Introduction

Over a hundred years ago Josef Breuer and Sigmund Freud published Studien über Hysterie (Breuer & Freud, 1895), which ushered in a new century for psychiatry. Now, however, hysteria as a clinical picture—the model of psychoanalysis and the prototype of neurosis—seems to have all but disappeared and has been banished from diagnostic manuals (American Psychiatric Association, 1994).

What is the significance of hysteria for present-day psychoanalysis? A historical review of the development of the concept over the last hundred years may help us to answer this question.

History

It was only towards the end of the eighteenth century that hysteria and hypochondria were linked to the nervous system (Foucault, 1961; Veith, 1965). This development paved the way for the science of psychiatry. Like Janet, Breuer and Freud sought a psychological explanation for hysteria, a diagnosis that was hard to define even in those days; as Freud put it, ‘hysteria is not an independent clinical entity’ (Breuer & Freud, 1895p. 259). Nowadays we distinguish a range of personality disturbances—for example ‘borderline’ and ‘narcissistic’—which may or may not have hysterical characteristics (Kernberg).

The importance of the studies for psychoanalysis

Freud's ideas about hysteria resulted in a theory of the unconscious; this was certainly the most important philosophical revolution brought about by the Studies (Livingstone Smith, 1992). The Cartesian dualism of body and mind was replaced by a materialistic unity consisting of two kinds of (un)consciousness. Dissociation and splitting—the latter then still being described as an ‘act of will’ (Freud, 1894)—would only later become ‘repression’.

Janet did not invoke only psychic forces to explain how unwelcome thoughts, such as sexual fantasies, were kept out of consciousness. Nor was the unconscious new (James, 1890; Ellenberger, 1970). Breuer and Freud also considered the unconscious to be ‘split off’, instead of ‘repressed’. They identified it as 'the archaic mother' (Freud, 1895).

1975, 1976). The structure of the hysterical personality, with its typical cognitive style and its dynamic, economic and adaptive features, has been described in detail (Krohn, 1978; Mentzos, 1993; Horowitz, 1991).

Notwithstanding his polemical tone, Freud (Breuer & Freud, 1895) shows a closer relationship to Janet (Ellenberger, 1970; Gay, 1988; Gödde, 1994) than to Charcot (1886), who, after all, was first and foremost a somatist.

Studies on Hysteria can be seen as the starting point of psychoanalysis, as Freud was to call the new discipline in 1896. The trauma was deemed to be psychic, consisting of unpleasant memories or repugnant thoughts that had to be excluded from consciousness (Breuer & Freud, 1893). ‘Hysteric suffer mainly from reminiscences’ (Breuer & Freud, 1895p. 7). Note that the word used is ‘reminiscences’ and not ‘memories’ (Stein, 1986).
‘dissociated’ from consciousness (but not yet ‘repressed’). Splitting (the term had been introduced by Janet) led to dissociative disturbances (Freud, 1896). Splitting of the ego was described by Le Couthre in the Netherlands as the central manifestation of neurosis (Le Couthre, 1993). The phenomenon has always been at the heart of the Kleinian conception (Bell, 1992). Kernberg adopts the notion and uses it, for example, to explain the hysterical personality (Kernberg, 1975). The approach of the Studies proves consistent with both modern cognitive psychology and present-day psychoanalysis.

A revolution took place also on the therapeutic level. Both Freud and Breuer listened every day for hours to (mostly female) patients, who at that time were seen more as under-age children than as adults (Decker, 1991). Explanations such as heredity, degeneration and constitution were as far as possible relegated to the background in favour of psychogenesis. Breuer and Freud at first used ‘catharsis’ to overcome hysterical symptoms (usually conversions). Together with the brilliant Bertha Pappenheim, alias Anna O, Breuer developed the ‘private theatre’ and the ‘talking cure’ (Hirschmüller, 1989).

It had not yet been definitely established that the source of hysteria lay in psychosexual development. Only in the last chapter of the Studies did Freud conclude that sexuality was the underlying cause of all complaints and that Breuer had performed a Sisyphean task with Anna O (Breuer & Freud, 1895p. 263). For all Freud’s assertions to the contrary, the Studies were not badly received (Ellenberger, 1970p. 486; Gay, 1988p. 77).

