Anna O. demonstrated and overcame the first obstacle to the scientific examination of the human mind. This obstacle, the amnesia characteristic of the hysterical patient, led Breuer and Freud to the realization that an unconscious series of mental processes lay behind the conscious mind and that, clearly,

some special instrument would have to be developed to get at such processes. Freud himself explains the inadequacy of hypnotic suggestion as such an instrument—with many patients of little use at all. He describes how he gradually developed the system of free association, at first with the occasional use of pressure on the forehead. The attempt to get the patient to free-associate raised the next obstacle— the patient's resistance to the treatment. Freud's decision not to shout down or force away this resistance but rather to investigate it like other mental phenomena led him directly to the whole field of psychoanalysis.

It is of interest that the central theoretical assumption in *Studies on Hysteria* is expressed in the principle of constancy: that the human mind tries to keep the quantity of excitation constant. This principle accounts for the clinical necessity for abreacting affect and the pathogenic results of affect. The idea of "cathexis" (which first appears in this work), that the whole or part of the mental apparatus carries charges of energy, is presupposed by the principle of constancy. The concept of psychic energy, which is still controversial today (Peterfreund 1971), represents the beginning of metapsychology. I hasten to add that by 1905 Freud finally and explicitly repudiated all

intention of using the term "cathexis" in any but a psychological sense, and abandoned all attempts at equating neuronal tracts or special neurons with paths of mental associations.

Gedo et al. (1976) did a careful study of the differing methodologies of Breuer and Freud in *Studies on Hysteria* and reached the conclusion that the book has been neglected because of "the difficulty of culling the scientific logic from this monumental volume supersaturated with new concepts." Gedo et al. "reduced" the book to a series of statements classified according to a schema borrowed from Waelder (Gedo et al. 1976, p. 172) and paraphrased as follows:

1. *The data of observation.* Facts of conscious life, derivatives from the unconscious, and their configurations

2. *Clinical interpretations.* Interconnections among the data of observation and their relationships with other behavior

3. *Clinical generalizations.* Statements about a particular type of category such as sex, an age group, a symptom, a disease, etc.

4. *Clinical theory.* Concepts implicit in clinical interpretations or logically derived from them such as repression,

defense, etc.

5. *Metapsychology.* More abstract concepts, such as cathexis, psychic energy, etc.

6. *The author's philosophy or Weltanschaung.* For example, scientific humanism

This classification is an excellent starting point for the evaluation of any of Freud's writing or, indeed, any writing on psychotherapy, and I urge the reader to keep it in mind. Note especially that, "The data of observation we call 'lower-level' statements; clinical interpretations and generalizations we place at the middle level of abstractions, while clinical theories and metapsychological propositions are at the highest levels" (p. 172).

Gedo et al. (1976) conclude that no statements of the authors' philosophy appear in *Studies on Hysteria* and that the entire book contains only three metapsychological propositions: (1) the brain works with a varying but limited amount of energy: (2) there is tendency to keep intracerebral excitation constant; and (3) psychic forces' operate in dynamic interrelationships.

What emerges with the most compelling clarity from the Gedo et

al. study is the difference in methods used by Freud and Breuer. Thus Breuer displayed considerable talent and creative ability in building hypotheses based on deductive reasoning, but the kind of hypotheses developed did not lend themselves to further clinical testing and remained a kind of speculative superstructure. "Freud, on the other hand, clearly subjected his inspirational hunches to thorough inductive revision in the light of the clinical evidence available to him. In other words, the internally consistent evolution of psychoanalysis was a process which took place exclusively within Freud's mind" (p. 168). These authors, although they give much credit to Breuer, were impressed by "the tightness of Freud's inductive thinking and his restraint in refusing to outdistance his evidence, as Breuer consistently did" (p. 183).

Of course, the essential difference was that Freud was able to persist in the face of internal conflicts stirred up by his discoveries, while Breuer withdrew. As we shall see in the next chapters, "Freud's great and extraordinary achievement was his capacity to extend the range of psychological observation to include not only his patients but also himself" (p. 204).

Turning directly to an examination of *Studies on Hysteria* (Freud 1895D; 2:21ff), the basic clinical discovery of Breuer and Freud was 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 affect, and when the patient had described that event in the greatest possible detail and had put the affect into words" (p. 6).

