Chapter One

Freud’s heroic era: the first ten years

Slightly before, slightly beyond

Chapter summary

The title of the chapter is from Walter Stewart’s book, *Psychoanalysis: The First Ten Years* (1963). In this chapter we look at the beginning of Freud’s career as a therapist and an emerging psychoanalyst. He attempts to formulate a theory where psychological disturbances are caused by a combination of environmental events and physiological conditions. He is strongly influenced by the neurophysiologists of his era, and the familiar Freudian concepts such as fantasy and transference do not play a prominent role in the theory of this era. Rather, in adults there are actual causes that produce neurotic symptoms. The sexual practices of the era are thought by Freud to produce symptoms such as anxiety and neurasthenia. He calls neuroses that are produced by sexual practices, such as excessive masturbation or coitus interruptus, actual neuroses. Neuroses that are caused by conditions in childhood are called psychogenic neuroses, but these disorders are also caused by “real” events, trauma in childhood. The trauma that Freud finds most often involves sexual abuse (before the child’s eighth birthday). This is a real event that causes psychological disturbance, and here Freud uses the concept of undischarged tension or libido to explain both the actual and psychological neuroses. Freud’s emerging psychological treatment is one where he is attempting to extirpate pathogenic memories through the cathartic method. In effect, he is attempting to have patients experience strong emotional reaction (abreaction) by bringing memories to consciousness. In this period, Freud has not fully developed the idea of unconscious ideas and his treatment method involves trying to pressure patients into

remembering and abreacting. During this era, Freud moves from the use of hypnosis (Breuer's technique) to a psychotherapy that is labelled the pressure technique.

Despite the fact that Freud has not yet developed his psychoanalytic theory, one can see many of his concepts in embryonic form. The concept of defence, resistance, and the beginning of the concept of unconscious motivation all have their roots in this period of Freud's career. There are, of course, many other fragments in his emerging theory, including ideas about dreams and the importance of fantasy. Freud also begins his self-analysis during this period, and this is one factor that will lead Freud to question whether his patient's reports of sexual abuse are real or the product of fantasy developed early in the person's life.

Brief historical introduction

In 1882, a meeting occurred that contributed to changing the history of psychiatry and, indeed, of intellectual life in the Western hemisphere during the twentieth century and perhaps beyond. In this meeting, Josef Breuer told Sigmund Freud about his treatment of Anna O (Bertha Pappenheim). This discussion strongly contributed to Freud's subsequent decision to begin to study hysteria. Freud began to collaborate with Breuer a number of years after this conversation, and in the interim he studied with Charcot and learnt about the views of Janet and Bernheim. He also translated and wrote a preface to Bernheim's (1888) book *Suggestion*. Although various analysts have tried to minimize the effect of Breuer's work and theoretical formulations on Freud, in my view it was the intrigue of the narrative that Breuer was experiencing with Bertha Pappenheim that captured Freud. Breuer, at this point in time, was a sophisticated reader of the scientific literature and his views about cortical tonicity also influenced Freud at various points in his career. However, it was the narrative of Ms Pappenheim and of the patients after her, in what Stewart (1963) calls Freud's heroic period, that truly fascinated the young physician whose literary tendencies in many ways were more prominent than his scientific interests (Steiner, 2001).

It is not the aim of the present chapter(s) to trace the intellectual influences on Freud; rather, we will evaluate his contributions as the most convincing evidence of how the intellectual ferment of his era affected his writings. We begin this chapter at a time (1892–1898) when Freud is starting to revolutionize the world of psychiatry with his theoretical concepts and his new psychotherapeutic technique. At this point in his career, Freud's theoretical attempts are intimately intermingled with his therapeutic venture. (In a previous volume [1991] I expressed the view that, as Freud's career progressed, he became increasingly involved in theoretical issues and that the psychoanalytic situation lost a position of primary importance. This was not a linear progression, for, in the era 1907–1916, he was active in writing about psychoanalytic treatment as well as bringing forth seminal theoretical papers. However, later in his career, when he was putting forth his best known works such as