After abandoning techniques such as hypnosis, pressure on the forehead and massage, Freud increasingly allowed himself to be guided by his patients’ free associations. He was fascinated by such phenomena as ‘defence’ and ‘resistance’. Problems of ‘counterwill’ and ‘transference’, including ‘transference love’ — which was not to be named until later — were discussed for the first time in the Studies. It was only subsequently, with Dora, that Freud was to realise fully that psychoanalysis could not succeed without a thorough elaboration of the action of the mutual therapeutic relationship, the ‘transference’ (Freud, 1905). In his chapter on the psychotherapy of hysteria (Breuer & Freud, 1895), however, Freud does already mention the need to analyse the transference.

Hysteria led him to ‘free association’, a method whereby transference is provoked and satisfaction is ruled out. This paradox of mutual seduction is itself a form of ‘hysterical interaction’ (Donnet, 1986). Finding himself no more capable than the sorcerer’s apprentice of standing up to what he had unleashed, the inventor put the blame for it on to his hysterica (Guillaumin, 1985).

The concept of trauma

At the time of the Studies, trauma could still assume a wide variety of guises — for instance, long-term nursing of a sick father, distress over an unhappy love relationship, or the witnessing of an erotic scene. Although the significance and experience of sexuality were amply acknowledged by psychiatry at the end of the nineteenth century, the subject did not yet feature prominently in the Studies. This may have resulted from the two authors’ differing views. Breuer presumably held Freud back (Masson, 1984p. 151), because sexuality was a key explanatory element for Freud both before the Studies (Freud, 1894) and immediately after the break between the two men. He himself has the following to say about it:

When I began to analyse the second patient, Frau Emmy von N., the expectation of a sexual neurosis being the basis of hysteria was fairly remote from my mind. I had come fresh from the school of Charcot, and I regarded the linking of hysteria with the topic of sexuality as a sort of insult — just as the women patients themselves do (Breuer & Freud, 1895p. 259f.).

Psychic trauma calls for more detailed elucidation because the concept has given rise to misunderstandings about the role of the internal and external worlds. Even before 1895, Freud had noted that an idea was always involved, whether or not linked to a trauma that had been actually experienced. The decisive element was not the objective event but the significance assigned to it by the individual. A forbidden wish could also act as a trauma. Secondly, it was not a matter of just one trauma but of a series of traumas and the associated fantasies. Freud’s treatment traced this chain back to sexuality, which, being forbidden by the ego and superego, was traumatic.

Before Freud rejected the ‘seduction theory’ — which was first so called by Kris (1954) — he had, as it happens, already entertained a succession of different trauma theories (Blass & Simon, 1992, 1994). For a few years Freud’s attention was focused on ‘trauma’ in the sense of child sexual seduction or abuse, whether or not by a parent (usually the father).

Freud’s self-analysis followed around 1897, after the death of his father and against the background of his increasing depression. ‘Psychic reality’, the paramount importance of the subject’s own experience and the subjective elements in both his theorising and his clinical practice increasingly forced themselves upon him. However, contrary to some commonly heard assertions, the abandonment of the so-called seduction theory was both a gradual and a painful process.1 Freud

1 Critics such as Masson and Alice Miller are just as wrong, and just as reductionistic and biased, as the psychoanalysts who take the view that Freud abandoned the so-called seduction theory suddenly. The former asserts that he did so out of deliberate calculation and the latter that the sole reason was the discovery of the Oedipus complex. However, the historical process in Freud’s mind was more complicated, more subtle and more gradual, as Blass & Simon have explained in a number of papers, which constitute a fascinating account of their historical research (see also Schinek, 1987). These authors show how Freud struggled with his own wishes and projections and how these interacted with his scientific arguments.

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but himself plays an important part in the formation of his own history. Freud discovered the neuropathogenic effect of the child's fantasies.

Dora

The importance of the external world is evident from the seduction traumas experienced by Dora (Freud, 1905), an adolescent with whom Freud showed little sympathy (Blass, 1992). The theory of the girl's Oedipus complex here proves, on closer inspection, to be less central and also less well founded than is and has always been assumed. The aetiology in Dora's case remains unclear: is it a matter of masturbation, of the seduction by Herr K, or of sexual desires for her father? There are no subsequent case studies by Freud featuring the female Oedipus complex.

