Hysteria, Discourse and Narrative:
Freud's Early Case Histories of Women in Context

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Abstract

In this thesis, I look at the way Freud's work constituted an epistemological shift in the late 19th century. To this end, I propose a reading of the cases in Studies in Hysteria and the Dora case. These texts are examined against the backdrop of the 19th century discursive hegemony. The prevalent neurological views on the aetiology and the treatment of hysteria, especially those of Freud's teachers Charcot and Bernheim are investigated. A set of discursive constructs which served to reinforce the mastery of the therapist over the patient emerges from this analysis. It is demonstrated that Freud too shared in these constructs. However, the Freudian psychoanalytic encounter which has patient and therapist engaging jointly in the construction of a narrative of the patient's life, constitutes a possible way out of such therapeutic mastery. Nevertheless, this breakthrough is subject to hegemonic constraints which mitigated its revolutionary potential.

Résumé

J'examine comment la pensée freudienne fait l'effet d'un mouvement épistémologique au 19e siècle. Ainsi, je propose une lecture des six études de cas des Etudes sur l'hystérie et du cas Dora. Ces textes sont examinés en tenant compte de l'hégémonie socio-discursive du 19e siècle. Les principales opinions circulant dans le domaine neurologique au sujet de l'étiologie et du traitment de l'hystérie, notamment celles de Charcot et de Bernheim, sont scrutinées. Une série de thèmes discursifs servant à renforcer la maîtrise du thérapeute sur le patient, se dessine nettement. Ces thèmes se rapportent également à l'oeuvre de Freud. Cependant, la rencontre psychanalytique freudienne, qui voit thérapeute et patient se partager la narration de la vie du patient, constituerait une éventuelle porte de sortie hors de la relation de pouvoir thérapeutique. Mais le novum que ceci représente est sujet à des contraintes hégémoniques qui limitent son potentiel révolutionnaire.

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Introduction

Freud's theories about the nature of the human psyche have enjoyed immense popularity and respect in our century. Despite important developments in pharmaceutical research, they continue to influence the treatment of neurotic and even psychotic patients. But Freudian thought has of course strayed far beyond the scientific and medical context out of which it originally evolved. It reaches, sometimes quite discretely, most areas of learned and popular discourse dealing with the Western subject's perception of self and world. In the light of the pervasiveness of Freudian concepts and terminology in most facets of our culture, one might be tempted to speak of knowledge in pre or post-Freudian ways.

However such a stand would imply that Freud precipitated a break in the way the nineteenth century subject viewed the divide and/or link between madness and sanity, consciousness and unconsciousness. A basic stand that this thesis takes from the outset, has that, on the contrary, the differences between Freud and contemporary thinkers researching similar issues are considerably less striking than their similarities. This is necessarily so, due to the very nature of cognitive change. The break, if indeed a break did occur, was not of a decisive nature but rather set along a smooth path of logical continuity between

concepts and was well within a framework of acceptable ideas.

The strategy of exploring the background to Freudian thought is certainly not a new one. Indeed, much of the criticism of Freud, from its beginnings to the present could easily be divided into that insisting on the originality of Freud's work and that denying it. These two stands usually connote a value judgment, since originality is often seen as a matter of intellectual merit. Early proponents of the psychoanalytic movement were certainly sensitive to this idea. Ernest Jones' biography of Freud, and indeed Freud's own autobiographical and historical writings about the birth of the psychoanalytic movement contribute to an image of Freud laboring in isolation against a backdrop of general opposition. More recent work stressing the continuity between Freud and other contemporary thinkers is often critical of psychoanalysis. Ellenberger's The Discovery of the Unconscious for example, seeks to show that Freud's theory is just one possible system of dynamic psychiatry among others, and moreover one which does not possess any more intrinsic value than, say, Janet's.

This thesis does not propose to address the question of the validity of psychoanalysis as a theory or its efficacy as a cure. Its aim lies solely in attempting to demonstrate through the exploration of the origins of Freud's theory, the evolution of a certain type of knowledge, which has come to be identified as "psychoanalytic knowledge". The thesis

will show how it came into being by transforming to a point of no return certain assumptions on which accepted scientific knowledge was based. It was at this stage that psychoanalytic knowledge came to be thought of as "new". This hypothesis will be proved through a contextualisation of Freud's early writings, namely his case histories of hysterics, by reading them against the work on hysteria produced simultaneously, or just before him, by members of the Paris and Nancy schools.

The continuity provided by a contextualisation of Freudian concepts renders it necessary to question the possibility of a "break" occurring in knowledge, yet this is exactly what is usually implied by the terms change and newness. It leaves one no choice but to redefine both these notions, since discarding them altogether is not a logically viable alternative. Nobody would argue with the fact that what is known today is quite different from what was known a hundred years ago. However knowledge being of a discursive nature, it is subject to hegemonic constraints. This last assertion follows the theories of the socio-critical school of thought which holds that knowledge, in its acquisition, transmission and evolution is subject to strict, but hidden --because implicit-- laws governing all social interaction. In a given society, at a given time, what is sayable, writable, thinkable, in other words knowable, is subject to global(izing) limits (Angenot, 1984). A novum in the light of this hegemony delimiting the production of knowledge is

not a substitution, as implied by the potentially absolute terms "change" and "new", but a belabouring, an elaboration, a continuous process. It is therefore more sound to speak of a "labour of novelty" rather than of just newness.