The Ego and the Id [1923b] he was no longer intensely involved in the clinical situation. Rather, he had become a world figure who was doing training analyses which were frequently not serious analytic encounters, in my opinion.) We join him when he and Breuer are describing their experiences in treating patients that they have diagnosed as hysterics (Breuer & Freud, 1895d). In fact, the patients that Freud treated in the late 1880s and 1890s presented a wide assortment of symptomatology and complaints, including conversion symptoms (pain in limbs, paresis, aphonia, etc.), depression, impotence, and hallucinations. It does not take a particularly careful reading of Freud's cases to see that he was not only treating hysterics, but also patients who, in modern terms, run the gamut of diagnostic categories (including neurotic, borderline, and psychotic disorders). While Freud heard a wide array of symptoms and complaints in this, his "heroic era", his focus was on the dramatic symptomatology he was encountering. Given this concern, many of the patients Freud saw in these early "heroic days" would today not be diagnosed in the same manner that governed Breuer and Freud's nosological distinctions. Freud's first therapeutic attempts were designed to remove the patient's symptoms as rapidly as possible. He quickly learned that at times patients did not share his goals.

In the *Standard Edition* (Volume 2) the editors state that, "The *Studies on Hysteria* are usually regarded as the starting point of psycho-analysis". They contend that the most important of Freud's achievements recorded in this volume is the "invention of the first instrument for the scientific examination of the human mind" (*S.E*. *2*, p. xvi). This comment on the part of the editors reveals their particular bias in understanding Freud's work. The use of the term scientific is difficult to deal with in today's psychoanalytic world. On the one hand, researchers might criticize the term, since Freud in any ordinary sense of the term was not conducting scientific research. Certain clinicians, on the other hand, have criticized Freud for being overly scientific. They maintain that he did not sufficiently emphasize the literary aspects of psychoanalysis. It is fascinating "to trace the early steps of the development" (*S.E*., *2*, p. xvi) of his psychotherapeutic method, but the theoretical concepts that he formulates and comes to accept in this volume can be viewed as equally important in the history of psychoanalysis. He gives graphic clinical examples of how he conceptualizes his new ideas about the nature of defence and defence hysteria. (He does not, at this time, distinguish between resistance and defence, although he uses both terms.) He also gives us a clear indication of how he is conceiving of an idea that is not in consciousness. There is a temptation to say an idea that is unconscious, but, at this point in time, Freud has not yet fully elaborated this theoretical concept. Freud does present one of his first notions of the organization of ideas outside of consciousness (or in what he calls the secondary group of ideas). Freud, at this point, distinguishes between a primary group of ideas or associations, which are conscious, and a secondary split of group of ideas, which are outside of consciousness. Where are they, one might ask? There are two possible answers to this question: it is possible to think of a splitting of consciousness, or one might think of the ideas as unconscious. Freud, at this point, has not fully thought through where his concept of

defence is about to take him and psychoanalysis. We will look at this issue more systematically in this and the next chapter.

The attempt to delineate an era is of course highly artificial, and we will, at times, need to make reference to Freud's earlier work (or activities) to gain a clearer vision of his theoretical positions during this period. In a similar vein, while we will not be focusing on biographical material, at times we will look at aspects of Freud's life. For example, it is hard to understand some of Freud's theoretical preoccupations unless one has some inkling of his relationship during this period with Fliess, Freud's confidant, co-conspirator and the recipient of a good deal of Freud's transference. In this brief introduction, we have gone over some of Freud's career prior to this period; here we can begin to look at the new concepts that Freud is beginning to develop.

We will begin by looking at Freud's first publication with Breuer and showing how it presages many of his concepts during this period. Then we will systematically look at the development of each of the ideas that Freud has introduced in his preliminary communication. In this chapter, we will look quote Freud extensively to give the reader more of a first-hand sense of Freud's conceptualizations in this, perhaps most unfamiliar, era of his work.