When Freud considered that he had found what he was looking for—namely, the central importance of sexuality—he very much wanted to see his hypotheses confirmed. Partly for this reason, he had less patience than at the time of his collaboration with Breuer for listening to the patient without preconceived notions. Owing to the growing emphasis on sexuality, and notwithstanding the abandonment of hypnosis, Freud's method became more suggestive and more coercive. He could scarcely control his anger at Dora's tendency to make him powerless—which he saw as her hysterical drive to assert herself. The treatment was ultimately broken off prematurely by Dora. Nevertheless, Freud's description of the transference and the mutual seduction in the interaction with this girl, incomprehensible and uncomprehended as she remained, constitutes a brilliant account of all the elements that play a part in the concept of hysteria, which remains as mysterious as ever today.

The fantasies about the other-sex parent in Freud's self-analysis had led to the discovery of the male Oedipus complex. At the time of the Dora analysis, Freud was trying to extend this theory to the girl. The task of harmonising female development with what he declared to be the universally applicable Oedipus complex of the boy pursued Freud throughout his career (Simon, 1991; Simon & Blass, 1991). The fact that he did not discover the importance of the mother as the central figure until the end of his life caused him problems and for a long time prevented him from gaining insight into the development of the girl and the genesis of the perversions (Halberstadt-Freud, 1991).

Hysteria after the studies

By 1900, interest in hysteria had already declined markedly. This was partly due to the unsolved problems of the transference and countertransference. Apart from his paper on the phobia of Little Hans (1909b), Freud published a few more short contributions and scattered remarks, but never developed a coherent theory of hysteria capable of replacing the account given in the Studies (Rangell, 1959; Blacker & Tupin, 1977, 1991). This work remained fundamental for the understanding of hysterical psychic functioning, both in Freud's self-analysis and in the analyses of his patients.

Freud's quest for the source of hysteria led him to psychoanalysis and the discovery of the laws of unconscious thought. Symptom formation, the structure of dreams, parapraxes and jokes thereby became accessible. Freud also owed the formulation of phenomena such as repression, transference and defence to his troublesome hysteria patients.

When revolutions go too far, they are followed by a restoration. Many early Freudian concepts and ideas are now back in vogue because they sometimes proved to be more serviceable than Freud's later theories. Both Grotstein (1992) and, before him, Fairbairn (1954) regret that Freud's later model of the drives replaced splitting of the ego. The internalised object relations were neglected as a result. Freud's later libido theory, based on erotogenic zones and phases, was not an advance. Concerning the conversion of bodily zones, the concept of hysteria is more applicable than the language of drives and phases. The anus as an 'erotogenic zone' explains little without the associated object relations. Gastro-intestinal complaints as hysterical conversion symptoms can better be interpreted as a metaphor for the concept of hysteria is more applicable than the language of drives and phases. The anus as an 'erotogenic zone' explains little without the associated object relations. Gastro-intestinal complaints as hysterical conversion symptoms can better be interpreted as a metaphor for the concept of the aetiology in Dora's case remains unclear: is it a matter of masturbation, of the seduction by Herr K, or of sexual desires for her father? There are no subsequent case studies by Freud featuring the female Oedipus complex.

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on an oral fixation accompanied by poor appreciation of reality. We may disregard hysterical psychosis because it features relatively infrequently in the psychoanalytic literature, although we could characterise the pathology of Freud's patients from the Studies on Hysteria as such.

The British psychoanalyst Eric Brenman includes the following quotable remark on the first page of his paper: ‘A few colleagues said they did not know what hysteria was but they knew an hysteric when they met one’ (1985). He then tells of a man who manipulates him, makes him powerless and wants to make him believe in a spurious reality. It was, incidentally, already generally known in the last century that hysteria also occurs in men. The Don Juan figure is the usual example given.

As at 1995, it is still the case that no one knows what hysteria as a disease involves; the diagnosis has been replaced in DSM-IV (American Psychiatric Association, 1994) by ‘dissociative personality disturbance’ (conversion) or ‘histrionic personality disturbance’. The latest historical study on the subject calls it a ‘state of mind’ (Gilman et al., 1993).

**Back to the seduction theory?**

The main problem with which Freud was struggling—whether the memory reconstructed in treatment is fantasy or reality—remains unsolved to this day because it is a spurious problem. The dialectic of fantasy and reality is, after all, characteristic of every life story.

