FIVE LECTURES ON PSYCHO-ANALYSIS

Delivered on the Occasion of the Celebration
of the Twentieth Anniversary of the Foundation
of
CLARK UNIVERSITY, WORCESTER
MASSACHUSETTS

September 1909

To

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This Work is Gratefully Dedicated

FIRST LECTURE

LADIES AND GENTLEMEN,—It is with novel and bewildering feelings that I find myself in the New World, lecturing before an audience of expectant enquirers. No doubt I owe this honour only to the fact that my name is linked with the topic of psycho-analysis; and it is of psycho-analysis, therefore, that I intend to speak to you. I shall attempt to give you, as succinctly as possible, a survey of the history and subsequent development of this new method of examination and treatment.

If it is a merit to have brought psycho-analysis into being, that merit is not mine.[1] I had no share in its earliest beginnings. I was a student and working for my final examinations at the time when another Viennese physician, Dr. Josef Breuer,[2] first (in 1880–2) made use of this procedure on a girl who was suffering from hysteria. Let us turn our attention straightaway to the history of this case and its treatment, which you will find set out in detail in the *Studies on Hysteria* [1895*d*] [3] which were published later by Breuer and myself.

But I should like to make one preliminary remark. It is not without satisfaction that I have learnt that the majority of my audience are not members of the medical profession. You have no need to be afraid that any special medical knowledge will be required for following what I have to say. It is true that we

[1] (*Footnote added* 1923:) See, however, in this connection my remarks in 'A History of the Psycho-Analytic Movement' (1914*d*), where I assumed the entire responsibility for psycho-analysis.

[2] Dr. Josef Breuer, born in 1842, a Corresponding Member of the Kaiserliche Akademie der Wissenschaften [Imperial Academy of Sciences], is well known for his work on respiration and on the physiology of the sense of equilibrium. [His obituary by Freud (1925*g*) included a more detailed account of his career.]

[3] Some of my contributions to this book have been translated into English by Dr. A. A. Brill of New York: *Selected Papers on Hysteria* (New York, 1909). [This was the first Freud book to appear in English. The complete Breuer and Freud *Studies* were translated by Brill later (New York, 1936). A new translation appeared in 1955, forming the second volume of the Freud *Standard Edition*, where the case history of this patient (Fräulein Anna O.) will be found on p. 21 ff.]

shall go along with the doctors on the first stage of our journey, but we shall soon part company with them and, with Dr. Breuer, shall pursue a quite individual path.

Dr. Breuer's patient was a girl of twenty-one, of high intellectual gifts. Her illness lasted for over two years, and in the course of it she developed a series of physical and psychological disturbances which decidedly deserved to be taken seriously. She suffered from a rigid paralysis, accompanied by loss of sensation, of both extremities on the right side of her body; and the same trouble from time to time affected her on her left side. Her eye movements were disturbed and her power of vision was subject to numerous restrictions. She had difficulties over the posture of her head; she had a severe nervous cough. She had an aversion to taking nourishment, and on one occasion she was for several weeks unable to drink in spite of a tormenting thirst. Her powers of speech were reduced, even to the point of her being unable to speak or understand her native language. Finally, she was subject to conditions of '*absence*',[1] of confusion, of delirium, and of alteration of her whole personality, to which we shall have presently to turn our attention.

When you hear such an enumeration of symptoms, you will be inclined to think it safe to assume, even though you are not doctors, that what we have before us is a severe illness, probably affecting the brain, that it offers small prospect of recovery and will probably lead to the patient's early decease. You must be prepared to learn from the doctors, however, that, in a number of cases which display severe symptoms such as these, it is justifiable to take a different and a far more favourable view. If a picture of this kind is presented by a young patient of the female sex, whose vital internal organs (heart, kidneys, etc.) are shown on objective examination to be normal, but who has been subjected to violent *emotional* shocks—if, moreover, her various symptoms differ in certain matters of detail from what would have been expected—then doctors are not inclined to take the case too seriously. They decide that what they have before them is not an organic disease of the brain, but the enigmatic condition which, from the time of ancient Greek medicine, has been known as 'hysteria' and which has the power of producing illusory pictures of a whole number of serious diseases. They

[1] [The French term.]

consider that there is then no risk to life but that a return to health—even a complete one—is probable. It is not always quite easy to distinguish a hysteria like this from a severe organic illness. There is no need for us to know, however, how a differential diagnosis of that kind is made; it will suffice to have an assurance that the case of Breuer's patient was precisely of a kind in which no competent physician could fail to make a diagnosis of hysteria. And here we may quote from the report of the patient's illness the further fact that it made its appearance at a time when she was nursing her father, of whom she was devotedly fond, through the grave illness which led to his death, and that, as a result of her own illness, she was obliged to give up nursing him.