Studies on hysteria: preliminary communication

Freud tells us "that psycho-analysis started with researches into hysteria" (1913m, p. 207) and that hypnosis was his original therapeutic technique. In his publication with Breuer (Breuer & Freud, 1893a) he is describing his experiences treating patients who are diagnosed as hysterics. Today, many of these patients would not be diagnosed as having hysterical disorders. Rather, many of them would be seen as having conversion symptoms, at times with more severe diagnoses. By and large, these patients are women (Freud had presented a paper on his treatment of a male hysteric, and some members of the audience treated this report with some scepticism) whose complaints have usually not been taken seriously by the physicians of Freud's Vienna or, indeed, by physicians in most of the European continent. Breuer, in 1882, had told Freud of a hysterical patient he had treated and this conversation had what might be considered a deferred influence on Freud. We know that, several years later, Freud travelled to Paris to study with Charcot. Freud told Charcot of Breuer's treatment of Anna O (Bertha Pappenheim); however, Charcot seemed to evince little interest in the case report. Nevertheless, when Freud returned to Vienna, he found a path back to Breuer and Breuer's method of treatment where he utilized hypnosis, called the cathartic method. By the time Breuer and Freud are publishing their preliminary communication (1893a), Freud has already treated several hysterical patients using hypnosis and the cathartic method. He has also begun to experiment with other methods of treatment and, in 1895, he publishes his new method and his new ideas about hysteria.

In 1893, he and Breuer tell us that the aim of his hypnotic technique is to bring about the "reproduction of a memory which was of importance in bringing about the onset of the hysteria… the memory [is] either of a single major trauma… or of a series of interconnected part-traumas" (Breuer & Freud, 1893a, p. 14). It was Freud's view that "hysterics suffer mainly from reminiscences" (*ibid*.). These memories or reminiscences are the result of psychical trauma "or more precisely the memory of the trauma… [which] acts like a foreign body long after its entry must continue to be regarded as an agent that is still at work" (*ibid*., p. 6). Breuer and Freud reported that, to their surprise,

> 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 effect into words. Recollection without affect almost invariably produces no result. [*ibid*.]

Thus, in Freud's early conceptualizations, he is attempting to establish the precipitating cause(s) of hysterical attacks. He has found that usually the patient is unaware of the meaning of these attacks. As a result of his and Breuer's investigations, they have seen that external events determine the pathway of hysterical attacks and that each attack is related to the first attack. This relationship may extend over many years, and they comment on the similarity of hysteria to the traumatic neuroses. There is a clear precipitating event and a clear relationship between the precipitating event and subsequent attacks. They wondered whether all neuroses are formed in the way that they have conceptualized the hysterical neuroses.

Beyond this attempt to describe the course of hysterical symptoms, Freud also points out that the symptoms are related to painful, anxiety-provoking memories that are stored apart from the person's primary or conscious (primary system) ideas about themselves. These thoughts, which are stored as a secondary group (secondary system) of ideas, are not readily accessible to consciousness. Freud contrasts hysterics with normal or "healthy" experiences. In normal circumstances, the affect associated with disturbing events is worn away or discharged. In the following paragraph, we can see Freud's ideas of how memories are normally managed.

> The fading of a memory or the losing of its affect depends on various factors. The most important of these is whether there has been an energetic reaction to the event that provokes an affect. By "reaction" we here understand the whole class of voluntary and involuntary reflexes—from tears to acts of revenge—in which, as experience shows us, the affects are discharged. If this reaction takes place to a sufficient amount a large part of the effect disappears as a result. Linguistic usage bears witness to this fact of daily observation by such phrases as "to cry oneself out", and to "blow off steam" (literally "to rage oneself out"). If the reaction is suppressed, the affect remains attached to the memory. An injury

> that has been repaid, even if only in words, is recollected quite differently from one that has had to be accepted. [1893a, p. 8]