It is necessary to find out as well who profits from the restraints which the hegemony imposes. The concept of ideology lies at the heart of the construct of discursive hegemony. Ideology always implies the attempt to preserve a certain status quo within the hegemony, regulating and maintaining a certain distribution of power. Jacques Dubois's pragmatic definition of the term is a good example of recent theoretical thinking about the function of ideology as a regulator of power relations: "En dernier recours, il s'agit toujours de justifier des inégalités économiques, sociales et politiques en leur conférant la transparence du naturel; il s'agit par le dispositif idéologique d'assurer la domination d'une classe ou fraction de classe sur d'autres sans recourir à la force ou à la violence". (Dubois, 63). Ideology acts as an agent of regulation in discourse as in social hierarchies, allowing some concepts to be expressed and others not, in keeping with the proposition that knowledge via discourse equals power. As Pierre Bourdieu's research warns us, we must not consider language as "un objet d'intellection" but as "un instrument d'action et de pouvoir" (Bourdieu 1980 a., 17).

Bourdieu has also pointed elsewhere (Bourdieu 1980 b.) to the necessity of considering the kind of knowledge

conveyed or expressed through practice. This type of knowledge operates as well under hegemonic restraints, albeit different ones from those which regulate discursive knowledge. Interesting discrepancies which undermine the homogenizing aims of ideology, can thus occur between discourse and practice. We shall be encountering just such discrepancies in the field of neurology, as the theory of hysterical disorders sometimes conflicts with its actual therapy. However both theory and therapy offer us the opportunity to understand the basic relationship at work between patient and therapist. It is one of power and is based on the authority of the therapist's knowledge.

In this aspect we refer to Michel Foucault who has constructed in his life work, a theory of the dynamic, dialectic side to power relations. Foucault sees that there is a definite movement implied in the fact that power can be shared, transmitted, wrested away, given up, transformed, transmitted, loaned and borrowed. An idea of movement and transience is born out of and supported by the conception of power implying a relation between the one who exercises it and the one who feels its effects. This relation has all the potential of becoming a dialectic play of cause and effect. Furthermore, if one assumes that holding power implies controlling knowledge, this movement in turn provides a way out of the implication of stasis which a belief in discursive hegemonies might imply. Indeed the fact that hegemonies develop, stretch and change is almost a matter of

common sense. This leads us back to the truism that we now think and know things which were inexpressible a hundred years ago.

A study of the birth of psychoanalytic knowledge from the fertile soil of fin-de-siècle science in general, and in the writings surrounding hysteria in particular, constitutes a good example of how the transformation of a discursive hegemony might occur. What is at stake in changing power relations is explicitly played out in the written case histories, a record of the interaction between patient and therapist, as well as between the therapist and the rest of the scientific community interested in the treatment of that particular disorder. Furthermore, the writings of the main therapists of hysteria of the time, namely Charcot, Bernheim, and their respective colleagues, show how the preconditions for an epistemological impact such as the one that Freud is considered to have produced, were already present in the discursive hegemony of late 19th century Vienna and Paris.

The immediate discursive context of Freud's work is provided by a particular branch of scientific knowledge: neurology. It serves as the most useful frame for an exploration of the reasons and circumstances surrounding the putting into discourse and circulation of evolving ideas regarding madness and sanity. The field of neurology also serves to investigate the hegemonic background against which change necessarily takes place. Freud's five cases in

Studies in Hysteria, and the Dora case, officially known as "A Fragment of an Analysis of a Case of Hysteria" will be subjected to a close reading. They will be considered against the backdrop of Charcot, Bernheim and their colleagues on the theory and therapy of hysteria.

One of the key elements of psychoanalytic theory lies in positing a chain of continuity from psychosis through neurosis to normalcy. But this stand is not a novel one, neither in terms of philosophy nor in terms of therapy. The way a given society views and treats madness is a direct key into the way it considers itself. As Foucault has pointed out in Histoire de la folie, the construct of madness serves as a necessary point of contrast and comparison for the sane subject to measure itself against, in a form of dialectic mirroring. "l'homme apparaît dans la folie comme étant un autre lui-même; mais dans cette altérité, il révèle la vérité qu'il est lui-même, et ceci indéfiniment dans le mouvement bavard de l'aliénation" (Foucault 1972, 547). Hysteria, became during the 19th century a choice object of medical scrutiny. It was an especially useful conceptual tool to explore the thresholds between various physical and psychic states.

The existence of the field of neurology itself attests to the erosion of the dichotomy between the normal and the abnormal, sanity and madness which in turn rendered possible a certain dialectical play between these notions. It functioned in fact, as the bridge between the science of the

body and the science of the mind. It was a new field: a chair of neurology was first created for Charcot in 1882. In its somaticism it maintained very close links with physiology but incorporated more and more issues hitherto pertaining to psychology and philosophy, especially regarding the treatment of hysteria (Postel & Quetel, 404). The presence at la Salpêtrière, of a researcher with Janet's essentially non-medical background, for example, attested to this fact. This particular aspect of the field of neurology, showing it to be a cross-over area between psychological and physiological concerns, highlighted its place within another, perhaps even more significant play of oppositions: that between the physical and the mental. In other words, it was situated within the very tradition of the old Cartesian mind/body debate. It is within the context of that debate, in turn, that one must understand the construct of the unconscious, a concept very much in existence and use at the time Freud began writing. Michel Henry dates it back at least to the time of Descartes. "Le concept d'inconscient fait apparition dans la pensée moderne en même temps que la conscience et comme son exacte conséquence" (Henry, 6).