So far it has been an advantage to us to accompany the doctors; but the moment of parting is at hand. For you must not suppose that a patient's prospects of medical assistance are improved in essentials by the fact that a diagnosis of hysteria has been substituted for one of severe organic disease of the brain. Medical skill is in most cases powerless against severe diseases of the brain; but neither can the doctor do anything against hysterical disorders. He must leave it to kindly Nature to decide when and how his optimistic prognosis shall be fulfilled.[1]

Thus the recognition of the illness as hysteria makes little difference to the patient; but to the doctor quite the reverse. It is noticeable that his attitude towards hysterical patients is quite other than towards sufferers from organic diseases. He does not have the same sympathy for the former as for the latter: for the hysteric's ailment is in fact far less serious and yet it seems to claim to be regarded as equally so. And there is a further factor at work. Through his studies, the doctor has learnt many things that remain a sealed book to the layman: he has been able to form ideas on the causes of illness and on the changes it brings about—e.g. in the brain of a person suffering from apoplexy or from a malignant growth—ideas which must to some degree meet the case, since they allow him to understand

[1] I am aware that this is no longer the case; but in my lecture I am putting myself and my hearers back into the period before 1880. If things are different now, that is to a great extent the result of the activities whose history I am now sketching.

the details of the illness. But all his knowledge—his training in anatomy, in physiology and in pathology—leaves him in the lurch when he is confronted by the details of hysterical phenomena. He cannot understand hysteria, and in the face of it he is himself a layman. This is not a pleasant situation for anyone who as a rule sets so much store by his knowledge. So it comes about that hysterical patients forfeit his sympathy. He regards them as people who are transgressing the laws of his science—like heretics in the eyes of the orthodox. He attributes every kind of wickedness to them, accuses them of exaggeration, of deliberate deceit, of malingering. And he punishes them by withdrawing his interest from them.

Dr. Breuer's attitude towards his patient deserved no such reproach. He gave her both sympathy and interest, even though, to begin with, he did not know how to help her. It seems likely that she herself made his task easier by the admirable qualities of intellect and character to which he has testified in her case history. Soon, moreover, his benevolent scrutiny showed him the means of bringing her a first instalment of help.

It was observed that, while the patient was in her states of '*absence*' (altered personality accompanied by confusion), she was in the habit of muttering a few words to herself which seemed as though they arose from some train of thought that was occupying her mind. The doctor, after getting a report of these words, used to put her into a kind of hypnosis and then repeat them to her so as to induce her to use them as a starting-point. The patient complied with the plan, and in this way reproduced in his presence the mental creations which had been occupying her mind during the '*absences*' and which had betrayed their existence by the fragmentary words which she had uttered. They were profoundly melancholy phantasies—'day-dreams' we should call them—sometimes characterized by poetic beauty, and their starting-point was as a rule the position of a girl at her father's sick-bed. When she had related a number of these phantasies, she was as if set free, and she was brought back to normal mental life. The improvement in her condition, which would last for several hours, would be succeeded next day by a further attack of '*absence*'; and this in turn would be removed in the same way by getting her to put into

words her freshly constructed phantasies. It was impossible to escape the conclusion that the alteration in her mental state which was expressed in the '*absences*' was a result of the stimulus proceeding from these highly emotional phantasies. The patient herself, who, strange to say, could at this time only speak and understand English, christened this novel kind of treatment the 'talking cure' [1] or used to refer to it jokingly as 'chimney-sweeping'.[1]

It soon emerged, as though by chance, that this process of sweeping the mind clean could accomplish more than the merely temporary relief of her ever-recurring mental confusion. It was actually possible to bring about the disappearance of the painful symptoms of her illness, if she could be brought to remember under hypnosis, with an accompanying expression of affect, on what occasion and in what connection the symptoms had first appeared. 'It was in the summer during a period of extreme heat, and the patient was suffering very badly from thirst; for, without being able to account for it in any way, she suddenly found it impossible to drink. She would take up the glass of water that she longed for, but as soon as it touched her lips she would push it away like someone suffering from hydrophobia. As she did this, she was obviously in an *absence* for a couple of seconds. She lived only on fruit, such as melons, etc., so as to lessen her tormenting thirst. This had lasted for some six weeks, when one day during hypnosis she grumbled about her English "lady-companion", whom she did not care for, and went on to describe, with every sign of disgust, how she had once gone into this lady's room and how her little dog—horrid creature!—had drunk out of a glass there. The patient had said nothing, as she had wanted to be polite. After giving further energetic expression to the anger she had held back, she asked for something to drink, drank a large quantity of water without any difficulty, and awoke from her hypnosis with the glass at her lips; and thereupon the disturbance vanished, never to return.' [2]

