FURTHER REMARKS ON THE NEURO-PSYCHOSES OF DEFENCE
(1896)

In a short paper published in 1894, I grouped together hysteria, obsessions and certain cases of acute hallucinatory confusion under the name of 'neuro-psychoses of defence', because those affections turned out to have one aspect in common. This was that their symptoms arose through the psychical mechanism of (unconscious) defence - that is, in an attempt to repress an incompatible idea which had come into distressing opposition to the patient's ego. In some passages in a book which has since appeared by Dr. J. Breuer and myself (Studies on Hysteria) I have been able to elucidate, and to illustrate from clinical observations, the sense in which this psychical process of 'defence' or 'repression' is to be understood.

There, too, some information is to be found about the laborious but completely reliable method of psycho- analysis used by me in making those investigations - investigations which also constitute a therapeutic procedure.

My observations during my last two years of work have strengthened me in the inclination to look on defence as the nuclear point in the psychical mechanism of the neuroses in question; and they have also enabled me to give this psychological theory a clinical foundation. To my own surprise, I have come upon a few simple, though narrowly circumscribed, solutions of the problems of neurosis, and in the following pages I shall give a preliminary and brief account of them. In this kind of communication it is not possible to bring forward the evidence needful to support my assertions, but I hope to be able to fulfil this obligation later in a detailed presentation.

I

THE 'SPECIFIC' AETIOLOGY OF HYSTERIA

In earlier publications, Breuer and I have already expressed the opinion that the symptoms of hysteria can only be understood if traced back to experiences which have a 'traumatic' effect, and that these psychical traumas refer to the patient's sexual life. What I have to add here, as a uniform outcome of the analyses carried out by me on thirteen cases of hysteria, concerns on the one hand the nature of those sexual traumas, and, on the other, the period of life in which they occur. In order to cause hysteria, it is not enough that there should occur at some period of the subject's life an event which touches his sexual existence and becomes pathogenic through the release and suppression of a distressing affect. On the contrary, these sexual traumas must have occurred in early childhood (before puberty), and their content must consist of an actual irritation of the genitals (of processes resembling copulation).

I have found this specific determinant of hysteria - sexual passivity during the pre-sexual period - in every case of hysteria (including two male cases) which I have analysed. How greatly the claims of hereditary disposition are diminished by the establishment in this way of accidental aetiological factors as a determinant needs no more than a mention. Furthermore, a path is laid

open to an understanding of why hysteria is far and away more frequent in members of the female sex; for even in childhood they are more liable to provoke sexual attacks.

The most immediate objections to this conclusion will probably be that sexual assaults on small children happen too often for them to have any aetiological importance, or that these sorts of experiences are bound to be without effect precisely because they happen to a person who is sexually undeveloped; and further, that one must beware of forcing on patients supposed reminiscences of this kind by questioning them, or of believing in the romances which they themselves invent. In reply to the latter objections we may ask that no one should form too certain judgements in this obscure field until he has made use of the only method which can throw light on it - of psycho-analysis for the purpose of making conscious what has so far been unconscious.[1] What is essential in the first objections can be disposed of by pointing out that it is not the experiences themselves which act traumatically their revival as a memory after the subject has entered on sexual maturity.

My thirteen cases were without exception of a severe kind; in all of them the illness was of many years' duration, and a few came to me after lengthy and unsuccessful institutional treatment. The childhood traumas which analysis uncovered in these severe cases had all to be classed as grave sexual injuries; some of them were positively revolting. Foremost among those guilty of abuses like these, with their momentous consequences, are nursemaids, governesses and domestic servants, to whose care children are only too thoughtlessly entrusted; teachers, moreover, figure with regrettable frequency. In seven out of these thirteen cases, however, it turned out that blameless children were the assailants; these were mostly brothers who for years on end had carried on sexual relations with sisters a little younger than themselves. No doubt the course of events was in every instance similar to what it was possible to trace with certainty in a few individual cases: the boy, that is to say, had been abused by someone of the female sex, so that his libido was prematurely aroused, and then, a few years later, he had committed an act of sexual aggression against his sister, in which he repeated precisely the same procedures to which he himself had been subjected.

[1] I myself am inclined to think that the stories of being assaulted which hysterics so frequently invent may be obsessional fictions which arise from the memory-trace of a childhood trauma.

Active masturbation must be excluded from my list of the sexual noxae in early childhood which are pathogenic for hysteria. Although it is found so very often side by side with hysteria, this is due to the circumstance that masturbation itself is a much more frequent consequence of abuse or seduction than is supposed.