The first important clinical fact in the book is "Recollection without affect almost invariably produces no result" (p. 6). So much for the argument that psychotherapy is merely an intellectual process. Reading these marvelous case histories quickly reveals the emotion-laden interactions between the patient and the physician. For example, notice Breuer's remark that Anna O. would never begin to talk "until she had satisfied herself of my identity by carefully feeling my hands" (p. 30). Breuer mentions later that the talking cure could not be carried out by anyone but him.

Considerable argument (Reichard 1956) exists as to whether some of the cases in this book are really hysterics, schizophrenics, or

borderline patients—an argument that I regard as rather unfruitful because it seems to rest mainly on semantic debate about patients we cannot examine personally at this time. At any rate it is clear that these patients are all substantially emotionally disturbed; they are not bored ladies who have nothing better to do than to pass away the time in psychoanalysis. The procedure was designed and developed to help seriously emotionally disturbed individuals, and the importance of touching, feeling, and being held appears almost at once. Hollender (1969, 1970, 1970a) has discussed at length the need of such patients to be held and I have reviewed the subject in my book, *Intensive Psychotherapy of the Borderline Patient* (1977). The kinds of difficulty the psychotherapist can get into when he gives in to this need of patients to be held—even holding hands—is nowhere better illustrated than in what happened between Breuer and Fraulein Anna O.

Reichard (1956) divides the cases in *Studies on Hysteria* into two schizophrenic patients and three hysterical patients. She claims that Anna O. and Emmy von N. were schizophrenic because they had fixed, bizarre, and horrifying hallucinations with a pan-neurosis, a family riddled with pathology, conflicts which were mainly pregenital in

origin, various psychotic symptoms, and were hospitalized at times. The other three cases have less severe family pathology, fewer symptoms, and more lasting cures.

Reichard's definition of hysterical neurosis is:

> Hysteria is a neurosis showing a minimal degree of ego defect and is characterized by conversion symptoms, which are limited to changes in physical functions that represent solutions of unconscious sexual conflicts derived from the phallic or genital levels of psychosexual development and expressive of unresolved oedipal incestuous wishes (p. 160).

By this definition Lucy R„ Katharina, and Elisabeth von R. seem to be classical cases of hysteria, whereas Anna O. and Emmy von N. are not, although all five patients suffered from conversions which were the original basis of the diagnosis of hysteria. Whether Anna O. and Emmy von N. were schizophrenics suffering from a psychosis at the time of treatment (Reichard 1956) or borderline patients (Chessick 1977) is highly debatable. One must keep in mind that flamboyant hysterical symptomatology is much less common today, and patients manifesting such symptoms tend to be diagnosed as schizophrenics with hysterical features.

Also revealing is the remark by Breuer about just how ill-tempered and malicious Anna O. could become, especially when he was away from her. The rage, hatred, and need for revenge in the hysteric and especially in the borderline patient have also been discussed at length. Here is a clinical example from my practice:

> Ms. B. was an attractive young woman in her twenties whose chief complaint was frigidity. This frigidity consisted of the absolute inability to become aroused or to experience orgasm under any circumstances with her husband or her previous boyfriends. She was an attractive modern young woman who was apparently genuinely concerned that she was missing something important in life. She went first to a psychoanalyst who recommended a formal psychoanalysis and began with her on the couch four times a week. This lasted two weeks, for by the time the second week had passed the patient was in a total rage at the psychoanalyst because she "could not bear" not being allowed to see him, and at the "difference in power" as she perceived it in the psychoanalytic situation; the idea that he could see her while she could not see him, and the idea that she had to say everything that came to her mind while he said very little were absolutely intolerable to her. She terminated the treatment.
>
> Since she was clearly unsuitable for formal psychoanalysis he referred her to me. The patient then engaged in a sitting-up psychotherapy twice weekly which lasted for seven

years and ended successfully in her achievement of satisfactory orgasms with her husband. The essence of the treatment consisted of seven years of the patient raging at me in the transference. This began in the most intense manner, accompanied by diarrhea before and after the sessions, and a general temper tantrum and raging of every possible kind and description at the slightest indication that I had any kind of control or power over her. For example, the end of each session was often characterized by her leaving the treatment a minute or two early and slamming the door, because she could not tolerate the fact that she had to leave at the time appointed by me when the session was due to conclude.