Hysteria was the disease par excellence to serve as neurology's object of scrutiny. It was a "chameleon disease", adapting itself particularly well to "the ideas and mores current in each society" (Veith, viii; Krohn, 56-57). It was characterized as well by its mimicry of other

disturbances. Hysteria could masquerade as other less problematic neurological illnesses like epilepsy or chorea, for example. It could even produce undeniable organic symptoms such as vivid bruises on the skin, or deformations of the limbs.

Mainly a woman's illness, it had a strong somatic connotation inherited from the days when the name hysteria literally reflected the fact that it was thought of as the disease "the wandering womb". But the puzzle of the apparent randomness of its symptoms pointed increasingly towards an ill-defined "mental" component. "L'hystérie fait encore partie {...} de ces maladies *sine materia* ou au moins dont la matière est encore a déceler" (Gilles de la Tourette 1898, 154). Clinically observed and proven aphasias, paralyses, unexplained by actual physiological disturbances invited questioning as to where the sphere of the body began and that of the mind ended, and vice-versa. This caused the seemingly well-defined boundaries between the two domains to fluctuate. Charcot would say "il faut prendre l'hystérie pour ce qu'elle est, c'est-à-dire pour une maladie psychique par excellence" (Gilles de la Tourette 1898, 155) as he simultaneously proceeded to a rigorous classification of the disease's physical manifestations.

Hysteria's ambiguous but definite relationship with the body was maintained long after the etymological link between woman and the disease was no longer directly significant. Although the possibility of male hysteria was

occasionally brought up as early as Graeco-Roman times (Veith, 22), and an effort was made on Charcot's part to promote the idea of male hysteria beyond the status of a mere curiosity (Charcot 1887), the hysteric was still, in the popular, and even the scientific conception of the disease, overwhelmingly identified with woman. This would seem to indicate that questions of gender were at the heart of the matter. Accordingly, the power relations involved in the knowledge and the treatment of hysteria, can be legitimately explored in terms of the relation between the sexes, as in the relation between the male therapist and the female patient serving as a paradigm for the distribution of knowledge within a patriarchal society. (1)

Questions of gender, lead smoothly to questions of sexuality. Research into the history of hysteria points to a continuous line of awareness of the fact that repressed sexuality is an important but more or less unconscious driving force behind the aetiology of the disease. The theme of widows and maidens as being the chief sufferers of hysteria, is a recurrent one since ancient times. The remedies prescribed range from the overtly to the covertly sexual, and include the "tried-and-true" remedy of the hasty marriage. This was explicitly acknowledged by the popular discourse on hysteria, but underplayed and even denied by official scientific discourse.

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1 To reinforce this point, throughout the thesis I have used the pronoun "he" in reference to the therapist, and "she" in reference to the patient, except, of course, when dealing explicitly with male hysteria.

Several important epistemological issues thus surrounded hysteria and its treatment. These included the confrontation of body -- diseased or not, sexed or neutral, and the mind -- mad or sane, conscious or not. The hysteric's role in the unfolding of knowledge was crucial: through the inexplicability of her symptoms, she bore on her physical being, on the irreducible presence of her body, the traces of the action of something hidden, something of the order of the mind, but twice removed, of the order of the unconscious mind. She thus allowed for the possibility of unraveling its mysteries, providing someone succeeded in breaking the secret code of her body's language. Freud, of course, would prove more than any of his contemporaries able to provide a coherent system which would make hysterical symptoms intelligible.

In their practice, Freud's two major influences, Jean-Martin Charcot, one of the great neurologists of the nineteenth century, and head of l'Ecole de la Salpêtrière, also known as Ecole de Paris, and the less renowned Hippolyte Bernheim, head of the rival Ecole de Nancy, presented two neatly contrasting alternatives to the understanding of hysteria. Charcot's essentially somatic approach to neurology revealed his strong ties with physiology. He observed the patient in front of him, located symptoms, and named them. He eliminated through identification but not through explanation. He was furthermore limited in his capacity to cure by a

deterministic belief in the hereditary taint, a predisposition to nervous disease. His use of hypnosis, then the gateway par excellence to the unconscious, was solely a diagnostic one: ability to be hypnotized signifying a predisposition to hysteria. Bernheim, on the other hand, took into account what he perceived as the universal suggestibility of people, albeit recognizing varying degrees of this quality. He sought to use this suggestibility to cure hysteria, by establishing a rapport between a patient under hypnosis --and thus in a heightened state of suggestibility, and the therapist. But Bernheim's use of a therapeutic relationship, like Charcot's methods, constituted no real attempt to actually explain the symptoms.