It is not at all rare for both of the two children to fall ill later on of a defence neurosis - the brother with obsessions and the sister with hysteria. This naturally gives the appearance of a familial neurotic disposition. Occasionally, however, this pseudo-heredity is resolved in a surprising fashion. In one of my cases a brother, a sister, and a somewhat older male cousin were all of them ill. From the analysis which I carried out on the brother, I learnt that he was suffering from

self-reproaches for being the cause of his sister's illness. He himself had been seduced by his cousin, and the latter, it was known in the family, had been the victim of his nursemaid.
I cannot say for certain what the upper age-limit is below which sexual injury plays a part in the aetiology of hysteria; but I doubt whether sexual passivity can bring on repression later than between the eighth and tenth years, unless it is enabled to do so by previous experiences. The lower limit extends as far back as memory itself - that is, therefore, to the tender age of one and a half or two years! (I have had two cases of this.) In a number of my cases the sexual trauma (or series of traumas) occurred in the third and fourth years of life. I should not lend credence to these extraordinary findings myself if their complete reliability were not proved by the development of the subsequent neurosis. In every case a number of pathological symptoms, habits and phobias are only to be accounted for by going back to these experiences in childhood, and the logical structure of the neurotic manifestations makes it impossible to reject these faithfully preserved memories which emerge from childhood life. True, it would be useless to try to elicit these childhood traumas from a hysteric by questioning him outside psycho-analysis; their traces are never present in conscious memory, only in the symptoms of the illness.

All the experiences and excitations which, in the period of life after puberty, prepare the way for, or precipitate, the outbreak of hysteria, demonstrably have their effect only because they arouse the memory- trace of these traumas in childhood, which do not thereupon become conscious but lead to a release of affect and to repression. This role of the later traumas tallies well with the fact that they are not subject to the strict conditions which govern the traumas in childhood but that they can vary in their intensity and nature, from actual sexual violation to mere sexual overtures or the witnessing of sexual acts in other people, or receiving information about sexual processes.[1]
In my first paper on the neuroses of defence there was no explanation of how the efforts of the subject, who had hitherto been healthy, to forget a traumatic experience of this sort could have the result of actually effecting the intended repression and thus opening the door to the defence neurosis. It could not lie in the nature of the experiences, since other people remained healthy in spite of being exposed to the same precipitating causes. Hysteria, therefore, could not be fully explained from the effect of the trauma: it had to be acknowledged that the susceptibility to a hysterical reaction had already existed before the trauma.
The place of this indefinite hysterical disposition can now be taken, wholly or in part, by the posthumous operation of a sexual trauma in childhood. 'Repression' of the memory of a distressing sexual experience which occurs in maturer years is only possible for those in whom that experience can activate the memory- trace of a trauma in childhood.

[1] In a paper on the anxiety neurosis, I remarked that 'anxiety neurosis can be produced in girls who are approaching maturity by their first encounter with the problem of sex. . . . Such an anxiety neurosis is combined with hysteria in an almost typical fashion.' I know now that the occasion on which this 'virginal anxiety' breaks out in young girls does not actually represent

their first encounter with sexuality, but that an experience of sexual passivity had previously occurred in their childhood, the memory of which is aroused by this ‘first encounter’.

[2] A psychological theory of repression ought also to throw light on the question of why it is only ideas with a sexual content that can be repressed. Such an explanation might start out from the following indications. It is known that having ideas with a sexual content produces excitatory processes in the genitals which are similar to those produced by sexual experience itself. We may assume that this somatic excitation becomes transposed into the psychical sphere.

As a rule the effect in question is much stronger in the case of the experience than in the case of the memory. But if the sexual experience occurs during the period of sexual immaturity and the memory of it is aroused during or after maturity, then the memory will have a far stronger excitatory effect than the experience did at the time it happened; and this is because in the meantime puberty has immensely increased the capacity of the sexual apparatus for reaction. An inverted relation of this sort between real experience and memory seems to contain the psychological precondition for the occurrence of a repression. Sexual life affords - through the retardation of pubertal maturity as compared with the psychical functions - the only possibility that occurs for this inversion of relative effectiveness. The traumas of childhood operate in a deferred fashion as though they were fresh experiences; but they do so unconsciously. I must postpone entering into any more far-reaching psychological discussion till another occasion. Let me add, however, that the period of ‘sexual maturity’ which is in question here does not coincide with puberty but falls earlier (from the eighth to the tenth year).

Obsessions similarly presuppose a sexual experience in childhood (though one of a different nature from that found in hysteria). The aetiology of the two neuro-psychoses of defence is related as follows to the aetiology of the two simple neuroses, neurasthenia and anxiety neurosis. Both the latter disorders are direct effects of the sexual noxae themselves, as I have shown in my paper on anxiety neurosis (1895b); both the defence neuroses are indirect consequences of sexual noxae which have occurred before the advent of sexual maturity - are consequences, that is, of the psychical memory-traces of those noxae. The current causes which produce neurasthenia and anxiety neurosis often at the same time play the part of exciting causes of the neuroses of defence; on the other hand, the specific causes of a defence-neurosis - the traumas of childhood - can at the same time lay the foundations for a later development of neurasthenia.