The patient exhibited a clear-cut example of extreme narcissistic rage, and over the years this rage was abreacted and gradually abated itself until the patient began to have orgasms in intercourse. Actually there was little direct discussion of sexuality in the treatment; the discussions focused on her rage and need to control, her fear of vulnerability, and above all, her fear of losing control—especially to a man.

The patient was raised by a cold, unfeeling mother and a father who encouraged her to climb on his lap and reach out for affectionate caresses; when she did he would scratch her with his whiskers, tease her, poke, and pinch her. He often woke the patient in the morning by pulling off her bedclothes and pinching her bare buttocks. The father used many other forms of teasing cruelty to ward off his

> own sexual and sadistic desires toward his daughters. A profound disappointment in both parents produced the patient's chronic narcissistic rage. The gradual working-through of her narcissistic problems and catharsis of rage, in a situation which at least she could barely tolerate, enabled the normal developmental forces to take over once more.

In Breuer's situation, as he points out, he was faced at times by a malicious hysteric, "refractory, lazy, disagreeable, and ill-natured." He explains how her "true character," the opposite of all these, reappeared after the various abreaction sessions. There is no question that profound narcissistic rage is an important, if not the most important, element in borderline cases and severe hysterias.

This extremely difficult nosological problem—What do we mean by severe hysterias?—still rages today. We are reminded by Lazare (1971) that Freud's early cases dealt with symptoms—blindness, convulsions, contractures, and disturbances in sensation. "Character traits often associated with hysteria, such as increased excitability, instability of mood, and suggestibility, were mentioned only in passing." Hysteria is here used as a diagnostic term for these various symptoms of psychological—not neurological—origin, believed

related to disturbed sexuality.

Returning to *Studies on Hysteria,* Freud's case of Emmy von N. introduces us to the method of free association; one might say that again the patient led the way: "It is as though she had adopted my procedure and was making use of our conversation, apparently unconstrained and guided by chance, as a supplement to her hypnosis" (p. 56). Patients often guide us when we have gone in the wrong direction, if we are willing and able to listen to them.

The term "conversion" is used in this case history (although it was first introduced elsewhere). The meaning of the term—by which Freud signified "the transformation of psychical excitation into chronic somatic symptoms, which is so characteristic of hysteria"—still remains mysterious, and indeed many authors still speak of the "mysterious leap from the mind to the body." Furthermore, the question of whether conversion is to be restricted more or less to cases of hysteria, or exists throughout the realm of psychopathology, remains a matter of debate (Rangell 1959). Certainly the ubiquitous presence and the unpredictable shifts of conversion symptoms form one of the most dramatic manifestations in the realm of

psychopathology, and the removal of conversion symptoms by the use of hypnosis or barbiturates is often convincing demonstration to beginners of the influence of mental processes on body phenomena.

Today, florid conversion symptoms are rarely found away from rural communities. The disappearance of dramatic classical conversion symptoms seems to be related to the growing sophistication about sexuality in our society and to the acceptance of the sexual needs of women. Perhaps the preponderance of florid conversion symptoms among nineteenth-century women can partly be blamed for Freud's chauvinistic comment about "the moral seriousness with which she viewed her duties, her intelligence and energy, which were no less than a man's." This unfortunate disparagement of women, as we shall see in later chapters, occurs from time to time throughout Freud's work and is due partly to his Victorian mentality and partly to the then-prevailing theory that hysteria involved some kind of degeneracy or inferiority in the nervous system, a theory which Freud gradually abandoned. In spite of this bias, it does not logically follow that all Freud's views or discoveries are to be rejected; his material must be judged on the basis of clinical experience and logical consistency.

The third case, Lucy R, was treated entirely without the use of hypnotism and represents the application of the forehead-pressuring technique. The case illustrates the notion that an idea is "intentionally repressed" from consciousness, forcing an accumulation of excitation which, being cut off from psychical association, "finds its way all the more easily along the wrong path to a somatic innervation." The basis for the repression is the feeling of unpleasure, "the incompatibility between the single idea that is to be repressed and the dominant mass of ideas constituting the ego. The repressed idea takes its revenge, however, by becoming pathogenic" *(Studies on Hysteria,* p. 116). This is the basis of the whole notion of psychodynamics. (Notice the metaphorical and poetic language; in the fourth case, of Katharina, Freud's literary genius soars into an almost pure poetic short-story.)