With your permission, I should like to pause a moment over this event. Never before had anyone removed a hysterical symptom by such a method or had thus gained so deep an insight into its causation. It could not fail to prove a momentous

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

[2] *Studies on Hysteria* [*Standard Ed.*, **2**, 34].

discovery if the expectation were confirmed that others of the patient's symptoms—perhaps the majority of them—had arisen and could be removed in this same manner. Breuer spared no pains in convincing himself that this was so, and he proceeded to a systematic investigation of the pathogenesis of the other and more serious symptoms of the patient's illness. And it really *was* so. Almost all the symptoms had arisen in this way as residues —'precipitates' they might be called—of emotional experiences. To these experiences, therefore, we later gave the name of 'psychical traumas', while the particular nature of the symptoms was explained by their relation to the traumatic scenes which were their cause. They were, to use a technical term, 'determined' by the scenes of whose recollection they represented residues, and it was no longer necessary to describe them as capricious or enigmatic products of the neurosis. One unexpected point, however, must be noticed. What left the symptom behind was not always a *single* experience. On the contrary, the result was usually brought about by the convergence of several traumas, and often by the repetition of a great number of similar ones. Thus it was necessary to reproduce the whole chain of pathogenic memories in chronological order, or rather in reversed order, the latest ones first and the earliest ones last; and it was quite impossible to jump over the later traumas in order to get back more quickly to the first, which was often the most potent one.

No doubt you will now ask me for some further instances of the causation of hysterical symptoms besides the one I have already given you of a fear of water produced by disgust at a dog drinking out of a glass. But if I am to keep to my programme I shall have to restrict myself to very few examples. In regard to the patient's disturbances of vision, for instance, Breuer describes how they were traced back to occasions such as one on which, 'when she was sitting by her father's bedside with tears in her eyes, he suddenly asked her what time it was. She could not see clearly; she made a great effort, and brought her watch near to her eyes. The face of the watch now seemed very big—thus accounting for her macropsia and convergent squint. Or again, she tried hard to suppress her tears so that the sick man should not see them.' [1] Moreover, all of the patho-

[1] *Studies on Hysteria* [*Standard Ed.*, **2**, 39–40].

genic impressions came from the period during which she was helping to nurse her sick father. 'She once woke up during the night in great anxiety about the patient, who was in a high fever; and she was under the strain of expecting the arrival of a surgeon from Vienna who was to operate. Her mother had gone away for a short time and Anna was sitting at the bedside with her right arm over the back of her chair. She fell into a waking dream and saw a black snake coming towards the sick man from the wall to bite him. (It is most likely that there were in fact snakes in the field behind the house and that these had previously given the girl a fright; they would thus have provided the material for her hallucination.) She tried to keep the snake off, but it was as though she was paralysed. Her right arm, over the back of the chair, had gone to sleep, and had become anaesthetic and paretic; and when she looked at it the fingers turned into little snakes with death's heads (the nails). (It seems probable that she had tried to use her paralysed right hand to drive off the snake and that its anaesthesia and paralysis had consequently become associated with the hallucination of the snake.) When the snake vanished, in her terror she tried to pray. But language failed her: she could find no tongue in which to speak, till at last she thought of some children's verses in English and then found herself able to think and pray in that language.' [1] When the patient had recollected this scene in hypnosis, the rigid paralysis of her left arm, which had persisted since the beginning of her illness, disappeared, and the treatment was brought to an end.

When, some years later, I began to employ Breuer's method of examination and treatment on patients of my own, my experiences agreed entirely with his. A lady, aged about forty, suffered from a *tic* consisting of a peculiar 'clacking' sound which she produced whenever she was excited, or sometimes for no visible reason. It had its origin in two experiences, whose common element lay in the fact that at the moment of their occurrence she had formed a determination not to make any noise, and in the fact that on both these occasions a kind of counter-will led her to break the silence with this same sound. On the first of these occasions one of her children had been ill, and, when she had at last with great difficulty succeeded in getting it off to

[1] *Studies on Hysteria* [*Standard Ed.*, **2**, 38–9].

sleep, she had said to herself that she must keep absolutely still so as not to wake it. On the other occasion, while she was driving with her two children in a thunderstorm, the horses had bolted and she had carefully tried to avoid making any noise for fear of frightening them even more.[1] I give you this one example out of a number of others which are reported in the *Studies on Hysteria*.[2]