Finally, it not infrequently happens, too, that neurasthenia or anxiety neurosis is maintained, not by current sexual noxae, but, instead, solely by the persisting effect of a memory of childhood traumas.[1]

II

THE NATURE AND MECHANISM OF OBSESSIONAL NEUROSIS

Sexual experiences of early childhood have the same significance in the aetiology of obsessional neurosis as they have in that of hysteria. Here, however, it is no longer a question

of sexual passivity, but of acts of aggression carried out with pleasure and of pleasurable participation in sexual acts - that is to say, of sexual activity. This difference in the aetiological circumstances is bound up with the fact that obsessional neurosis shows a visible preference for the male sex.

[1] (Footnote added 1924:) This section is dominated by an error which I have since repeatedly acknowledged and corrected. At that time I was not yet able to distinguish between my patients' phantasies about their childhood years and their real recollections. As a result, I attributed to the aetiological factor of seduction a significance and universality which it does not possess. When this error had been overcome, it became possible to obtain an insight into the spontaneous manifestations of the sexuality of children which I described in my Three Essays on the Theory of Sexuality (1905d). Nevertheless, we need not reject everything written in the text above. Seduction retains a certain aetiological importance, and even to-day I think some of these psychological comments are to the point.

In all my cases of obsessional neurosis, moreover, I have found a substratum of hysterical symptoms which could be traced back to a scene of sexual passivity that preceded the pleasurable action. I suspect that this coincidence is no fortuitous one, and that precocious sexual aggressivity always implies a previous experience of being seduced. However, I can as yet give no definitive account of the aetiology of obsessional neurosis; I only have an impression that the decision as to whether hysteria or obsessional neurosis will arise on the basis of traumas in childhood depends on chronological circumstances in the development of the libido.

The nature of obsessional neurosis can be expressed in a simple formula. Obsessional ideas are invariably transformed self-reproaches which have re-emerged from repression and which always relate to some sexual act that was performed with pleasure in childhood. In order to elucidate this statement it is necessary to describe the typical course taken by an obsessional neurosis.

In a first period - the period of childhood immorality - the events occur which contain the germ of the later neurosis. First of all, in earliest childhood, we have the experiences of sexual seduction that will later on make repression possible; and then come the acts of sexual aggression against the other sex, which will later appear in the form of acts involving self-reproach.

This period is brought to a close by the advent of sexual 'maturation', often itself unduly early. A self- reproach now be comes attached to the memory of these pleasurable actions; and the connection with the initial experience of passivity makes it possible - often only after conscious and remembered efforts - to repress them and to replace them by a primary symptom of defence. Conscientiousness, shame and self- distrust are symptoms of this kind, with which the third period begins - the period of apparent health, but actually, of successful defence.

The next period, that of the illness, is characterized by return of the repressed memories - that is, therefore, by the failure of the defence. It is not certain whether the awakening of those memories occurs more often accidentally and spontaneously or as a result of current sexual

disturbances, as a kind of by- product of them. The re-activated memories, however, and the self reproaches formed from them never re- emerge into consciousness unchanged: what become conscious as obsessional ideas and affects, and take the place of the pathogenic memories so far as conscious life is concerned, are structures in the nature of a compromise between the repressed ideas and the repressing ones.

In order to describe clearly and with probable accuracy the processes of repression, the return of the repressed and the formation of pathological compromise-ideas, one would have to make up one's mind to quite definite assumptions about the substratum of psychical events and of consciousness. So long as one seeks to avoid this, one must be content with the following remarks which are intended more or less figuratively. There are two forms of obsessional neurosis, according to whether what forces an entrance into consciousness is solely the mnemic content of the act involving self-reproach, or whether the self- reproachful affect connected with the act does so as well.

The first form includes the typical obsessional ideas, in which the content engages the patient's attention and, as an affect, he merely feels an indefinite unpleasure, whereas the only affect which would be suitable to the obsessional idea would be one of self-reproach. The content of the obsessional idea is distorted in two ways in relation to the obsessional act of childhood. First, something contemporary is put in the place of something past; and secondly, something sexual is replaced by something analogous to it that is not sexual. These two alterations are the effect of the inclination to repress, still in force, which we will ascribe to the 'ego'. The influence of the re-activated pathogenic memory is shown by the fact that the content of the obsessional idea is still in part identical with what has been repressed or follows from it by a logical train of thought. If, with the help of the psycho-analytic method, we reconstruct the origin of an individual obsessional idea, we find that from a single current impression two different trains of thought have been set going. The one which has passed by way of the repressed memory proves to be as correctly logical in its structure as the other, although it is incapable of being conscious and insusceptible to correction. If the products of the two psychical operations do not tally, what takes place is not some sort of logical adjustment of the contradiction between them; instead, alongside of the normal intellectual outcome, there comes into consciousness, as a compromise between the resistance and the pathological intellectual product, an obsessional idea which appears absurd. If the two trains of thought lead to the same conclusion, they reinforce each other, so that an intellectual product that has been arrived at normally now behaves, psychologically, like an obsessional idea. Wherever a neurotic obsession emerges in the psychological sphere, it comes from repression. Obsessional ideas have, as it were, a compulsive psychical currency, not on account of their intrinsic value, but on account of the source from which they derive or which has added a contribution to their value.