In this formulation, Freud maintained that under normal or optimal circumstances people are able to deal with, or wear away, distressing affect by fully experiencing or discharging the affect. They may also deal with an affect by being able to counteract an experience in thought or action. If, for instance, a situation stimulated an idea that brought up the affect of shame, the person might be able to nullify this idea by reminding themselves of their positive attributes. They might assure themselves that the event that caused the affect of shame was a singular or infrequent occurrence, and this might allow them to wear away this affect. Alternatively, they might do something in reality to counteract this experience. Thus, normal people are continually discharging affect or putting a memory of a disturbing or humiliating circumstance into appropriate perspective. They are able to this "by considering (one's) own worth" (*ibid*., p. 9). Put in other terms, a normal person can have either small abreactions (discharges of affect through thought or action) or deal with the personal insult or aversive effect more gradually "through the process of association" (*ibid*.). Forgetting, or, more accurately, the fading of memories, takes place when the affect is "worn away". Freud believed that memories can be fully recaptured when the affect is reunited with the idea or representation. Thus, even normal memories are potentially available if the affect is reunited with the idea. For this to occur in this model, the affect must be stimulated by an external source. This point will become clearer as we progress further into Freud's ideas. Freud has implicitly introduced several of the themes that will continue in his work to the end of his career. The first of these has already begun to surface, that is, the concept of psychic energy. This theoretical assumption is more formally stated in "The neuro-psychoses of defence" (1894a), but here this concept is present as an accompaniment to his ideas about defence. Defence is a concept that is lurking behind and within the phrase, "hysterics suffer from reminiscences". In addition, Freud states that the reminiscences are "experiences… completely absent from the patients' (normal or conscious) memory" (1893a, p. 9). This is what Freud is referring to as the secondary group of ideas, or what we might say is the beginning of his theory of unconscious processes. Forgetting takes place when the affect is worn away from the idea, this is true in both normal and neurotic experience. The difference is how the affect is worn away: in normal experience, it is worn away in the primary associational pathway; in neurotic experience, it is dispatched through the process of defence.

Defence in hysteria and the psychoneuroses

Breuer, Janet, and Charcot: alternative concepts

A reader of Breuer and Freud's preliminary communication would have been hard pressed to guess what was in store for the psychiatric world during the next few years. Freud gave little indication of his new theoretical inclinations in his chapter with Breuer. In this chapter, hypnoid states are mentioned as an important factor in the aetiology of hysteria. (*Studies on Hysteria* was published in 1895, but the first chapter in this book (co-authored by Breuer and Freud) had been published previously as a paper in 1893.) In Breuer's theoretical chapter in *Studies on Hysteria*, he presents a sophisticated neuro-physiological theory about the genesis of hypnoid states. Breuer saw hypnoid states as a necessary condition for the formation of hysterical or conversion symptoms. It was his view that, during this type of hypnogogic (what I mean here is a state that is close to sleep onset, as hypnogogic imagery is that imagery that one has while falling asleep) state the person was more prone to be overwhelmed (traumatized) by stimuli. His theory stated the conditions for a threshold shift that made the cortex more susceptible to trauma. While Breuer did not stress innate factors, he certainly was influenced by the *zeitgeist* of the times, where innate factors were taken to be the main variable in the causal chain leading to hysterical conditions. Janet had previously maintained that hysteria "is based on an innate weakness of the capacity for psychical synthesis" (Freud, 1894a, p. 46). Although Charcot designated certain types of hysteria as traumatic in origin, the ultimate causal factor for him was also an inherited predisposition. Freud did not, at this time, actively dispute these theoretical accounts and, in fact, as we will see, he had his own hypothesis about the type of physiological factors that predisposed patients to hysteria. However, by 1894, in "The neuro-psychoses of defence", Freud is distancing himself from Janet, and implicitly from Charcot, and, by 1895, from Breuer as well. Let us look at his comments about Janet.