Ladies and Gentlemen, if I may be allowed to generalize—which is unavoidable in so condensed an account as this—I should like to formulate what we have learned so far as follows: *our hysterical patients suffer from reminiscences*. Their symptoms are residues and mnemic symbols of particular (traumatic) experiences. We may perhaps obtain a deeper understanding of this kind of symbolism if we compare them with other mnemic symbols in other fields. The monuments and memorials with which large cities are adorned are also mnemic symbols. If you take a walk through the streets of London, you will find, in front of one of the great railway termini, a richly carved Gothic column—Charing Cross. One of the old Plantagenet kings of the thirteenth century ordered the body of his beloved Queen Eleanor to be carried to Westminster; and at every stage at which the coffin rested he erected a Gothic cross. Charing Cross is the last of the monuments that commemorate the funeral cortège.[3] At another point in the same town, not far from London Bridge, you will find a towering, and more modern, column, which is simply known as 'The Monument'. It was designed as a memorial of the Great Fire, which broke out in that neighbourhood in 1666 and destroyed a large part of the city. These monuments, then, resemble hysterical symptoms in being mnemic symbols; up to that point the comparison seems justifiable. But what should we think of a Londoner who paused

[1] *Studies on Hysteria* [*Standard Ed.*, **2**, 54 and 58].

[2] Extracts from that volume, together with some later writings of mine on hysteria, are now to be had in an English translation prepared by Dr. A. A. Brill of New York. [See footnote p. 9. The case here reported is that of Frau Emmy von N., the second in *Studies on Hysteria*, *Standard Ed.*, **2**, 48 ff.]

[3] Or rather, it is a modern copy of one of these monuments. As Dr. Ernest Jones tells me, the name 'Charing' is believed to be derived from the words '*chère reine*'.

to-day in deep melancholy before the memorial of Queen Eleanor's funeral instead of going about his business in the hurry that modern working conditions demand or instead of feeling joy over the youthful queen of his own heart? Or again what should we think of a Londoner who shed tears before the Monument that commemorates the reduction of his beloved metropolis to ashes although it has long since risen again in far greater brilliance? Yet every single hysteric and neurotic behaves like these two unpractical Londoners. Not only do they remember painful experiences of the remote past, but they still cling to them emotionally; they cannot get free of the past and for its sake they neglect what is real and immediate. This fixation of mental life to pathogenic traumas is one of the most significant and practically important characteristics of neurosis.

I am quite ready to allow the justice of an objection that you are probably raising at this moment on the basis of the case history of Breuer's patient. It is quite true that all her traumas dated from the period when she was nursing her sick father and that her symptoms can only be regarded as mnemic signs of his illness and death. Thus they correspond to a display of mourning, and there is certainly nothing pathological in being fixated to the memory of a dead person so short a time after his decease; on the contrary, it would be a normal emotional process. I grant you that in the case of Breuer's patient there is nothing striking in her fixation to her trauma. But in other cases—such as that of the *tic* that I treated myself, where the determinants dated back more than fifteen and ten years—the feature of an abnormal attachment to the past is very clear; and it seems likely that Breuer's patient would have developed a similar feature if she had not received cathartic treatment so soon after experiencing the traumas and developing the symptoms.

So far we have only been discussing the relations between a patient's hysterical symptoms and the events of her life. There are, however, two further factors in Breuer's observation which enable us to form some notion of how the processes of falling ill and of recovering occur.

In the first place, it must be emphasized that Breuer's patient, in almost all her pathogenic situations, was obliged to *suppress* a powerful emotion instead of allowing its discharge in

the appropriate signs of emotion, words or actions. In the episode of her lady-companion's dog, she suppressed any manifestation of her very intense disgust, out of consideration for the woman's feelings; while she watched at her father's bedside she was constantly on the alert to prevent the sick man from observing her anxiety and her painful depression. When subsequently she reproduced these scenes in her doctor's presence the affect which had been inhibited at the time emerged with peculiar violence, as though it had been saved up for a long time. Indeed, the symptom which was left over from one of these scenes would reach its highest pitch of intensity at the time when its determining cause was being approached, only to vanish when that cause had been fully ventilated. On the other hand, it was found that no result was produced by the recollection of a scene in the doctor's presence if for some reason the recollection took place without any generation of affect. Thus it was what happened to these affects, which might be regarded as displaceable magnitudes, that was the decisive factor both for the onset of illness and for recovery. One was driven to assume that the illness occurred because the affects generated in the pathogenic situations had their normal outlet blocked, and that the essence of the illness lay in the fact that these 'strangulated' affects were then put to an abnormal use. In part they remained as a permanent burden upon the patient's mental life and a source of constant excitation for it; and in part they underwent a transformation into unusual somatic innervations and inhibitions, which manifested themselves as the physical symptoms of the case. For this latter process we coined the term 'hysterical conversion'. Quite apart from this, a certain portion of our mental excitation is normally directed along the paths of somatic innervation and produces what we know as an 'expression of the emotions'. Hysterical conversion exaggerates this portion of the discharge of an emotionally cathected mental process; it represents a far more intense expression of the emotions, which has entered upon a new path. When the bed of a stream is divided into two channels, then, if the current in one of them is brought up against an obstacle, the other will at once be overfilled. As you see, we are on the point of arriving at a purely psychological theory of hysteria, with affective processes in the front rank.