A second form of obsessional neurosis comes about if what has forced its way to representation in conscious psychical life is not the repressed mnemic content but the likewise repressed self-reproach. The affect of self-reproach can, by means of some mental addition, be transformed into any other unpleasurable affect. When this has happened there is no longer anything to prevent the substituted affect from becoming conscious. Thus self-reproach (for

having carried out the sexual act in childhood) can easily turn into shame (in case some one else should find out about it), into hypochondriacal anxiety (fear of the physical injuries resulting from the act involving the self-reproach), into social anxiety (fear of being punished by society for the misdeed), into religious anxiety, into delusions of being noticed (fear of betraying the act to other people), or into fear of temptation (a justified mistrust of one's own moral powers of resistance), and so on. In addition, the mnemic content of the act involving self-reproach may be represented in consciousness as well, or it may remain completely in the background - which makes diagnosis much more difficult. Many cases which, on a superficial examination, seem to be common (neurasthenic) hypochondria, belong to this group of obsessional affects; what is known as 'periodic neurasthenia' or 'periodic melancholia' seems in particular to resolve itself with unexpected frequency into obsessional affects and obsessional ideas - a discovery which is not a matter of indifference therapeutically.

Besides these compromise symptoms, which signify the return of the repressed and consequently a collapse of the defence that had been originally achieved, the obsessional neurosis constructs a set of further symptoms, whose origin is quite different. For the ego seeks to fend off the derivatives of the initially repressed memory, and in this defensive struggle it creates symptoms which might be classed together as 'secondary defence'. These are all of them 'protective measures', which have already done good service in the fight against obsessional ideas and obsessional affects. If these aids in the defensive struggle genuinely succeed in once more repressing the symptoms of the return which have forced themselves on the ego, then the obsession is transferred to the protective measures themselves and creates a third form of 'obsessional neurosis'- obsessional actions. These actions are never primary; they never contain anything but a defence - never an aggression. A psychical analysis of them shows that, in spite of their peculiarity, they can always be fully explained by being traced back to the obsessional memories which they are fighting against.[1]

[1] To take a single example only. An eleven-year-old boy had in an obsessional way instituted the following ceremonial before going to bed. He did not go to sleep until he had told his mother in the minutest detail all the experiences he had had during the day; there must be no bits of paper or other rubbish on the carpet in his bedroom in the evening; his bed had to be pushed right up against the wall, three chairs had to be placed in front of it, and the pillows had to lie in a particular way. In order to go to sleep he was obliged first to kick both his legs out a certain number of times and then lie on his side. This was explained in the following manner. Years before, a servant-girl who put the nice looking boy to bed had taken the opportunity of lying down on him and abusing him sexually. When, later on, this memory was aroused in him by a recent experience, it manifested itself in his consciousness in a compulsion to perform the ceremonial I have described above. The meaning of the ceremonial was easy to guess and was established point by point by psycho-analysis. The chairs were placed in front of the bed and the bed pushed against the wall in order that nobody else should be able to get at the bed; the pillows were arranged in a particular way so that they should be differently arranged from how they were on that evening; the movements with his legs were to kick away the person who was

lying on him; sleeping on his side was because in the scene he had been lying on his back; his circumstantial confession to his mother was because, in obedience to a prohibition by his seductress, he had been silent to his mother about this and other sexual experiences; and, finally, the reason for his keeping his bedroom floor clean was that neglect to do so had been the chief reproach that he had so far had to hear from his mother.

Secondary defence against the obsessional ideas may be effected by a forcible diversion on to other thoughts with a content as contrary as possible. This is why obsessional brooding, if it succeeds, regularly deals with abstract and suprasensual things; because the ideas that have been repressed are always concerned with sensuality. Or else the patient tries to make himself master of each of his obsessional ideas singly by logical work and by having recourse to his conscious memories. This leads to obsessional thinking, to a compulsion to test things and to doubting mania. The advantage which perception has over memory in such tests at first causes the patient, and later compels him, to collect and store up all the objects with which he has come into contact. Secondary defence against obsessional affects leads to a still wider set of protective measures which are capable of being transformed into obsessional acts. These may be grouped according to their purpose: penitential measures (burdensome ceremonials, the observation of numbers), precautionary measures (all sorts of phobias, superstition, pedantry, increase of the primary symptom of conscientiousness); measures to do with fear of betrayal (collecting scraps of paper, seclusiveness), or to ensure numbing (dipsomania). Among these obsessional acts and obsessional impulses, phobias, since they circumscribe the patient's existence, play the greatest part.
There are cases in which one can observe how the obsession is transferred from the idea or from the affect on to the protective measure; others in which the obsession oscillates periodically between the symptom of the return of the repressed and the symptom of the secondary defence; and yet other cases in which no obsessional idea is constructed at all, but, instead, the repressed memory is at once represented by what is apparently a primary measure of defence. Here we reach at one bound the stage which elsewhere only completes the course run by the obsessional neurosis after the defensive struggle has taken place. Severe cases of this disorder end in the ceremonial actions becoming fixated, or in a general state of doubting mania, or in a life of eccentricity conditioned by phobias.