In effect, Freud came under the direct influence of both these approaches. He apprenticed under Charcot in 1886, and under Bernheim in 1889. His early case histories combine the methodologies of both Charcot and Bernheim, the two great schools of thought in the treatment of hysterical neurosis. The one was oriented towards the elimination of symptoms mainly through their identification, and limited by a belief in an inevitable hereditary destiny. The other concentrated on the strength of the therapeutic relationship established, on the influence of the therapist over the patient.

The two theories seem on the surface largely incompatible --the two schools, were after all openly

feuding. However, they actually shared a common ground in the issue of therapeutic mastery. In Charcot's case, mastery was achieved by making the symptoms conform to predetermined patterns, the best that could be achieved, since the patients' bad heredity presented an insurmountable obstacle. Bernheim's mastery lay in his unshakable belief in his powers of suggestion. We will look at how Freud's thought system articulates itself against this common ground of mastery, both in terms of the explanation it proposes for hysterical patients' illnesses, and in the praxis of the relationship between those patients and the therapist.

One necessary constraint of the research, a constraint which can also serve as a tool, is the delimitation of a particular object of study. The criterion for its selection is manageability, which in turn must include pertinence, and must not prevent extrapolation towards a more general application. Freud's early case histories meet just such standards. They are relevant to the problem of changing discursive and practical knowledge, as they bear the traces of a confrontation between the new science and the established one, on both theoretical and practical grounds.

In the texts, this can be seen on the thematic level of narration, in the way basic topoi of scientific discourse, such as the concept of heredity, are used: whether they are considered as facts, implicitly accepted, or as mere hypotheses, elaborately argued for or against. But more importantly, one can also look at how the narrative

structure reflects the basic story of the confrontation of a certain scientific knowledge with a certain type of disease. A further evolution of knowledge is also perceivable through the case studies in as much they constitute a record of the therapeutic relationship. How power is divided between patient and therapist is guaged by looking at the value granted respectively to what the therapist and patient know. It can even be questioned whether the fact that the patient knows anything of value is thinkable at all, whether her voice can be heard or whether it is the therapist who does all the telling.

What emerges from the preceding discussion is that the key concepts of what was to become psychoanalytic theory, namely the existence of an unconscious state, the continuum between madness and sanity, the importance of sexuality, the curing power inherent in the therapeutic relationship, to focus on the more general notions, were already part of the discourse of the time. However this is not to say that all that Freud did was merely to pluck these ideas out of the morass of an all-encompassing discursive hegemony, and put them together. Rather it was the late 19th century discursive hegemony which rendered possible Freudian thought in all its distinctness and originality. The concept of the unconscious had first to be thinkable in order for the Freudian unconscious to be articulated, and similarly with the other distinctive Freudian elements. An analysis of the key components of the discourse on hysteria as they appeared

in 19th century neurology, and of the manner in which Freud combined them in his earlier case histories shows how that articulation occurred and how it effectively caused a distinct epistemological development.

I. Contexts: Vienna and Paris: politics and science.

The exploration of Freud's immediate context requires an awareness of the broader social spectrum of fin-de-siècle Europe, and the particular constellation of details which illuminate Freud's position within that spectrum. Freud was a neurologist, but also Viennese, a member of the bourgeoisie and Jewish. These factors should be taken into account when attempting to consider the encounter of his particular scientific stand with what were essentially French theories.

Freud's position as a Jew in Viennese society is probably the single most immediately apparent of these external classifying and "structuring" factors, to use the terminology of Bourdieu. It placed him within other broader social structures, and instilled in him, his followers as well as his interpreters and critics an automatic "sense of his/their place" (Bourdieu 1979, esp. 523-564), which was at odds with the scientific aspirations of psychoanalysis to universality. One of the most obvious indications of this lies in a particular perception of Freud's work, one not restricted to his contemporaries. Psychoanalysis was known almost from its inception, as "the Jewish science" and still is, to a certain residual extent. The most directly observable effect was negative and brutal: the burning of Freud's books and psychoanalysis' suppression under the Nazi regime. Another one of the direct effects was of course, the

initial "ghettoisation" of psychoanalysis, most of the pioneering analysts and a lot of the pioneering patients being Jewish. Several scholars have set out specifically to explore the connections of Freud with his Jewish background. The studies range from straightforward ones showing the parallels between Freud's techniques and Talmudic interpretations, for example Bakan's Sigmund Freud and the Jewish Mystical Tradition. These books are bent on reinforcing, whether the attitude of their authors is sympathetic or not, the restrictive definition of psychoanalysis as a Jewish science -- and therefore of limited applicability and universality. Much more subtle texts, such as Krüll's biographic Freud and his Father, or McGrath's The Politics of Hysteria, and the chapter on Freud in Schorske's Fin-de-siècle Vienna, can be described as sharing a sociocritical methodology, as they present Freud's position as a Jew as one important contextual facet to the understanding of the psychoanalytic text, inextricably linked with politics, culture and ethnicity.