A second observation of Breuer's, again, compels us to attach great importance, among the characteristics of the pathological chain of events, to states of consciousness. Breuer's patient exhibited, alongside of her normal state, a number of mental peculiarities: conditions of '*absence*', confusion, and alterations of character. In her normal state she knew nothing of the pathogenic scenes or their connection with her symptoms; she had forgotten the scenes, or at all events had severed the pathogenic link. When she was put under hypnosis, it was possible, at the expense of a considerable amount of labour, to recall the scenes to her memory; and, through this work of recollecting, the symptoms were removed. The explanation of this fact would be a most awkward business, were it not that the way is pointed by experiences and experiments in hypnotism. The study of hypnotic phenomena has accustomed us to what was at first a bewildering realization that in one and the same individual there can be several mental groupings, which can remain more or less independent of one another, which can 'know nothing' of one another and which can alternate with one another in their hold upon consciousness. Cases of this kind, too, occasionally appear spontaneously, and are then described as examples of '*double conscience*'.[1] If, where a splitting of the personality such as this has occurred, consciousness remains attached regularly to one of the two states, we call it the *conscious* mental state and the other, which is detached from it, the *unconscious* one. In the familiar condition known as 'post-hypnotic suggestion', a command given under hypnosis is slavishly carried out subsequently in the normal state. This phenomenon affords an admirable example of the influences which the unconscious state can exercise over the conscious one; moreover, it provides a pattern upon which we can account for the phenomena of hysteria. Breuer adopted a hypothesis that hysterical symptoms arise in peculiar mental conditions to which he gave the name of 'hypnoid'. On this view, excitations occurring during these hypnoid states can easily become pathogenic because such states do not provide opportunities for the normal discharge of the process of excitation. There consequently arises from the process of excitation an unusual product—the symptom. This finds its way, like a foreign body, into the normal state, which

[1] [The French term for 'dual consciousness'.]

in turn is in ignorance of the hypnoid pathogenic situation. Wherever there is a symptom there is also an amnesia, a gap in the memory, and filling up this gap implies the removal of the conditions which led to the production of the symptom.

This last part of my account will not, I fear, strike you as particularly clear. But you should bear in mind that we are dealing with novel and difficult considerations, and it may well be that it is not possible to make them much clearer—which shows that we still have a long way to go in our knowledge of the subject. Moreover, Breuer's theory of 'hypnoid states' turned out to be impeding and unnecessary, and it has been dropped by psycho-analysis to-day. Later on, you will at least have a hint of the influences and processes that were to be discovered behind the screen of hypnoid states erected by Breuer. You will have rightly formed the opinion, too, that Breuer's investigation has only succeeded in offering you a very incomplete theory and an unsatisfying explanation of the phenomena observed. But complete theories do not fall ready-made from the sky and you would have even better grounds for suspicion if anyone presented you with a flawless and complete theory at the very beginning of his observations. Such a theory could only be a child of his speculation and could not be the fruit of an unprejudiced examination of the facts.

SECOND LECTURE

LADIES AND GENTLEMEN,—At about the same time at which Breuer was carrying on the 'talking cure' with his patient, the great Charcot in Paris had begun the researches into hysterical patients at the Salpêtrière which were to lead to a new understanding of the disease. There was no possibility of his findings being known in Vienna at that time. But when, some ten years later, Breuer and I published our 'Preliminary Communication' on the psychical mechanism of hysterical phenomena [1893*a*], we were completely under the spell of Charcot's researches. We regarded the pathogenic experiences of our patients as psychical traumas, and equated them with the somatic traumas whose influence on hysterical paralyses had been established by Charcot; and Breuer's hypothesis of hypnoid states was itself nothing but a reflection of the fact that Charcot had reproduced those traumatic paralyses artificially under hypnosis.