The fact that the obsessional ideas and everything derived from them meet with no belief is no doubt because at their first repression the defensive symptom of conscientiousness has been formed and that that symptom, too, acquires an obsessional force. The subject's certainty of having lived a moral life throughout the whole period of his successful defence makes it impossible for him to believe the self- reproach which his obsessional idea involves. Only transitorily, too, on the appearance of a new obsessional idea and occasionally in melancholic states of exhaustion of the ego, do the pathological symptoms of the return of the repressed compel belief. The 'obsessional' character of the psychical formations which I have described here has quite generally nothing to do with attaching belief to them. Nor is it to be confused with

the factor which is described as the ‘strength’ or ‘intensity’ of an idea. Its essence is rather indissolubility by psychical activity that is capable of being conscious; and this attribute undergoes no change, whether the idea to which the obsession attaches is stronger or weaker, or less or more intensely ‘illuminated’, or ‘cathected with energy’ and so on.
The cause of this invulnerability of the obsessional idea and its derivatives is, however, nothing more than its connection with the repressed memory from early childhood. For if we can succeed in making that connection conscious - and psychotherapeutic methods already appear able to do so - the obsession, too, is resolved.

III

ANALYSIS OF A CASE OF CHRONIC PARANOIA [1]

For a considerable time I have harboured a suspicion that paranoia, too - or classes of cases which fall under the heading of paranoia - is a psychosis of defence; that is to say, that, like hysteria and obsessions, it proceeds from the repression of distressing memories and that its symptoms are determined in their form by the content of what has been repressed. Paranoia must, however, have a special method or mechanism of repression which is peculiar to it, in the same way as hysteria effects repression by the method of conversion into somatic innervation, and obsessional neurosis by the method of substitution (viz. by displacement along the lines of certain categories of associations). I had observed several cases which favoured this interpretation, but had found none which proved it; until, a few months ago, I had an opportunity, through the kindness of Dr. Josef Breuer, of undertaking the psycho-analysis for therapeutic purposes of an intelligent woman of thirty-two, in whose case a diagnosis of chronic paranoia could not be questioned. I am reporting in these pages, without waiting further, some of the information I have been able to obtain from this piece of work, because I have no prospect of studying paranoia except in very isolated instances, and because I think it possible that my remarks may encourage a psychiatrist better placed than I am in this matter to give its rightful place to the factor of ‘defence’ in the discussion as to the nature and psychical mechanism of paranoia which is being carried on so actively just now. I have, of course, on the strength of the following single observation, no intention of saying more than: ‘This case is a psychosis of defence and there are most probably others in the class of "paranoia" which are equally so.’

[1] (Footnote added 1924:) More correctly, no doubt, dementia paranoides.

Frau P., thirty-two years of age, has been married for three years and is the mother of a child of two. Her parents were not neurotic; but her brother and sister are to my knowledge, like her, neurotic. It is doubtful whether she may not, at one time in her middle twenties, have become temporarily depressed and confused in her judgement. In recent years she was healthy and capable, until, six months after the birth of her child, she showed the first signs if her present

illness. She became uncommunicative and distrustful, showed aversion to meeting her husband's brothers and sisters and complained that the neighbours in the small town in which she lived were behaving differently towards her from how they did before and were rude and inconsiderate to her. By degrees these complaints increased in intensity, although not in definiteness. She thought people had something against her, though she had no idea what; but there was no doubt that everyone - relatives and friends - had ceased to respect her and were doing all they could to slight her. She had racked her brains, she said, to find the reason for this, but had no idea. A little time later she complained that she was being watched and that people were reading her thoughts and knew everything that was going on in her house. One afternoon she suddenly had the idea that she was being watched while she was undressing in the evening. From that time on she took the most precautionary measures when she undressed; she got into bed in the dark and did not begin to take off her things till she was under the bedclothes. Since she avoided all contact with other people, ate poorly and was very depressed, she was sent in the summer of 1895 to a hydropathic establishment. There, fresh symptoms appeared and those she already had increased in strength. Already in the spring of that year, when she was alone one day with her housemaid, she had suddenly had a sensation in her lower abdomen, and had thought to herself that the girl had at that moment had an improper idea. This sensation grew more frequent during the summer and became almost continual. She felt her genitals 'as one feels a heavy hand'. Then she began to see images which horrified her - hallucinations of naked women, especially of the lower part of a woman's abdomen with pubic hairs, and occasionally of male genitals as well. The image of the abdomen with hair and the physical sensation in her own abdomen usually occurred together. The images became very tormenting, for they happened regularly when she was in the company of a woman, and it made her think that she was seeing the woman in an indecent state of nakedness, but that simultaneously the woman was having the same picture of her (!). At the same time as these visual hallucinations - which vanished again for several months after their first appearance in the hydropathic establishment - she began to be pestered by voices which she did not recognize and which she could not account for. When she was in the street, they said: 'That's Frau P.- There she goes! Where's she going to?' Every one of her movements and actions was commented on; and at times she heard threats and reproaches. All these symptoms became worse when she was in company or in the street. For that reason she refused to go out; she said that eating disgusted her; and her state of health rapidly deteriorated.