It follows from the premise quoted above that the therapeutic goal is to compel the split-off ideas to unite once more with the conscious stream of thought, and Freud remarks that "strangely enough" success does not run *pari passu* with the amount of work done—only when the last piece of work was completed did recovery suddenly take place. This phenomenon introduces another important clinical problem in that it is not possible to predict by an algebraic

formula the relationship of the rate of recovery and the bringing of unconscious ideation to the conscious mind. Very often patients appear to improve in quantum jumps after long, tedious plateaus of work.

The final case in the book (Elisabeth von R.) deals above all with the problem of psychogenic pain and the clinical distinction between the patient's description of psychogenic pain and other forms of pain. The hysteric shows the well-known facial indifference and cheerfulness while giving an indefinite description of the severe pain. These descriptions are all the more surprising in their indefiniteness because the patient is often intelligent. In contrast, a patient suffering from organically based pains usually describes them definitely and calmly. "He will say, for instance, that they are shooting pains, that they occur at certain intervals, that they extend from this place to that and that they seem to him to be brought on by one thing or another" (p. 136). Hypochondriacal pain, which is more characteristic of the narcissistic neuroses, as described by a patient gives the impression of his:

> being engaged on a difficult task to which his strength is quite unequal. His features are strained and distorted as

> though under the influence of a distressing affect. His voice grows more shrill and he struggles to find a means of expression. He rejects any description of his pains proposed by the physician, even though it may turn out afterwards to have been unquestionably apt. He is clearly of the opinion that language is too poor to find words for his sensations and that those sensations are something unique and previously unknown, of which it would be quite impossible to give an exhaustive description. For this reason he never tires of constantly adding fresh details, and when he is obliged to break off he is sure to be left with the conviction that he has not succeeded in making himself understood by the physician (p. 136).

No better description can be found of pain in the narcissistic neuroses as a symptom of the impending fragmentation of the sense of self (Kohut 1971).

The procedure of clearing away pathogenic psychical material layer-by- layer is compared to the technique of excavating a buried city. At the same time that this archeological work was going on, however, Freud contributed a considerable amount of encouragement, persuasion, and authoritative instruction. He took it for granted, at this point, that such behavior on the part of the physician is *essential* to the treatment. "For instance, I sent her to visit her sister's grave, and I

encouraged her to go to a party at which she might once more come across the friend of her youth" (p. 149).

Freud also did a considerable amount of consoling and soothing. In his efforts to develop a scientific theory of psychotherapy he tends to deemphasize this sort of empathetic, intuitive material. Perhaps he simply and modestly assumed that the physicianly vocation (Stone 1961) of the therapist would always be present in any doctor-patient relationship. For example, when it occurred to Elisabeth that her sister's husband would be free if her sister died and she could then marry him, the period that followed "was a hard one for the physician." Freud deals with the shattering effect on the patient of the recovery of this unacceptable and therefore repressed idea by "two pieces" of consolation in the best tradition of pastoral counseling: "that we are not responsible for our feelings, and that her behavior, the fact that she had fallen ill in these circumstances, was sufficient evidence of her moral character" (p. 157). There is an interesting contrast between Freud's consciously "dry" presentation of interpretations, and his shift to soothing, physicianly behavior when the patient is upset.

The cases presented convinced Freud that in hysteria two

separate psychic groups are formed; one is intolerable to the adult conscious; the other is repressed by the ego to preserve harmony; the mechanism of conversion, which Freud confesses he cannot explain, is used to spare psychic pain by substituting physical pain. The resistance to the treatment springs from and is proportional to the repressing force that holds the unacceptable ideas in the unconscious mind. Again the tendency to keep excitation constant, the principle of constancy, is assumed behind this explanation.

Freud could be very authoritative; for example, he insists, because he is convinced of the trustworthiness of his technique that *something* must occur to the patient when she is asked to say what comes to her mind. We still use this technique today. The section of *Studies on Hysteria* entitled "The Psychotherapy of Hysteria" depicts psychotherapy as a laborious and a time-consuming procedure for the physician and presupposes both his "great interest in psychological happenings" and "personal concern for the patients as well."