The great French observer, whose pupil I became in 1885–6, was not himself inclined to adopt a psychological outlook. It was his pupil, Pierre Janet, who first attempted a deeper approach to the peculiar psychical processes present in hysteria, and we followed his example when we took the splitting of the mind and dissociation of the personality as the centre of our position. You will find in Janet a theory of hysteria which takes into account the prevailing views in France on the part played by heredity and degeneracy. According to him, hysteria is a form of degenerate modification of the nervous system, which shows itself in an innate weakness in the power of psychical synthesis. Hysterical patients, he believes, are inherently incapable of holding together the multiplicity of mental processes into a unity, and hence arises the tendency to mental dissociation. If I may be allowed to draw a homely but clear analogy, Janet's hysterical patient reminds one of a feeble woman who has gone out shopping and is now returning home laden with a multitude of parcels and boxes. She cannot contain the whole heap of them with her two arms and ten fingers. So first of all one object slips from her grasp; and when she stoops to pick it up, another

one escapes her in its place, and so on. This supposed mental weakness of hysterical patients is not confirmed when we find that, alongside these phenomena of diminished capacity, examples are also to be observed of a partial increase in efficiency, as though by way of compensation. At the time when Breuer's patient had forgotten her mother tongue and every other language but English, her grasp of English reached such heights that, if she was handed a German book, she was able straight away to read out a correct and fluent translation of it.

When, later on, I set about continuing on my own account the investigations that had been begun by Breuer, I soon arrived at another view of the origin of hysterical dissociation (the splitting of consciousness). A divergence of this kind, which was to be decisive for everything that followed, was inevitable, since I did not start out, like Janet, from laboratory experiments, but with therapeutic aims in mind.

I was driven forward above all by practical necessity. The cathartic procedure, as carried out by Breuer, presupposed putting the patient into a state of deep hypnosis; for it was only in a state of hypnosis that he attained a knowledge of the pathogenic connections which escaped him in his normal state. But I soon came to dislike hypnosis, for it was a temperamental and, one might almost say, a mystical ally. When I found that, in spite of all my efforts, I could not succeed in bringing more than a fraction of my patients into a hypnotic state, I determined to give up hypnosis and to make the cathartic procedure independent of it. Since I was not able at will to alter the mental state of the majority of my patients, I set about working with them in their *normal* state. At first, I must confess, this seemed a senseless and hopeless undertaking. I was set the task of learning from the patient something that I did not know and that he did not know himself. How could one hope to elicit it? But there came to my help a recollection of a most remarkable and instructive experiment which I had witnessed when I was with Bernheim at Nancy [in 1889]. Bernheim showed us that people whom he had put into a state of hypnotic somnambulism, and who had had all kinds of experiences while they were in that state, only *appeared* to have lost the memory of what they had experienced during somnambulism; it was possible to revive

these memories in their normal state. It is true that, when he questioned them about their somnambulistic experiences, they began by maintaining that they knew nothing about them; but if he refused to give way, and insisted, and assured them that they *did* know about them, the forgotten experiences always reappeared.

So I did the same thing with my patients. When I reached a point with them at which they maintained that they knew nothing more, I assured them that they *did* know it all the same, and that they had only to say it; and I ventured to declare that the right memory would occur to them at the moment at which I laid my hand on their forehead. In that way I succeeded, without using hypnosis, in obtaining from the patients whatever was required for establishing the connection between the pathogenic scenes they had forgotten and the symptoms left over from those scenes. But it was a laborious procedure, and in the long run an exhausting one; and it was unsuited to serve as a permanent technique.

I did not abandon it, however, before the observations I made during my use of it afforded me decisive evidence. I found confirmation of the fact that the forgotten memories were not lost. They were in the patient's possession and were ready to emerge in association to what was still known by him; but there was some force that prevented them from becoming conscious and compelled them to remain unconscious. The existence of this force could be assumed with certainty, since one became aware of an effort corresponding to it if, in opposition to it, one tried to introduce the unconscious memories into the patient's consciousness. The force which was maintaining the pathological condition became apparent in the form of *resistance* on the part of the patient.

It was on this idea of resistance, then, that I based my view of the course of psychical events in hysteria. In order to effect a recovery, it had proved necessary to remove these resistances. Starting out from the mechanism of cure, it now became possible to construct quite definite ideas of the origin of the illness. The same forces which, in the form of resistance, were now offering opposition to the forgotten material's being made conscious, must formerly have brought about the forgetting and

must have pushed the pathogenic experiences in question out of consciousness. I gave the name of '*repression*' to this hypothetical process, and I considered that it was proved by the undeniable existence of resistance.