I gathered all this from her when she came to Vienna for treatment with me in the winter of 1895. I have set it out at length because I want to convey the impression that what we are dealing with here really is a quite frequent form of chronic paranoia - a conclusion with which the details of her symptoms and behaviour which I have still to describe will be found to tally. At that time she concealed from me the delusions which served to interpret her hallucinations, or else the delusions had in fact not yet occurred to her. Her intelligence was undiminished; the only unusual thing I learnt was that she had repeatedly made appointments with her brother, who lived in the neighbourhood, in order to confide something important to him, but had never told

him anything. She never spoke about her hallucinations, and towards the end she no longer said much either about the slights and persecutions of which she was subjected.

What I have to report about this patient concerns the aetiology of the case and the mechanism of the hallucinations. I discovered the aetiology when I applied Breuer's method, exactly as in a case of hysteria - in the first instance for the investigation and removal of the hallucinations. In doing so, I started out from the assumption that in this case of paranoia, just as in the two other defence neuroses with which I was familiar, there must be unconscious thoughts and repressed memories which could be brought into consciousness in the same way as they were in those neuroses, by overcoming a certain resistance. The patient at once confirmed my expectation, for she behaved in analysis exactly like, for instance, a hysterical patient; with her attention on the pressure of my hand,[1] she produced thoughts which she could not remember having had, which at first she did not understand and which were contrary to her expectations.

The presence of significant unconscious ideas was thus demonstrated in a case of paranoia as well, and I was able to hope that I might trace the compulsion of paranoia, too, to repression. The only peculiarity was that the thoughts which arose from the unconscious were for the most part heard inwardly or hallucinated by the patient, in the same way as her voices.

[1] Cf. my Studies on Hysteria.

Concerning the origin of the visual hallucinations, or at least of the vivid images, I learned the following. The image of the lower part of a woman's abdomen almost always coincided with the physical sensation in her own abdomen; but the latter was much more constant and often occurred without the image. The first images of a woman's abdomen had appeared in the hydropathic establishment a few hours after she had in fact seen a number of naked women at the baths; so they turned out to be simple reproductions of a real impression. It was therefore to be presumed that these impressions had been repeated only because great interest was attached to them. She told me that she had felt ashamed for these women; she herself had been ashamed to be seen naked for as long as she could remember. Since I was obliged to regard the shame as something obsessional, I concluded, in accordance with the mechanism of defence, that an experience must have been repressed here about which she had not felt ashamed. So I requested her to let the memories emerge which belonged to the theme of feeling ashamed. She promptly reproduced a series of scenes going back from her seventeenth to her eighth year, in which she had felt ashamed of being naked in her bath in front of her mother, her sister and the doctor; but the series ended in a scene at the age of six, in which she was undressing in the nursery before going to bed, without feeling any shame in front of her brother who was there. On my questioning her, it transpired that scenes like this had occurred often and that the brother and sister had for years been in the habit of showing themselves to one another naked before going to bed. I now understood the meaning of her sudden idea that she was being watched as she was going to bed. It was an unaltered piece of the old memory which involved self-reproach, and she was now making up for the shame which she had omitted to feel as a child.

My conjecture that we had to do with an affair between children, as is so often found in the aetiology of hysteria, was strengthened by the further progress of the analysis, which at the same time yielded solutions of individual details that frequently recurred in the clinical picture of the paranoia. The patient's depression began at the time of a quarrel between her husband and her brother, as a result of which the latter no longer came to the house. She had always been very fond of this brother and she missed him very much at that time. Besides this she spoke of a certain moment in her illness at which for the first time 'everything became clear to her' - that is, at which she became convinced of the truth of her suspicion that she was despised by everyone and deliberately slighted. This certainty came to her during a visit from her sister-in law who, in the course of conversation, let fall the words: 'If anything of that sort happens to me, I treat it in a light vein.' At first Frau P. took this remark unsuspectingly; but later, after the visitor had left, it seemed to her that the words had contained a reproach, as if she was in the habit of taking serious things lightly; and from that moment on she was certain that she was the victim of general slander. When I questioned her as to what made her feel justified in applying the words to herself, she answered that it was the tone of voice in which her sister-in-law had spoken that had (although, it is true, only subsequently) convinced her of it. This is a detail which is characteristic of paranoia. I now obliged her to remember what her sister-in-law had been saying before the remark she complained of, and it emerged that the sister-in-law had related how in her parents' home there had been all sorts of difficulties with her brothers, and had added the wise comment: 'In every family all sorts of things happen that one would like to draw a veil over. But if anything of the kind happens to me, I take it lightly.' Frau P. now had to admit that her depression was attached to the statements made by her sister-in-law before her last remark. Since she had repressed both the statements which might have awakened a memory of her relations with her brother, and had only retained the insignificant last one, it was with it that she was obliged to connect her feeling that her sister-in-law was making a reproach against her; and since its content offered no basis for this, she turned from the content to the tone in which the words had been spoken. This is probably a typical piece of evidence that the misinterpretations of paranoia are based on a repression.