> According to the theory of Janet the splitting of consciousness is a primary feature of the mental change in hysteria. It is based on an innate weakness of the capacity for psychical synthesis, on the narrowness of the field of consciousness (champ de la conscience) which, in the form of a psychical stigma, is evidence of the degeneracy [by this, Janet meant a capacity for neurological degeneracy] of hysterical individuals. In contradistinction to Janet's view, which seems to me to admit of a great variety of objections, there is the view put forward by Breuer in our joint communication (Breuer and Freud, 1893). According to him, "the basis and sine qua non of hysteria" is the occurrence of peculiar dream-like states of consciousness with a restricted capacity for association, for which he proposes the name "hypnoid states". In that case, the splitting of consciousness is secondary and acquired; it comes about because the ideas which emerge in hypnoid states are cut off from associative communication with the rest of the content of consciousness.
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> I am now in a position to bring forward evidence of two other extreme forms of hysteria in which it is impossible to regard the splitting of consciousness as primary in Janet's sense. In the first of these [two further] forms I was repeatedly able to show that the splitting of the content of consciousness is the result of an act of will on the part of the patient; that is to say, it is initiated by an act of will whose motive can be specified. By this I do not of course, mean that the patient intends to bring about a splitting of consciousness. His intention is a different one; but, instead of attaining its aim, it produces a splitting of consciousness.

> In the third form of hysteria, which we have demonstrated by means of a psychical analysis of intelligent patients, the splitting of consciousness plays an insignificant part, or perhaps none at all. They are those cases in which what has happened is only that the reaction to traumatic stimuli has failed to occur, and which can also, accordingly, be resolved and cured by "abreaction". These are the pure retention hysterias.
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> As regards the connection with phobias and obsessions, I am only concerned with the second form of hysteria. For reasons which will soon be evident, I shall call this form "defence hysteria", using the name to distinguish it from hypnoid hysteria and retention hysteria. I may also provisionally present my cases of defence hysteria as "acquired" hysteria, since in them there was no question either of a grave hereditary taint or of an individual degenerative atrophy. [Freud, 1894a, pp. 46–47]

In this extract, we see Freud not only naming a new type of disorder (defence hysteria), but also rejecting the idea that hysteria is primarily based on an inherited predisposition. Janet's view of the innate weakness of the hysteric's capacity for psychical synthesis is specifically cast aside, but, implicitly, he is also disagreeing with Charcot's view of hysteria. Charcot divided hysteria into two forms. In the idiopathic or constitutional form, his view was quite similar to Janet's ideas. He distinguished a traumatic hysteria where an event (a train crash, for example) gave rise to the symptoms of hysteria. He thought this type of hysteria admitted of a psychogenic explanation, but still felt that the proclivity for hysteria was an innate tendency. He reasoned that not all passengers in a train crash developed hysterical symptoms and the distinction between those who did and did not rested on their innate tendencies. Although Freud maintains in "The neuro-psychoses of defence" that there are three types of hysteria (defence, retention, and hypnoid), in Chapter Four of *Studies on Hysteria*, written in 1895, he implies that all hysterical disorders can be seen as a form of defence hysteria.

In this paper, we see Freud tactfully rejecting the idea that either retention or hypnoid hysteria is an actual clinical entity. For Freud, defence is at the heart of hysteria and in (1894) he has extended the idea of defence to both phobias and obsessions. Why did Freud need to postulate the concept of defence? He knew from both his experiences with Breuer and Charcot that, in some cases, traumatic circumstances condition various aspects of hysterical symptoms. His clinical observations were that patients were affected by trauma memories for a long period of time after these events took place. Why, perhaps with Breuer's concept, was this not enough of an explanation? Both retention and hypnoid hysteria hypotheses are forms of trauma overwhelming the central nervous system. Again, Breuer thought that the distressing thoughts and feelings occurred during a hypnoid state which was not part of normal consciousness. Given that these thoughts and feelings happened during a hypnoid (or twilight) state, they were not accessible to normal consciousness or the primary associational pathway. The retention hypothesis logic was similar in that, in this view, the person was not able to consciously retain the trauma. The amount of stimulation involved in the trauma, in this formulation, overwhelms the capacity of the primary associational pathways and was, therefore, not retained in

consciousness. More frequently, the way these hypotheses (hypnoid and retention) were stated was that there was a split in the person's consciousness. Freud, in abandoning these ideas for the concept of defence, still had to explain the same phenomena. In "The neuropsychoses of defence", Freud is more explicit about the role of defence:

> The task which the ego, in its defensive attitude, sets itself of treating the incompatible idea as "nonarrivee" simply cannot be fulfilled by it. Both the memory trace and the affect which is attached to the idea are there once and for all and cannot be eradicated. But it amounts to an approximate fulfilment of the task if the ego succeeds *in turning the powerful idea into a weak one*, in robbing it of the affect—the sum of excitation—with which it is loaded. The weak idea will then have virtually no demands to make on the work of association. But the sum of excitation which has been detached from it must be put to another use. [1894a, pp. 48–49]

Defence is, then, a process that turns a strong idea into a weak one, but in what form is the weak idea stored? Moreover, in Freud's conceptualization, if it was the quota of affect that determined the strength of an idea, we can then ask what happened to the affect associated with an idea that was strong and yet distressing (i.e., an incompatible idea in the primary associational pathway)? Before we answer these questions, let us turn to Freud where he relates his experience with patients and how he deals with "defensive" patients and comes upon the concept of defence.

> When, at our first interview, I asked my patients if they remembered what had originally occasioned the symptom concerned, in some cases they said they knew nothing of it, while in others they brought forward something which they described as an obscure recollection and could not pursue further. If, following the example of Bernheim when he awoke in his patients impressions from their somnambulistic state which had ostensibly been forgotten, I now became insistent—if I assured them that they did know it, that it would occur to their minds,—then, in the first cases, something did actually occur to them, and, in the others, their memory went a step further. After this I became still more insistent; I told the patients to lie down and deliberately close their eyes in order to "concentrate"—all of which had at least some resemblance to hypnosis. I then found that without any hypnosis new recollections emerged which went further back and which probably related to our topic. Experiences like this made me think that it would in fact be possible for the pathogenic groups of ideas, that were after all certainly present, to be brought to light by mere insistence; and since this insistence involved effort on my part and so suggested the idea that I had to overcome a resistance, the situation led me at once to the theory that by means of my psychical work I had to overcome a psychical force in the patients which was opposed to the pathogenic ideas becoming conscious (being remembered). A new understanding seemed to open before my eyes when it occurred to me that this must no doubt be the same psychical force that had played a part in the generating of the hysterical symptom and had at that time prevented the pathogenic idea from becoming conscious.... From all this there arose, as it were automatically, the thought of defence. [1895d, p. 268]

Defence, hysteria, and the other neuroses

What can we say about defence in Freud's formulation? Defence is a force, but one that can be overcome by an appropriate act of will. If Freud can convince the patient to try hard enough, they will be able to overcome this force by a greater force, or act of will. The physician or analyst is there to help encourage the person to produce the pathogenic ideas or memories. Freud then concludes that a

> psychical force, aversion on the part of the ego,[1] had originally driven the pathogenic idea out of association and was now opposing its return to memory. The patient's "not knowing" was in part a "not wanting to know", a not wanting which might be to a greater or less extent conscious. [*ibid*., pp. 269–270]

Here, Freud is not only using the term ego, but he is also allowing for gradations of consciousness in terms of a person's awareness of their use of defence. This idea is one that will change when Freud has more clinical experience and feels compelled to use fewer pressure techniques. In any case, here we see Freud characterize defence as an active process, and, in his chapter on psychotherapy, he implicitly states that all hysteria is related to what he is calling defence hysteria. Even though Freud does not explicitly say so, it is clear that he believes all hysteria is related to defensive processes. Later, we will explore the different conceptions of hysteria that were present during this time period.

In the next extract, we see Freud talking about pathogenic memories as ideas that are lurking close to consciousness.

> The pathogenic idea which has ostensibly been forgotten is always lying ready close at hand and can be reached by associations that are easily accessible. It is merely a question of getting some obstacle out of the way. This obstacle seems once again to be the subject's will, and different people can learn with different degrees of ease to free themselves from their intentional thinking and to adopt an attitude of completely objective observation towards the psychical processes taking place in them. What emerges under the pressure of my hand is not always a "forgotten" recollection; it is only in the rarest cases that the actual pathogenic recollections lie so easily… on the surface. It is much more frequent for an idea to emerge which is an intermediate link in the chain of associations between the idea from which we start and the pathogenic idea which we are in search of… [*ibid*., p. 271]