The further question could then be raised as to what these forces were and what the determinants were of the repression in which we now recognized the pathogenic mechanism of hysteria. A comparative study of the pathogenic situations which we had come to know through the cathartic procedure made it possible to answer this question. All these experiences had involved the emergence of a wishful impulse which was in sharp contrast to the subject's other wishes and which proved incompatible with the ethical and aesthetic standards of his personality. There had been a short conflict, and the end of this internal struggle was that the idea which had appeared before consciousness as the vehicle of this irreconcilable wish fell a victim to repression, was pushed out of consciousness with all its attached memories, and was forgotten. Thus the incompatibility of the wish in question with the patient's ego was the motive for the repression; the subject's ethical and other standards were the repressing forces. An acceptance of the incompatible wishful impulse or a prolongation of the conflict would have produced a high degree of unpleasure; this unpleasure was avoided by means of repression, which was thus revealed as one of the devices serving to protect the mental personality.

To take the place of a number of instances, I will relate a single one of my cases, in which the determinants and advantages of repression are sufficiently evident. For my present purpose I shall have once again to abridge the case history and omit some important underlying material. The patient was a girl,[1] who had lost her beloved father after she had taken a share in nursing him—a situation analogous to that of Breuer's patient. Soon afterwards her elder sister married, and her new brother-in-law aroused in her a peculiar feeling of sympathy which was easily masked under a disguise of family affection. Not long afterwards her sister fell ill and died, in the absence of the patient and her mother. They were summoned in all haste

[1] [This is the case of Fräulein Elisabeth von R., the fifth of the case histories fully reported in *Studies on Hysteria, Standard Ed.*, **2**, 135 ff.]

without being given any definite information of the tragic event. When the girl reached the bedside of her dead sister, there came to her for a brief moment an idea that might be expressed in these words: 'Now he is free and can marry me.' We may assume with certainty that this idea, which betrayed to her consciousness the intense love for her brother-in-law of which she had not herself been conscious, was surrendered to repression a moment later, owing to the revolt of her feelings. The girl fell ill with severe hysterical symptoms; and while she was under my treatment it turned out that she had completely forgotten the scene by her sister's bedside and the odious egoistic impulse that had emerged in her. She remembered it during the treatment and reproduced the pathogenic moment with signs of the most violent emotion, and, as a result of the treatment, she became healthy once more.

Perhaps I may give you a more vivid picture of repression and of its necessary relation to resistance, by a rough analogy derived from our actual situation at the present moment. Let us suppose that in this lecture-room and among this audience, whose exemplary quiet and attentiveness I cannot sufficiently commend, there is nevertheless someone who is causing a disturbance and whose ill-mannered laughter, chattering and shuffling with his feet are distracting my attention from my task. I have to announce that I cannot proceed with my lecture; and thereupon three or four of you who are strong men stand up and, after a short struggle, put the interrupter outside the door. So now he is 'repressed', and I can continue my lecture. But in order that the interruption shall not be repeated, in case the individual who has been expelled should try to enter the room once more, the gentlemen who have put my will into effect place their chairs up against the door and thus establish a 'resistance' after the repression has been accomplished. If you will now translate the two localities concerned into psychical terms as the 'conscious' and the 'unconscious', you will have before you a fairly good picture of the process of repression.

You will now see in what it is that the difference lies between our view and Janet's. We do not derive the psychical splitting from an innate incapacity for synthesis on the part of the mental

apparatus; we explain it dynamically, from the conflict of opposing mental forces and recognize it as the outcome of an active struggling on the part of the two psychical groupings against each other. But our view gives rise to a large number of fresh problems. Situations of mental conflict are, of course, exceedingly common; efforts by the ego to ward off painful memories are quite regularly to be observed without their producing the result of a mental split. The reflection cannot be escaped that further determinants must be present if the conflict is to lead to dissociation. I will also readily grant you that the hypothesis of repression leaves us not at the end but at the beginning of a psychological theory. We can only go forward step by step however, and complete knowledge must await the results of further and deeper researches.

Nor is it advisable to attempt to explain the case of Breuer's patient from the point of view of repression. That case history is not suited to this purpose, because its findings were reached with the help of hypnotic influence. It is only if you exclude hypnosis that you can observe resistances and repressions and form an adequate idea of the truly pathogenic course of events. Hypnosis conceals the resistance and renders a certain area of the mind accessible; but, as against this, it builds up the resistance at the frontiers of this area into a wall that makes everything beyond it inaccessible.