Krüll's work, for example, tells of the important influence of Freud's unconscious guilt over the assimilation of the family into the Viennese bourgeoisie, on his renunciation of the seduction theory. This guilt was passed on to Freud by his father. The assimilation of Jews was one of the by-products of the political liberalism of the Hapsburgh Empire in the 19th century. Liberalism had been one of the overt characteristics of Austrian, and in

particular Viennese society from the mid-century to the 1880's. For Jews this meant the abolition within Austria of the rather strict laws governing their freedom of movement and choice of occupation, which had been in effect throughout most parts of central Europe. This caused an influx of Jewish immigrants from the Baltic States and from the outer, more politically backward parts of the Austro-Hungarian Empire into the politically more attuned Viennese capital. The statistics are very telling: Vienna's Jewish population passed from a few hundred at the beginning of the 19th century to 72 000 in 1880 to 118 000 in 1890 and 147 000 in 1900 (Gay 1988, 20; Dennis Klein, 12). Freud's family itself had emigrated from Galicia, settling in Vienna in 1860.

However, Vienna was grappling with the contradiction inherent within the ideals of the liberalist state-- namely the fact that the interests which served a unified state, led by an Emperor-father (Schorske, 7) were essentially those of a united homogeneous family, a position which could only be achieved at the cost of repressing ethnic minorities. The ideal Austrian state would be anti-sectarian, pan-German, serving the interests of the ruling class (Germanic), and would sublimate the interests of other ethnic or social groups which were also supposedly included in the Empire on "equal" footing. (Dennis Klein, 4-5). The wealthier Jews were especially sought after as converts to the liberal cause. Not tied to any one nation

politically, they could bear allegiance more easily than others, to this greater ideal of political liberalism and to the Emperor as its figurehead or embodiment (Schorske, 125). Devotion to a liberal state could replace devotion to Jewish existence. It was an attractive proposition, offering an apparent integration with the "leaders" of the nation, through an espousal of their cause. It was all the more desirable if set against the political alternative, the repressive church-state Kulturkampf. (Dennis Klein, 4)

This new allegiance of the rising Jewish bourgeoisie with the liberal state would not be problem-free. The assimilated Jew would be caught in the middle, between the gentiles and the Jews newly arriving from the provinces. These recent arrivals forcibly reminded the assimilated Jews, through the crudeness of their habits, which openly mirrored their own unchangeable, or at least slowly changing, inner structures or habitus, of their origins and their consequent distance from the gentile leaders of society, with whom identification was not complete, and indeed could never be complete.

Effectively, the liberalist stand began to crumble around the time when Freud was attending medical school. The stock market crashed in 1873, unsettling the liberal state. Confronted with sudden financial instability, the Austrians in their reaction which hastened to find scapegoats, proved the actual precariousness of the Jewish position in their midst. "Journalists held the machinations of Jewish bankers

responsible for the collapse, popular cartoonists depicted hook-nosed and curly-haired brokers gesticulating wildly in front of the Vienna stock-exchange" (Gay 1988, 15).

This little vignette reminds us as well to what extent Jews were vulnerable to theories of racial stereotyping which played such an important part in 19th century discourse. Jews were certainly affected by researches in racial biology, which encouraged the production of stereotypes, and which may be described as "a science of boundaries between groups and the degenerations that threaten when those boundaries were transgressed" (Stepan, 98). Assimilation of Jews surely constituted an unacceptable transgression of boundaries. A point of no-return was duly reached with the election of Karl Lueger as mayor of Vienna, on a specifically anti-semitic platform in 1897.

However an intrinsically quixotic goal, assimilation, remained nevertheless a desirable state for the educated Viennese Jew. Two traditional and time-tested ways for Jews to achieve that goal was through the accumulation of either money or knowledge (Robert, 51). These ways were of course equally grist for the stereotyping mill. The concept of Jewish assimilation through the acquisition of knowledge is particularly applicable in Freud's case. It can be read as an extension/distortion of a customary respect for learning in the traditional orthodox Jewish communities, where the intellectual talents of particularly gifted boys were recognized and encouraged to an extent which included

financial contributions from the entire community if necessary. These boys, even if initially poor, were able through their learning, to reach the socially exalted status of scholars of the Torah. (Krüll, 80-81). This is a graphic illustration of the "knowledge equals power" equation. But for the Jewish man (1) trying to assimilate into a social system within which he is considered intrinsically inferior, such an equation does not necessarily hold. His position on the margins of the social system distanced him even from the hope of ever being able to exercise power. In Vienna, the particular power granted by a Jew's knowledge, was little more than the power to assimilate, to move away from the margins closer to the centre of the social structure, but still nowhere near the top of the hierarchy within it.

Another alternative was to use knowledge within the limits of the position of marginality, to attain a position of power on one's own terms. "Because I was a Jew I found myself free from many prejudices which restricted others in the use of their intellect and as a Jew I was prepared to join the Opposition and to do so without agreement with compact majority" (Freud, S.E. XX, 274). This quote actually spells out a "nothing to lose" reckless attitude towards social ambitions. Interestingly enough, Freud's biographers speak of his boyhood political ambitions set within the social system itself, and thwarted by a variety of

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1 For the Jewish woman, of course, the situation was compounded by the marginality within the patriarchal social system, of women of any race, class or religion.

circumstances amongst which antisemitism plays not a small role (McGrath; Schorske, 181-207). Freud's later ambition was for scientific legitimation through a University posting. His pain at being repeatedly passed over for a post, due to partially or even principally anti-semitic reasons, is woven through his autobiographical Interpretation of Dreams. Freud's dream of "the Uncle with the Yellow Beard", for example, in which he wishes he could "step into the minister's shoes" describes his longing to overcome the denominational obstacles to his professional ambition (Freud, S.E. IV, 134-141; 191-193).