The clinical problems of defense and resistance are again taken up. For example, regarding situations where an idea is brought to the conscious and 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." Freud answers, "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" (p. 280). Thus *the most important clinical problem* in intensive psychotherapy is to overcome the continual resistance.

Freud asks, in a magnificent passage, about the techniques we have at our disposal for overcoming this continual resistance. His answer, which deserves careful study, is that the available techniques are few "but they include almost all those by which one man can ordinarily exert a psychical influence on another."

Freud first counsels patience, since resistance can only be resolved "slowly and by degrees." Then he advises explanation and informing the patient about the "marvelous world of psychical processes" to make the patient into a collaborator and to "induce him to regard himself with the objective interest of an investigator." The

strongest method, however, is persuasion by various means, in which one does one's best "as an elucidator, 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." Here is where it becomes impossible to state psychotherapeutic process in formulae since one is limited by the "capacity of one's own personality and by the amount of sympathy that one can feel for the particular case" (pp. 282-3). In addition Freud emphasizes directly:

> 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 than 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 (p. 283).

The essence of the treatment in intensive, psychoanalytically informed psychotherapy is to cause the resistance to melt. We begin, as he explains, at the periphery of the psychical structure and we work gradually, through the procedure of getting the patient to talk down to a deeper and deeper understanding of what has happened. Of trying 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."

In his attempt to describe the process of psychotherapy, Freud uses a number of similes which he recognizes as having only a limited resemblance to his subject and which moreover "are incompatible with one another." Although this method throws light "from different directions on a highly complicated topic which has never yet been represented," an unfortunate side effect is that these similes have from time to time been taken too seriously and concretely by later authors. This has produced confusion and contradiction in post-Freudian writing. In later chapters we will see the appearance of these similes and literary allusions throughout our examination of Freud's work.

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" (p. 298). The abundant causal connections and the multiple determination of symptoms are described by Freud, and the procedure works in such a

way that if mistakes are made in interpretations, the context will later on tell us to reject them because the material will have become inconsistent.

The subject of the failure of the psychotherapeutic technique is first raised in this work. Freud approaches the topic in the same manner he approaches everything else—to study objectively what has happened. He concentrates on disturbances of the patient's relation to the physician— "the worst obstacle that we can come across." There may be a personal estrangement if, for example, the patient feels neglected or too little appreciated or insulted, or if she has heard unfavorable comments on the physician or the method of treatment. The patient may be seized by a dread of becoming too dependent on the physician; and, most important, the patient may become frightened by finding she is transferring onto the figure of the physician the distressing ideas which arise from the content of the analysis.

Freud here raises for the first time the issue of *transference* as a false connection in which the unacceptable wish first appears linked to the person of the physician. The result of this is a mésalliance or "false

connection." It is part of the greatness of Freud to have been able whenever he had been "similarly involved personally, to presume that a transference and a false connection have once more taken place," rather than to have been fooled into believing that the patient had "really" developed personal feelings for him because he was "really" so wonderful or handsome or marvelous. Freud adds, "Strangely enough, the patient is deceived afresh every time this is repeated" (p. 303).

Freud's humility as a scientific investigator is nowhere better illustrated than in this brief discussion of transference. His humility is evident when he answers the patient's objection that since he cannot alter the circumstances and events of the patient's life, what kind of help does he have to offer? Freud (p. 305 >replies, in a quotation that has become famous, that "much will be gained if we succeed in transforming your hysterical misery into common unhappiness. With a mental life that has been restored to health you will be better armed against that unhappiness"—and this is all that Freud can promise.

Freud compares the technique of "cathartic psychotherapy" with surgical intervention, not so much for the purpose of the removal of what is pathological as for "the establishment of conditions that are

more likely to lead the course of the process in the direction of recovery." This is most important to understanding Freud's basic orientation, which is essentially quite a modest one and which differentiates his approach from the various other authoritative, directive, and organic approaches to the neuroses. Essentially in cathartic psychotherapy the conditions are established by the psychotherapist, through the arrangements of the treatment and the removal of the resistances, for the patient to take part in the healing process and gradually take it over, going forward to ever-increasing levels of complexity and maturity (Chessick 1974).

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All references to Freud in this bibliography follow the commonly accepted cross-reference list given in the Appendix to the Abstracts of the *Standard Edition* (Rothgeb 1973).

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