What is true is that psychoanalysis for a long time tended to close its eyes and ears to psychic trauma. This includes the abuse of power, for example by adults against children, as well as social terror and violation. The complaints of survivors who suffered persecution and were threatened with extermination were for too long attributed to neurotic mechanisms dating from childhood (De Wind, 1984). Ill-treatment of children, sexual abuse and incest were frequently overlooked (Simon, 1992).

We now observe excesses in the opposite direction: therapists who persuade their clients that they have ‘repressed’ memories of sexual abuse. They seize once again upon Freud’s old seduction theory, explain all disturbances by sexual traumas, and ignore his warning that these are often fantasies (Storr, 1995). These ‘recovered-memory’ therapists make the question whether a trauma is a matter of memory or fantasy relevant again today (Loftus, 1993). An often ill-tempered controversy rages about ‘false-memory syndrome’, in which early Freud is revered and the later Freud is presented as a villain (Crews, 1993, 1994, 1995).

Some critics of psychoanalysis take the repressed-memory therapists as living proof that Freud talked his patients into the idea that they had experienced a sexual trauma. Others, such as Miller (1981) and Masson (1984), make precisely the opposite assertion, claiming that Freud bowed to criticism of his work, having abandoned the seduction theory against his better judgement, although he knew that child abuse was the cause of hysteria.

**Hysteria today**

Brenman mentions four aspects of hysteria: disavowal of the reality of the internal and external worlds; the tendency to convince the other that one is in the right; identification with a fantasy object; and possessive but sterile dependence. Hysteria in his view is based on wishful thinking. Manipulation, penetration into the other’s thinking and feeling, is necessary in order to make the ‘other reality’ credible. At the same time a catastrophe is feared—this being expressed in the restrictive anxiety, phobia or conversion—while the subject denies that anything is the matter. In my experience, too, the hypomanic mood serves to defend against a depression that often lies concealed behind hysteria. The violence hides a sense of emptiness, occasioned by splitting and repression (dissociation). The intense and persistent transference love cries out to be answered in the same coin. The hysterical patient is not conscious of his anxiety about being unattractive and sexually inadequate. Attempts at seduction are made but do not lead to the desired (or undesired) aim because they have little or nothing to do with sexuality. Both frigidity and hypersexuality serve the purpose of denial of the sexual. Dramatic victimhood is intended to mask and disavow aggression (see Laplanche, 1974).

Feelings of inadequacy on the part of eroticising patients reflect the original interaction with a seducing parent, whose desires it was impossible for the child to satisfy.

A clearer view of the genesis of hysteria has now emerged. Brenman mentions the following characteristics of the (hysterical) mother-child relationship: the mother is anxious and fears catastrophes; she suggests that there are panaceas and thus does not present herself to the child as a realistic object for identification; she encourages disavowal of psychic reality, of what is true and what is untrue; and she supplies idealising love and sensuous stimulation, thereby promoting both ‘hypersexuality’ and dependence (see Laplanche, 1974; Brenman, 1985).

Nowadays it is generally assumed that hysteria is a matter more of defending against depression, abandonment anxiety and narcissistic dangers than of (genital) sexuality (Sperling, 1973). Subtle phobic mechanisms serve for avoiding the development of anxiety. Narcissistic problems are circumvented by compromise formations and displacement to the field of sexuality.

Almost all authors mention the homosexual conflict and fixation to bisexuality, as well as disavowal of the difference between the sexes, between the generations (a son must be capable of satisfying the mother and a daughter the father) and between subject and object. Fixation at the phallic level and castration anxiety are still deemed important. In hysteria, fantasy performs a symbolic function rather than that of wish-fulfilment. It leads to plans that (inevitably) miscarry and do not (or cannot) lead to satisfaction. The drives are inhibited, going no further than ideas divorced from action and from their object, possibly resulting in muscular tension and pain (Jeanneau, 1985). Out of anxiety at the possibility of repetition of traumas, object loss is actively courted (attraction and repulsion). Possessiveness and
intrusiveness are projected and then feared by identification. The analyst may be faced not only with an artificial transference but also with unresolvable resentment and irreparable deficiencies, resulting in intense countertransference feelings (Khan, 1975). Innocent and infantile manifestations or sadomasochistic accusations may arouse antipathy. The hysterical personality likes to spin a thrilling yarn, in the hope of receiving attention, love and admiration. He conceals the wish to make an impression behind his fascination and identification with the spectator (de Mijolla, 1986).