The political situation from the outset situated Freud, the Jew, on the margins, not only of society, but also of the scientific community in as much as that community is part of society. Just as his position as a Jew situated him on the edges of Viennese bourgeois society, his new-found French inspired interest in hysteria, and more so, the manner in which he approached the topic, placed him on the margins of Austrian neurology. But for Freud, the combination of the two marginalities, as Jew and as non-mainstream scientist, the first arguably leading him to the second, constituted a way out of the problem of his being excluded from power. As Marthe Robert points out, psychoanalysis resolved Freud's personal dilemma of pursuing his ambitions in the West European society, without betraying his Jewish past through an assimilation into Christian culture (Robert, 134-135).

This would be achieved through the universal scope of the rational scientific theory of psychoanalysis. The universality of the application of psychoanalysis was, however, more than just the rational universality of science. It actually rose above the divisiveness inherent in theories of degeneration and racial biology, which would, as we have seen, often serve anti-semitism by describing the Jewish race as separate and inferior. Freud attempted to place knowledge at the very center of the theory. Not a mysterious influence, such as Bernheim's suggestion, or a surface knowledge such as Charcot's symptomatology, but a deep-probing structural knowledge of universal applicability, if not universally wieldable. We are all Oedipus, the man, but only the especially sighted can become Joseph, the interpreter of dreams. Thus, a new division of power becomes instituted, once again hierarchical in nature, dictating that only the especially sighted can have the key to the science of dreams, with Freud himself in the supreme position, distributing that key, or psychoanalytic knowledge.

In the context of Jewish assimilationist aspirations within Viennese society, one can say that psychoanalysis provides the way to bridge the social gap between Jews and non-Jews. This it does not do by the forbidden means of assimilation into a non-Jewish culture, but by setting up a new universalizing system which simply eliminates the differences between them. But in the process it institutes a

new hierarchy between those who understand the new science and those who do not. Freud would thus achieve professional success, while not needing to leave the margins, which eventually become redundant.

Another interlocking context is crucial to the understanding of Freud's theories. It is of course that of mainstream science itself. Freud entered the Vienna medical school with his plans and interests on the whole vague. He spent eight years there, apprenticing himself to the great scientific and philosophical minds of the University and absorbing respected, and, at least within the system of scientific discourse, accepted knowledge. Freud attended Brentano's seminars in philosophy. He studied zoology in depth in the laboratory of Carl Claus, a scientist who was "among Darwin's most effective and prolific propagandists in the German language" (Gay 1988, 31), producing his first piece of published research on the reproductive system of the eel. He then moved on to neurophysiology and Brücke's laboratory. Brücke was also a staunch evolutionist, expanding on Helmholtz' teachings as well as Darwin's, essentially maintaining that all phenomena could be explained in terms of physical and chemical forces in motion. The scientific milieu with which Freud was in contact during his student years was thus one which maintained a strict positivist stand, and reacted to the spirit of "vitalism", a romantic and mystical philosophy of nature which had still up to that point, been permeating

Germanic scientific scholarship. (Jones I, 45-51; Gay 1988, 34-46). Freud's ambitions at this stage were to continue in the line of the rigorous physiological research he was conducting under Brücke, still, like his colleagues, clearly privileging matter over mind in his understanding of organisms. Noteworthy as well, is the information that it was in Brücke's circle of friends and colleagues that Freud met Breuer, his future collaborator in Studies in Hysteria and Anna O.'s therapist (Gay 1988, 32).

Changing life circumstances, namely his engagement and consequent need to improve his financial situation, forced Freud to abandon pure scientific research. He joined the staff of the General Hospital of Vienna, apprenticed in various departments including psychiatry, with a view to an eventual private practice as a neurologist. Meynert, "the greatest brain anatomist of his time" (Jones I, 72), headed the psychiatric clinic, and his teachings were quite in line with the positivist approach project which was the basic scientific outlook which Freud shared. Meynert's view of human behavior was meticulous and exacting. He considered that each stimulus which reached the central nervous system excited a corresponding area of the cortex, and engendered specific sensations and actions. He furthermore proposed a systematic classification of mental illness based on his anatomical studies (Alexander, 158).

It could be said that all in all, the Viennese scientific community to which Freud belonged appeared quite

homogeneous in its positivist and rational conception of the workings of the human organism, in both its healthy and pathological state. Its task was to promote the expansion of rational knowledge which could, given sufficient scope, explain everything. Michel Henry has recently argued that Freud's endeavors themselves are part of the positivist enterprise, psychoanalysis being a vast attempt to make the unconscious conscious. The unconscious after all can only be defined through what is empirically observed: symptoms, dreams, slips, etc. (Henry, 344-349). (2)

Historians of psychiatry, psychology or psychoanalysis, generally have no trouble in listing antecedents to most of Freud's ideas. This includes as well those concepts which do not easily fit in with the positivist context we have been exploring, of which the following serve as representative examples. Concerning the importance of sexuality in the etiology of disease, Reil, who wrote the first systematic treatise of psychotherapy in 1803 recognized in a rather crude fashion the role of sexual excitation in mental disturbances. He refers to hysterical