My patient's singular conduct, too, in making appointments with her brother, and then having nothing to tell him, was solved in a surprising fashion. Her explanation was that she had thought that if she could only look at him he would be bound to understand her sufferings, since he knew the cause of them. Now, as this brother was in fact the only person who could know about the aetiology of her illness, it was clear that she had been acting in accordance with a motive which, although she herself did not understand it consciously, could be seen to be perfectly justified as soon as it was supplied with a meaning derived from the unconscious.

I then succeeded in getting her to reproduce the various scenes in which her sexual relationship with her brother (which had certainly lasted at least from her sixth to her tenth year) had culminated. During this work of reproduction, the physical sensation in her abdomen 'joined in the conversation' as it were, as is regularly observed to happen in the analysis of hysterical mnemic residues. The image of the lower part of a woman's naked abdomen (but now reduced

to childish proportions and without hair on it) appeared with the sensation or stayed away, according as the scene in question had occurred in full light or in the dark. Her disgust at eating, too, found an explanation in a repulsive detail of these proceedings. After we had gone through this series of scenes, the hallucinatory sensations and images had disappeared, and (up to the present, at any rate) they have not returned.[1]

[1] Later on, when an exacerbation of her illness undid the successful results of the treatment - which were in any case meagre - the patient no longer saw the offensive images of other people's genitals but had the idea that other people saw her genitals whenever they were behind her.
(Added 1922) The fragmentary account of this analysis in the text above was written while the patient was still undergoing treatment. Very shortly after, her condition became so much more serious that the treatment had to be broken off. She was transferred to an institution and there went through a period of severe hallucinations which had all the signs of dementia praecox. Contrary to expectation, however, she recovered and returned home, had another child which was quite healthy, and was able for a long period (12 to 15 years) to carry out all her duties in a satisfactory manner. The only sign of her earlier psychosis was said to be that she avoided the company of all relatives, whether of her own family or of her husband's. At the end of this period, affected by very adverse changes in her circumstances, she again became ill. Her husband had become unable to work and the relatives she had avoided were obliged to support the family. She was again sent to an institution, and died there soon after, of a pneumonia which rapidly supervened.

I had found, therefore, that these hallucinations were nothing else than parts of the content of repressed childhood experiences, symptoms of the return of the repressed.
I now turned to the analysis of the voices. First and foremost what had to be explained was why such an indifferent content as 'Here comes Frau P.', 'She's looking for a house now', and so on, could have been so distressing to her; next, how it was that precisely these innocent phrases had managed to be marked out by hallucinatory reinforcement. From the first it was clear that the 'voices' could not be memories that were being produced in a hallucinatory way, like the images and sensations, but were rather thoughts that were being 'said aloud'.
The first time she heard the voices was in the following circumstances. She had been reading Otto Ludwig's fine story, Die Heiterethei, with eager interest, and she noticed that while she was reading, thoughts were emerging which claimed her attention. Immediately afterwards, she went for a walk along a country road, and, as she was passing a small peasant's house, the voices suddenly said to her 'That's what the Heiterethei's cottage looked like! There's the spring and there are the bushes! How happy she was in spite of all her poverty!' The voices then repeated to her whole paragraphs from what she had just been reading. But it remained unintelligible why the Heiterethei's cottage and bushes and spring, and precisely the most trivial and irrelevant passages of the story, should be forced on her attention with pathological strength. However, the solution of the puzzle was not difficult. Her analysis showed that while she was reading, she had had other thoughts as well and that she had been excited by quite different passages in the

book. Against this material - analogies between the couple in the story and herself and her husband, memories of intimacies in her married life, and of family secrets - against all this a repressing resistance had arisen because it was connected, by easily demonstrable trains of thought, with her aversion to sexuality and thus ultimately went back to the awakening of her old childhood experience. In consequence of this censorship exercised by the repression, the innocuous and idyllic passages, which were connected with the proscribed ones by contrast and also by propinquity, acquired the additional strength in their relation to consciousness which made it possible for them to be spoken aloud. The first of the repressed ideas, for instance, related to the slander to which the heroine, who lived alone, was exposed from her neighbours. My patient easily discovered the analogy with her own self. She, too, lived in a small place, met no one, and thought she was despised by her neighbours. This distrust of her neighbours had a real foundation. She had been obliged at first to be content with a small apartment, and the bedroom wall against which the young couple's double bed stood adjoined a room belonging to their neighbours. With the beginning of her marriage - obviously through an unconscious awakening of her childhood affair, in which she and her brother had played at husband and wife - she had developed a great aversion to sexuality. She was constantly worried in case her neighbours might hear words and noises through the party wall, and this shame turned into suspiciousness towards the neighbours.