The structure of the secondary system

During this period, we have one of Freud's first attempts at describing the relationship of the secondary and primary systems. He tells us that the secondary ideas are

> Stratified in at least three different ways. (I hope I shall presently be able to justify this pictorial mode of expression.) To begin with there is a nucleus consisting in memories of events or trains of thought in which the traumatic factor has culminated or the pathogenic idea has found its purest manifestation. [This nucleus, according to Freud, usually contains the original pathogenic memories that cause or made the person susceptible to conflict and neurotic symptoms.] Round this nucleus we find what is often an incredibly profuse amount of other mnemic material [a term that is used for memories] which has to be worked through in the analysis and which is, as we have said, arranged in a threefold order. [*ibid*., p. 288]

In this description of the secondary system, Freud is searching for a concept that brings together the principles of this system. In a sense, he fails in this attempt. He tries three overlapping possibilities: the temporal stratification, the concentric stratification, and then a certain type of logical organization that he tells us little about, except that it is the most important aspect of the secondary system. (One is tempted to be anachronistic and say that the logical thread that he is searching for is the logic of a concept soon to come, the primary process.) Here, we can see that even the idea of a pathogenic element invading the body is not entirely embraced by Freud. Although he uses the idea of a foreign body invading the organism, he also gives us a picture of normal and pathological blending at the boundaries of conscious experience. At this point, he is struggling to describe his experience when encountering clinical material. Thus, as one goes deeper towards the pathogenic nucleus, lines criss-cross around it and the resistance to remembering the pathogenic memories is greatest as one comes closer to this hypothesized nucleus. Here, clearly, Freud is envisioning memories, although incompatible ideas (defended ideas) need not be memories, but can be any type of psychological form of ideation.

I have quoted this passage from Freud to show how, at this point, he is searching for a principle that will explain the logic of the secondary system. Even though it might be easiest to think of this system as being layered chronologically, Freud already knew from his clinical experience that this did not account for how these “memories” became conscious in the various forms of treatment that he was inventing or utilizing at this point in his career.

Freud’s new concepts: looking backwards and forwards

In these few pages that we have gone over, we have seen Freud introduce a number of concepts that remind us of our vision of the more mature psychoanalytic theory. He has begun to develop the ideas about defence, of a secondary (not conscious) and primary (conscious) system, and of psychic energy. He has used the term ego, and, with this term as well as his other theoretical ideas, we will explore how these ideas change and are transformed depending on the overall structure of Freud’s theorizing at the time. There are two other premises of Freud’s that will continue become

crucial parts of psychoanalytic theorizing: childhood sexuality and the concept of transference. Childhood sexuality will become a cornerstone of Freud's theorizing in every era that follows the present time period. The idea of transference is one that certainly shook the therapeutic world of psychoanalysis (Ellman, 1991). Transference is by no means a concept that has utility only in the clinical setting. Others have utilized and developed Freud's thoughts on transference in areas far beyond the paths that Freud envisioned (e.g., Bion, 1959). Freud recognized the power of this idea, but, as with many of his premises, he did not explore the full implications of transference. Of course, at this time he was creating a theory, a technique, and a new profession.

Transference

Although, for Freud, the concept of transference was primarily related to the clinical situation, his clearest statement of the concept might be in his one of his most theoretical works, *The Interpretation of Dreams* (1900a). We are briefly reviewing the issue of transference in this volume, since one can also consider transference a theoretical concept that explains many aspects of fantasy as well as interpersonal relationships. Freud's first use of the term transference occurs in *Studies on Hysteria*, in his psychotherapy chapter (Chapter Four). Here, he tells us about three possible disruptions in the treatment of hysteria, the third of which he labels transference.