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2 Henry also proposes another reading which he regards as the most significant. It posits the Freudian unconscious as the essence of life, but defined in its radical resistance to representation. Joan Rivière's striking anecdote taken from her training analysis with Freud serves to illustrate this conception of the unconscious. "In my analysis one day he made some interpretation and I responded to it by an objection. He then said: "it is UNconscious". I was overwhelmed then by the revelation that I knew nothing about it. I knew nothing about it" (Rivière, 356). It is interesting to note that the patient experiences the unconscious as resisting understanding. For the therapist, on the other hand, the unconscious is tangible since he is able to read the patient's unconscious through her symptoms.

women who became disturbed because of their inability to bear children and who develop delusions of pregnancy (Alexander, 135-36). More striking is Dr Adolf Parze's observation regarding childhood sexuality. In 1845, he wrote in a footnote to a pamphlet on bordellos that "the sexual drive already manifests itself among little six, four, even three-year-old children" (Patze , Ueber Bordelle und die Sittenverderbniss unserer Zeit, 1845, cited in Gay 1985, 58).

Further examples of ideas which foreshadow Freudian concepts include those of Greisinger the doyen of German psychiatry on the general workings of the mind. He writes of the developmental stages of the "ego", which he viewed as a specific structure that becomes sick, damaged or altered causing disturbances of mood, thinking and will. (Ackenrecht, 64-71). Similarly, the early 19th century romantic trend in psychiatry, against which Freud's Viennese teachers were reacting, presents an even more telling example. Moreau de Tours, mainly known in reference to his ideas on degeneration, was preoccupied with the irrational, the illogical, and writes about the necessity to understand the "totality of diseased persons" and the "invisible psychological design behind madness" (Alexander, 139). Heinroth, a German contemporary, divided mental functioning into three levels, the highest being the "conscience". Mental illness would arise out of conflicts with this conscience. (Alexander, 141).

Thus, theories recognizing the importance of sexuality and of unconscious motivation were indeed in circulation in the scientific community in Europe when Freud started his neurological career. But Freud's work did not really achieve coherence and make a professional impact until he had started dealing more and more exclusively with the study of hysterical disturbances. This turn of events was closely linked with his exposure, in the form of a six month apprenticeship at la Salpêtrière in 1885, followed a few years later by a stay at Nancy, to French neurological practice, which held hysteria to be a particularly important and interesting disease.

French neurological ideas highlighted one crucial element largely overlooked by Viennese scientists which was a concern over the possibility of a dynamic interaction between the states of consciousness and unconsciousness. This was illustrated by the use of hypnotism as a means to alter states in a therapeutic context. In the end, as we shall see, the project of the French scientists was also positivist, perhaps even to a greater degree than that of their Viennese counterparts, for they aimed at a rational explanation of the unconscious state.

French neurology was greatly influenced by animal magnetism, the old craft of Anton Mesmer, which had always been regarded with much medical suspicion. In 1778, Mesmer, a doctor from the University of Vienna, arrived in Paris, hoping that the French capital would provide a more

receptive terrain for his theories than his place of provenance. His strange curing techniques soon began attracting attention. Mesmer believed in an elemental fluid circulating between all things. Illness, both physical and mental, was caused by a breakdown in this flow. The process of cure would involve a proper redistribution of the fluid. This could only be achieved through a rapport established between the patient and a specially trained, or rather endowed individual (the mystical content involved was high), the magnetist. He would restore the liquid balance through direct physical contact (rubbing various parts of the patient's body, touching knees or thumbs with her, for example). The encounter was, as a rule, charged with drama and produced in the patient a convulsive reaction called "la crise magnètique" which would initiate the cure. Mesmer himself must have cut a particularly impressive figure, beturbaned and clad in a flowing purple robe.

There was open recognition of the "impression" the magnetist produced and the "attachment" which the patient felt. A suspicion that this attachment may be of an erotic kind, or at the very least of a less than wholesome nature eventually contributed to magnetism being denounced repeatedly by the French Academy of Science. Mesmer himself however, seems to have been of irreproachable conduct, although some of his followers do appear to have taken advantage of the strong feelings the therapeutic relation of magnetism aroused in their patients. Statements affirming

that the "magnetic treatment cannot but be a threat to morality" were typical of the official discourse on magnetism. (Chertok & de Saussure, 17-26).

Suspicion also surrounded the validity of the actual theories of magnetism. A report by Louis XVI's delegates concludes that "L'imagination sans magnêtisme produit des convulsions...Le magnêtisme sans l'imagination ne produit rien." (cited in Jaccard I, 21). But interestingly enough, in the denigration of the value of magnetic science, the authors of the report were unwittingly giving voice to something else of great strength, then still called "imagination", but soon to be named "suggestion". Some of the more astute magnetists themselves recognized this, and were to integrate this "imaginary" element into their theories. Abbé de Faria, for example, readily admitted that no special force emanated from the magnetist, but that everything of import took place in the patient's mind, as she took in the magnetist's verbal suggestions (Chertok & de Saussure, 45). In his work, Puységur, Mesmer's greatest follower, paid particular attention to the state that magnetized patients would enter, calling it "le somnambulisme magnêtique". But scientific disregard, together with the sensationalist trappings and the rather outlandish claims of magnetism, considerably slowed down the incipient insight into the different states attainable by the patients, and the light these states might shed on the issue of consciousness and unconsciousness. And magnetism's

other defining feature, the particular relation established between therapist and patient, imbued as it was with the flavour of illicit eroticism, had to be put on hold in the context of scientific inquiry until, resurrected, it would lead from suggestion to transference.