Another characteristic is the cognitive style, expressed in observation and thought. The capacity to repress and to dissociate may be deemed to belong to the cognitive style of the hysterical defence. If, like Freud, we divide neurotics into two main types—obsessional and hysterical—the former can readily remember, observe and report precisely on what is remembered and observed, but cannot convey the associated feeling, whereas the latter tend to forget and to mystify; they are poor observers, whose stories are lacunary and clothed in feelings that give an exaggerated and artificial impression.

Finally, identification may be used as a means of relating to others. The hysterical personality identifies superficially with nonexistent fantasy objects. In his fantasy, he experiences through others what he lacks internally himself, while at the same time his capacity to empathise with the other as other inevitably suffers because of repression.

As stated, projective identification is used to combat uncertainty and feelings of inadequacy. Fain & Bégoin (1984) point out in this connection that the projective identifications concerned are in fact rapidly reversible pseudo-identifications.

The hysterical personality attempts to get rid of anxieties by projecting them into the object and then identifying with it at a distance. This is done by making the other powerless, thereby shifting the uncertainty from the subject to the object. The chaos and despair that the hysterical personality can generate in his or her partner was experienced by Breuer with Anna O, who ruled over him and led him up the garden path with her illnesses and helplessness. We are all familiar with the phenomenon of shopping around from therapist to therapist or with her constantly changing bodily state and the specific characteristics of the female have to be considered as another possible factor in the greater frequency of hysteria in women. Female sexuality is experienced as more diffuse and less readily localisable than that of men. The cognitive characteristics of hysteria, which are found in both sexes, are vagueness of observation and of narration (Khan, 1975).

Female sexual experience is normally directed less towards the organ than towards fusion and the abandonment of control. Men, on the other hand, cannot easily identify with the total surrender and dedication of which women are capable. In particular, the internal connection that the projective identifications concerned are in fact rapidly reversible pseudo-identifications.

The practitioner is first approached with an attitude of idealisation, but then disappoints and is reviled.

**Hysteria and women**

The view that bisexual aspirations—in particular, repressed masculine, phallic fantasies—cause women to be hysterical more frequently than men persists undiminished in Freud's later publications on hysteria (Freud, 1908, 1909a). A woman's special relationship with her constantly changing bodily state and the specific characteristics of the female have to be considered as another possible factor in the greater frequency of hysteria in women. Female sexuality is experienced as more diffuse and less readily localisable than that of men. The cognitive characteristics of hysteria, which are found in both sexes, are vagueness of observation and of narration (Shapiro, 1965). Female sexual experience is normally directed less towards the organ than towards fusion and the abandonment of control. Men, on the other hand, cannot easily identify with the total surrender and dedication of which women are capable. In particular, the internal representations—representation being such a central concept in hysteria—are claimed to be less clearly delineated in women, with their mysterious internal genitals. Both man and female hysteria is partly a matter of the absence of a representation of the female sex, as a result of which sexuality takes on a powerful phallic coloration (Schaeffer, 1986). In hysteria, the phallic mode is a substitute for and a defence against the dreaded femininity in both men and women. Repudiation of an excessively strong identification with the problematic mother figure plays a part in both sexes.

**Hysteria and French psychoanalysis**

The French psychoanalysts lay considerable emphasis on the anal-sadistic elements that are banished from the hysterical universe, both aggression and guilt being repressed and projected into the other.

French psychoanalysis has remained faithful to hysteria over the years. In 1973, 1984, 1985 and 1986, the *Revue Française de Psychanalyse* devoted entire issues and even volumes to papers on hysteria. Laplanche & Pontalis deal at length with hysteria in *The Language of Psycho-Analysis*. By contrast, the subject hardly features at all in the English-language journals. This difference is connected with the French tradition of the 'return to Freud', introduced by Lacan and others. Again, following de M'Uzan, Joyce McDougall detached psychosomatic illness from hysteria and turned it into an analytic theme in its own right (McDougall, 1989).