Thus the voices owed their origin to the repression of thoughts which, in the last analysis, were in fact self-reproaches about experiences that were analogous to her childhood trauma. The voices were accordingly symptoms of the return of the repressed. But they were at the same time consequences of a compromise between the resistance of the ego and the power of the returning repressed - a compromise which in this instance had brought about a distortion that went beyond recognition. In other instances in which I had occasion to analyse Frau P.'s voices, the distortion was less great. Nevertheless, the words she heard always had a quality of diplomatic indefiniteness: the insulting allusion was generally deeply hidden; the connection between the separate sentences was disguised by a strange mode of expression, unusual forms of speech and so on - characteristics which are common to the auditory hallucinations of paranoics in general and in which I see the traces of distortion through compromise. For instance, the remark, 'there goes Frau P.; she's looking for a house in the street', meant a threat that she would never recover; for I had promised her that after her treatment she would be able to go back to the small town in which her husband worked.(She had provisionally taken rooms in Vienna for a few months.)

In isolated instances Frau P. also received more definite threats - for example, in regard to her husband's relatives; yet there was still a contrast between the reserved manner in which they were expressed and the torment which the voices caused her. In view of what is known of paranoia apart from this, I am inclined to suppose that there is a gradual impairment of the resistances which weaken the self-reproaches; so that finally the defence fails altogether and the original self-reproach, the actual term of abuse, from which the subject was trying to spare himself, returns in its unaltered form. I do not know, however, whether this course of events is a

constant one, or whether the censorship of the words involving the self-reproach may be absent from the beginning or may persist to the end.

It only remains for me now to employ what has been learned from this case of paranoia for making a comparison between paranoia and obsessional neurosis. In each of them, repression has been shown to be the nucleus of the psychical mechanism, and in each what has been repressed is a sexual experience in childhood. In this case of paranoia, too, every obsession sprang from repression; the symptoms of paranoia allow of a classification similar to the one which has proved justified for obsessional neurosis. Part of the symptoms, once again, arise from primary defence - namely, all the delusional ideas which are characterized by distrust and suspicion and which are concerned with ideas of being persecuted by others. In obsessional neurosis the initial self-reproach has been repressed by the formation of the primary symptom of defence: self-distrust. With this, the self-reproach is acknowledged as justified; and, to weigh against this, the conscientiousness which the subject has acquired during his healthy interval now protects him from giving credence to the self-reproaches which return in the form of obsessional ideas. In paranoia, the self-reproach is repressed in a manner which may be described as projection. It is repressed by erecting the defensive symptom of distrust of other people. In this way the subject withdraws his acknowledgement of the self-reproach; and, as if to make up for this, he is deprived of a protection against the self-reproaches which return in his delusional ideas.

Other symptoms of my case of paranoia are to be described as symptoms of the return of the repressed, and they, too, like those of obsessional neurosis, bear the traces of the compromise which alone allows them to enter consciousness. Such are, for instance, my patient's delusional idea of being watched while she was undressing, her visual hallucinations, her hallucinations of sensation and her hearing of voices. In the delusional idea which I have just mentioned there is a mnemic content which is almost unaltered and has only been made indefinite through omission. The return of the repressed in visual images approaches the character of hysteria rather than of obsessional neurosis; but hysteria is in the habit of repeating its mnemic symbols without modification, whereas mnemic hallucinations in paranoia undergo a distortion similar to that in obsessional neurosis: an analogous modern image takes the place of the repressed one. (E. g., the abdomen of an adult woman appears instead of a child's, and an abdomen on which the hairs are especially distinct, because they were absent in the original impression.) A thing which is quite peculiar to paranoia and on which no further light can be shed by this comparison, is that the repressed self- reproaches return in the form of thoughts spoken aloud. In the course of this process, they are obliged to submit to twofold distortion: they are subjected to a censorship, which leads to their being replaced by other, associated, thoughts or to their being concealed by an indefinite mode of expression, and they are referred to recent experiences which are no more than analogous to the old ones.

The third group of symptoms that are found in obsessional neurosis, the symptoms of secondary defence, cannot be present as such in paranoia, because no defence can avail against the returning symptoms to which, as we know, belief is attached. In place of this, we find in paranoia another source for the formation of symptoms. The delusional ideas which have arrived in consciousness by means of a compromise (the symptoms of the return) make demands on the thought-activity of the ego until they can be accepted without contradiction. Since they are not themselves open to influence, the ego must adapt itself to them; and thus what corresponds here to the symptoms of secondary defence in obsessional neurosis is a combinatory delusional formation - interpretative delusions which end in an alteration of the ego. In this respect, the case under discussion was not complete; at that time my patient did not as yet exhibit any signs of the attempts at interpretation which appeared later. But I have no doubt that if we apply psycho- analysis to this stage of paranoia as well, we shall be able to arrive at a further important result. It should then turn out that the so-called weakness of memory of paranoics is also a tendentious one - that is to say, that it is based on repression and serves the ends of repression. A subsequent repression and replacement takes place of memories which are not in the least pathogenic, but which are in contradiction to the alteration of the ego which the symptoms of the return of the repressed so insistently demand.