> This is a frequent, and indeed in some analyses a regular, occur-rence. Transference on to the physician takes place through a false connection. [This is the first appearance of the use of transference in Freud's writings.] It is impossible to carry any analysis to a conclusion unless we know how to meet the resistance arising in these three ways. But we can find a way of doing so if we make up our minds that this new symptom that has been produced on the old model must be treated in the same way as the old symptoms. Our… task is to make the obstacle conscious to the patient. [1895d, pp. 302–303).
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> [Freud tells us that] To begin with I was greatly annoyed at this increase in my psychological work, till I came to see that the whole process followed a law; and I then noticed, too, that transference of this kind brought about no great addition to what I had to do. For the patient the work remained the same: she had to overcome the distressing affect aroused by having been able to entertain such a wish even for a moment; and it seemed to make no difference to the success of the treatment whether she made this psychical repudiation the theme of her work in the historical instance or in the recent one connected with me. The patients, too, gradually learnt to realize that in these transferences on to the figure of the physician it was a question of a compulsion and an illusion which melted away with the conclusion of the analysis. [*ibid*., p. 304]

It is interesting that Freud sees the idea of a disturbance in the patient's relation to the physician as an *external obstacle*, even though it is met with in every serious analysis. The three types of disturbances, including what Freud calls the transference,

are not the main arena of the treatment, but, rather, are considered to be material to be mastered and overcome as expeditiously as possible. He tells us that at first he was annoyed by the transference, but now has dealt with his annoyance, since transference does not really add to his work. Even in these few paragraphs, Freud vacillates in his view of transference. At times, he sees transference as an external obstacle, or even as a nuisance, deterring him from his main task of recovering pathogenic memories; at other times, he is surprisingly modern in his view of transference. Still, transference is restricted to distressing ideas arising from the content of the analysis, and they are ideas that are *false connections*. Freud, at this time, considered obsessive symptomatology as essentially false connections. Thus, if a person defended against one idea and obsessed about another substitute (conscious) idea, the conscious idea was a false connection. He theorized that these super-valent conscious ideas were the result of energy transfers. The process of defence was involved with making a strong idea a weak one, when this happened there was now a new, conscious, strong idea which was the false connection. Transference could be seen as just one type of false connection. Put in other terms, all false connections have a transfer of energy. These false connections, while important, are not the central issue for Freud's treatment to achieve success. At this point, he is still striving to help the patient recollect.

Later in his career, Freud had come to conceive of transference as a crucial aspect of the therapeutic process. The realization of the importance of transference was a painful one, given that it was conceived amid clinical difficulties and disappointments. It is noteworthy that Freud's interest in the topic fluctuated throughout his career. As early as his publication of the Dora case (1905e), Freud was on his way towards recognizing the clinical importance of transference. It was not until the era of his technique papers (1910–1915) that Freud seemed at home with the concept of transference. As we will see, his ease with the concept could not be charted in linear or monotonic terms. During the 1920s, Freud retreated somewhat from his revolutionary theory of transference and returned to some of the ideas that we have just explored. More specifically he returns to the idea involved in the capturing of (or remembering) pathogenic memories.

Sexuality and the psychogenic and actual neuroses

Psychogenic neuroses

To this point in the chapter, we have been discussing what Freud termed the psychogenic neuroses. The two neuroses that we have mentioned in this chapter are hysteria and obsessive–compulsive neuroses. Either of these disorders could be linked with phobic symptoms or anxiety. Freud also discussed psychotic disorders

(see “The neuro-psychoses of defence, 1894a) as psychogenic in origin. The origin of psychogenic disorders, until 1897, was what has been called the seduction hypothesis. In this hypothesis, Freud maintained that aetiology of psychogenic disorders was always related to sexual abuse in childhood. This abuse was thought to occur before the age of eight and was traumatic in nature. Freud assumed that the child was both abused and excited, and that there was no appropriate outlet for the excitement. The child, in this view, was not capable of sexual discharge, and this led to a situation where the excitement became aversive. The inability to discharge the stimulation led to a defensive process (where a strong idea is turned into a weak one) and is excluded from the primary system and included in the secondary system. Once sexual ideas and memories were in the secondary system, they were secure or quiescent until, or unless, some external event stimulated these memories. Freud, in his case histories, gives a number of instances of young women having sexual or sexualized experiences that reactivate defended-against memories. These memories might be represented directly or symbolically, but inevitably the memories have symptomatic expression. Most of the women that Freud wrote about developed