The most elegant combination of the two visions, the English and the French, is due to Laplanche (1974). Seduction, passivity, helplessness and sexuality are stated to be the nucleus of hysteria and of neurosis in general. Laplanche considers that orality in Freud's conception also belongs to sexuality in the wider sense and that the primal-scene fantasy that arises in the first year of life relates to oedipal triangulation. By using the word 'pregenital' rather than 'pre-oedipal', he links Klein and Freud together, just as Winnicott and Kernberg do.

**Hysteria in practice**

The idea that hysteria no longer occurs is mistaken. Indeed, nothing could be further from the truth. Both anxiety hysteria and conversions are still found in relatively uneducated subjects. The 'proto-professionalised' classes, who have acquired a smattering of psychoanalytic knowledge from its widespread popularisation, use more subtle forms that are less transparent. Hysteria varies according to time and place and follows in the wake of the process of civilisation. Hysteria meets the expectations of the social environment or the therapist. These currently comprise
existential complaints that are often difficult to classify nosologically (Laplanche, 1974).

In practice, hysteria is frequently misleading, tending to make the other powerless by seduction and blockage of any meaningful dialogue. Disavowal of depression and of mourning for lost love is converted into excitement (Ody, 1986). It is more fruitful to connect depression with narcissistic deficiency than with erotic elements in the transference and countertransference. The therapist must be able to withstand seduction to choose the sexual or genital level as a theme, whereas the anxieties operate in a much more primitive experiential layer of the personality.

Three examples

Mrs X is a woman in her late forties who suffers from depressive feelings, intense migraines, hyperventilation and panic attacks. Although she has been happily married to a famous man for ten years or so, she suddenly weeps when I ask her how she feels about having no children. She has come to me because she has heard that I am ‘so special’ and probably ‘the only person who can help’ her. I am the latest in a long line of doctors, physiotherapists, acupuncturists and other practitioners.

Mrs X is sweet, innocent and seductive, but has little to say about herself. She leaves it entirely to my creativity to discover what the matter is. She regularly informs me that she has still been having severe headaches. I suggest that it must amuse her to see me toiling away. She cannot help laughing—a always a sign of acknowledgment. Making me powerless takes us back to her own feeling of powerlessness, her self-image as lacking talent, worthless and a failure. She would have liked to be ‘intelligent’ and ‘well developed’. She admires me and would like to be admired herself. Instead, she feels that she has nothing to offer. Both her parents were working-class and climbed up the social ladder. However, she had little guidance from them and nothing was dealt with openly at home. What was clear was that she had to have a good education, make a respectable impression and behave presentably. All this met with stubborn resistance on her part. As a refractory teenager, she missed almost all her schooling. She has ‘never achieved anything special’ and also experiences the fact of not having had any children as a miserable failure. Finally, after many months, she tells me about an abortion and feels distressed. Mourning for what has been lost is lacking in hysteria (Ody, 1986). Mourning for what has not been attained, whether it be the love of the object or the high ego ideal, is a condition for success in the treatment. After a year of concealment and the spinning of yarns, the phobic nature of her complaints, steeped in the fear of failure, becomes clearer. Everything she does is for her a performance, the staging of a play that has to be a hit. Even her visit to me in all her finery is a show intended to occupy me agreeably. Only towards the end of the treatment does she admit her anger towards her mother.

Peter, a man in his forties, notwithstanding his ‘good marriage’ and a young son whom he loves, kept eloping with other women. These love affairs ended because the women in question did not want an exclusive or lasting relationship with him. He always came back to his wife, moving out of the house and back three times.

Peter was anxious in the transference and worried about the way I might see him. He felt worthless and was sure I looked down on him. I did not find him interesting enough or take his ambitions seriously. He often dreamed about being powerless, not in control, losing hold of the steering wheel. He was frightened about empty holes, crevices and tunnels. During the analysis he fell in love again and left his wife to live an adventurous life away from home. He was constantly very excited and felt like an adolescent again, young, vital, not needing more than a few hours' sleep each night. He kept telling me how thrilling his adventures were, how deeply in love he was, and how wonderfully romantic it all was.