Our most valuable lesson from Breuer's observation was what it proved concerning the relation between symptoms and pathogenic experiences or psychical traumas, and we must not omit now to consider these discoveries from the standpoint of the theory of repression. At first sight it really seems impossible to trace a path from repression to the formation of symptoms. Instead of giving a complicated theoretical account, I will return here to the analogy which I employed earlier for my explanation of repression. If you come to think of it, the removal of the interrupter and the posting of the guardians at the door may not mean the end of the story. It may very well be that the individual who has been expelled, and who has now become embittered and reckless, will cause us further trouble. It is true that he is no longer among us; we are free from his presence, from his insulting laughter and his *sotto voce* comments. But in

some respects, nevertheless, the repression has been unsuccessful; for now he is making an intolerable exhibition of himself outside the room, and his shouting and banging on the door with his fists interfere with my lecture even more than his bad behaviour did before. In these circumstances we could not fail to be delighted if our respected president, Dr. Stanley Hall, should be willing to assume the role of mediator and peacemaker. He would have a talk with the unruly person outside and would then come to us with a request that he should be re-admitted after all: he himself would guarantee that the man would now behave better. On Dr. Hall's authority we decide to lift the repression, and peace and quiet are restored. This presents what is really no bad picture of the physician's task in the psycho-analytic treatment of the neuroses.

To put the matter more directly. The investigation of hysterical patients and of other neurotics leads us to the conclusion that their repression of the idea to which the intolerable wish is attached has been a *failure*. It is true that they have driven it out of consciousness and out of memory and have apparently saved themselves a large amount of unpleasure. *But the repressed wishful impulse continues to exist in the unconscious*. It is on the look-out for an opportunity of being activated, and when that happens it succeeds in sending into consciousness a disguised and unrecognizable *substitute* for what had been repressed, and to this there soon become attached the same feelings of unpleasure which it was hoped had been saved by the repression. This substitute for the repressed idea—the *symptom*—is proof against further attacks from the defensive ego; and in place of the short conflict an ailment now appears which is not brought to an end by the passage of time. Alongside the indication of distortion in the symptom, we can trace in it the remains of some kind of indirect resemblance to the idea that was originally repressed. The paths along which the substitution was effected can be traced in the course of the patient's psychoanalytic treatment; and in order to bring about recovery, the symptom must be led back along the same paths and once more turned into the repressed idea. If what was repressed is brought back again into conscious mental activity—a process which presupposes the overcoming of considerable resistances—the resulting psychical conflict, which the patient had tried to avoid,

can, under the physician's guidance, reach a better outcome than was offered by repression. There are a number of such opportune solutions, which may bring the conflict and the neurosis to a happy end, and which may in certain instances be combined. The patient's personality may be convinced that it has been wrong in rejecting the pathogenic wish and may be led into accepting it wholly or in part; or the wish itself may be directed to a higher and consequently unobjectionable aim (this is what we call its 'sublimation'); or the rejection of the wish may be recognized as a justifiable one, but the automatic and therefore inefficient mechanism of repression may be replaced by a condemning judgement with the help of the highest human mental functions—conscious control of the wish is attained.

You must forgive me if I have not succeeded in giving you a more clearly intelligible account of these basic positions adopted by the method of treatment that is now described as 'psycho-analysis'. The difficulties have not lain only in the novelty of the subject. The nature of the incompatible wishes which, in spite of repression, succeed in making their existence in the unconscious perceptible, and the subjective and constitutional determinants which must be present in anyone before a failure of repression can occur and a substitute or symptom be formed—on all this I shall have more light to throw in some of my later observations.

THIRD LECTURE

LADIES AND GENTLEMEN,—It is not always easy to tell the truth, especially when one has to be concise; and I am thus to-day obliged to correct a wrong statement that I made in my last lecture. I said to you that, having dispensed with hypnosis, I insisted on my patients nevertheless telling me what occurred to them in connection with the subject under discussion, and assured them that they really knew everything that they had ostensibly forgotten and that the idea that occurred to them [1] would infallibly contain what we were in search of; and I went on to say to you that I found that the first idea occurring to my patients did in fact produce the right thing and turned out to be the forgotten continuation of the memory. This, however, is not in general the case, and I only put the matter so simply for the sake of brevity. Actually it was only for the first few times that the right thing which had been forgotten turned up as a result of simple insistence on my part. When the procedure was carried further, ideas kept on emerging that could not be the right ones, since they were not appropriate and were rejected as being wrong by the patients themselves. Insistence was of no further help at this point, and I found myself once more regretting my abandonment of hypnosis.

While I was thus at a loss, I clung to a prejudice the scientific justification for which was proved years later by my friend C. G. Jung and his pupils in Zurich. I am bound to say that it is sometimes most useful to have prejudices. I cherished a high opinion of the strictness with which mental processes are determined, and I found it impossible to believe that an idea produced by a patient while his attention was on the stretch could be an arbitrary one and unrelated to the idea we were in search of. The fact that the two ideas were not identical could be satisfactorily explained from the postulated psychological state

[1] [The German word here is '*Einfall*', which is often translated 'association'; but the latter is a question-begging word and is avoided here as far as possible, even at the price of such long paraphrases as the present one. When, however, we come to '*freier Einfall*', 'free association' (though still objectionable) is hardly to be escaped.]