I listened to his love stories and his mood swings with a mixture of empathy and surprise, wondering how the whole thing worked. Where did he get the energy to devote to his wife and child as well? We wondered together why he was not more successful in his affairs and what he was really after. What did it mean in the transference? Did he want to make me jealous, to excite me, to captivate my attention? On several occasions he threatened to leave the analysis and did in fact do so, staying away a few days or weeks, but each time he returned. Eventually I noticed that his stories began to bore me like penny-dreadfuls. I was no longer impressed by his wild outbursts of anger and his scenes of leaving me, and I felt there was enough mutual trust to tell him as much, in full earnest, exposing the seriousness of the situation as I saw it. This resulted in calmer times and after three years of analysis he himself wondered whether he had ever seriously wanted to leave his wife—or me, for that matter. A year later he finished his treatment. Meanwhile he had become content with his sex life, for the first time overcoming his timidity with his wife.

Like most hysterics, Peter had a seductive mother, who could not accept her life as it really was. He always had to please and excite her by being her dream prince. He had to be more intelligent and more successful than his father, as her husband was too mediocre for her taste. Peter had tried unsuccessfully to satisfy his disenchanted mother ever since he was a child. He still felt that his house was not luxurious enough to please his Mum, that his career lagged behind her expectations, and that his girlfriends (who were presented to her for tacit approval) were not sufficiently glamorous. In short, he lacked the resources to make his mother feel full and complete, just as he must have felt as a child: incompetent and utterly failing her.

A third patient, Maria, who was about 35 years old, suffered from a fear of sexuality, as well as abdominal and back pains. I was sure she was lying to me when she claimed sexual experience, pretending that she had had her first coitus just before the analysis started. When the transference situation felt safe enough, I told her about my doubts and her need to pretend out of shame. She denied this and little change ensued. Her complaints remained the same or increased. She often had bouts of anger against me, as the representative of her mother she could not forgive. She placed this anger in the context of reality rather than gaining insight and seeing me as a symbolic object in her representational world. After four years I discovered to my surprise that she was in group therapy twice a week. She had started this therapy long before commencing her analysis with me and had continued it without ever telling me. In the subsequent crisis I told her I felt too angry and betrayed and that in my view the indispensable trust between us was missing, so that I simply could not continue.
Conclusion

The Studies came into being at the time when Freud, who had not yet entirely freed himself from classifying, began to listen. The diagnosis of hysteria can serve as a caricature or a term of abuse. It is inappropriate when observed from the vantage-point of the psychoanalytic situation, in which, after all, we ourselves are involved (de Mijolla, 1986). Yet there is surely no lack of telling examples in our day-to-day clinical practice. Nowadays we complete the ‘pure picture’, which has never existed, with a more subtle diagnosis (Mentzos, 1993).

Freud still had little idea how to use either the negative or the positive transference as an instrument. The countertransference had an exclusively negative significance, indicating tendencies that had to be suppressed.

The insight concerning the importance of the technical capacity to utilise the analysand’s message creatively in order to arrive at an interpretation of the unique interaction seems to me to be the biggest change that has taken place in the last hundred years. Hysterical anxiety is still relevant, in both analyst and analysand.

The study of hysteria and its history makes it possible to understand, on both the intellectual and emotional levels, phenomena that would be overlooked without this knowledge. In the diagnosis of children in particular, a hysterical or obsessionall-neurotic trend in character-development can sometimes be discerned at an early stage. The hysterical cognitive attitude is also often identifiable in adults, even if the eventual diagnosis is different. Psychoanalytic diagnosis, like the practice of psychoanalysis, has been extended, refined and more subtly differentiated in the last hundred years. Nevertheless, the personality structure we commonly call ‘hysterical’ is indispensable to it. The original discoveries afforded Freud by hysteria not only are of great historical importance but also furnish clinical knowledge.

Indeed, in a number of respects the Studies are closer to our own time than Freud’s later work. They do not yet make assertions that lay claim to absolute validity; the doctrine of the phases of the sexual drives had not yet emerged; nor did the theory of the Oedipus complex exist. The search was still on, just as it is in our own day, when many axioms of psychoanalysis, as well as its theoretical structure, have lost their stability, whereas the clinical facts remain.

Freud’s warning to his fiancée, to the effect that the present cannot be understood without a knowledge of the past, applies just as much to the theory as to the individual. To understand the development of psychoanalysis, that entity, now celebrating its centenary, must be studied from its beginnings.

Psychoanalysis as both theory and science is currently teetering on its foundations. A certain way of thinking and observing is perhaps all that will remain of it in the long term. And this psychoanalytic attitude was already fully present in the Studies.

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