Nevertheless, there was continuous if minor interest in magnetism throughout the 19th century. Some decades after Puységur's death at the end of the 18th century, James Baird, in England, first used the term hypnosis, from hypnos- "sleep", to refer to the magnetic phenomena which provoked the somnambulistic state. The new name proposed to "cleanse" the act of the unsavoury associations which magnetism had come to have. (Chertok & de Saussure, 55). But afterwards, on the continent, this technique of hypnotism largely migrated from the domain of curing to that of entertainment. Some doctors, however did attend the travelling shows which brought it from town to town, as a form of fairground amusement. This sometimes contributed to a filtering back of the medical interest in hypnotic phenomena. (Ellenberger, 756).

Meanwhile, in Nancy, a country doctor, Liébeault, who in his youth had been fascinated by old magnetist texts, gave up his traditional medical practice to devote himself exclusively to curing by hypnosis. He drew his first clients by not charging any fees, but soon his practice grew enormously and by all accounts his results were impressive (Chertok & de Saussure, 62). His work attracted the

attention of Hippolyte Bernheim the renowned neurologist and professor at the University of Nancy. Bernheim was so impressed that he began investigating hypnotic phenomena himself, and in his subsequent works, declared himself to be Liébeault's pupil.

In 1882 Charcot, then at the zenith of his fame as "the greatest neurologist of his time" (Ellenberger, 89) presented a paper to the Academy of Sciences in Paris: "Sur les divers états nerveux déterminés par l'hypnotisation chez les hystériques". This apparently important move towards the revival of hypnosis was mitigated by Charcot giving a rigorously objective picture of the hypnotic state in purely neurological and descriptive terms. Indeed, Charcot was using hypnosis strictly as a diagnostic and demonstrative tool in his work with the hysterics of la Salpêtrière, and never really seems to have used it therapeutically as did Bernheim. At "le Premier congrès international de psychologie physiologique" held in Paris in 1889, Babinski a member of Charcot's school, outlined very clearly in four propositions, his master's position on hypnosis.

"Les caractères somatiques qu'on observe chez certains sujets dans l'hypnotisme ont une importance fondamentale, car ils permettent seuls d'affirmer légitimement l'absence de simulation.

"les phénomènes hypnotiques peuvent affecter un groupement spécial en trois états distincts. C'est là la forme la plus parfaite de l'hypnotisme, celle qu'on doit

prendre pour type, et à laquelle on propose de donner le nom de grand hypnotisme.

"Aux deux propositions précédentes s'en rattache une troisième qui consiste en ce que les propriétés somatiques de l'hypnose et le grand hypnotisme peuvent se développer indépendemment de toute suggestion.

"L'hypnose doit etre considérée dans ses formes les plus parfaites comme un état pathologique" (cited in Chertok & de Saussure, 70-71).

Meanwhile, in Nancy, two other thinkers were joining forces with Bernheim and Liébeault, driven by their interest in hypnosis. They were Beaunis, also a neurologist, and Liégeois, a lawyer. It was soon obvious that the views of these men on the hypnotic state were incompatible with the theories being promulgated at la Salpêtrière. In a paper presented in 1883 Bernheim maintained that it was not a physical act which constituted the hypnotic factor, but a psychic process, an idea, generated by verbal suggestion. (Chertok & de Saussure, 62). The Nancy school, further explored what that verbal suggestion might or might not be capable of achieving. Beaunis and Liégeois were primarily interested in the legal aspects of suggestion and hypnosis, whether people could be induced to commit crimes when in a hypnotic state. Bernheim following Liébeault, explored the possibility of curing various nervous diseases through suggestion, among which hysteria held a prominent place. His most famous work known as "De la suggestion et de ses

applications à la thérapeutique", first published in 1884 as "De la suggestion dans l'état hypnotique et dans l'état de veille" was renamed in 1886 to accentuate his interest in therapy. The Nancy school, in its approach to hypnosis, was concentrating on the act rather than the state, and was thus moving in a direction diametrically opposed to the one taken by the practitioners at la Salpêtrière. The conflict was sharply defined when Bernheim firmly took on the position that there was no hypnotic state, only suggestion. "Tout est dans la suggestion" (Bernheim 1891, 94).

Hysteria was probably the most popular disease of the nervous system treated either at Nancy or at la Salpêtrière. The diagnoses for hysteria in fact reached such a high level in the mid 1880s that more than 17% of patients admitted to la Salpêtrière were diagnosed as suffering from it (Goldstein, 210). The great majority of these hysterics, obviously, were women. Feminist scholars have argued that this growth of hysteria among women was a form of reaction, or protest, against the repressive framework of the patriarchal bourgeois family unit, within which their energies, talents, and sexuality were pathologically stunted. These silenced voices emerged as the body language of hysterical symptoms. The women were rebelling against their lives whose submissive idleness had become accentuated since the industrial revolution changed production patterns,

separating "true" or directly marketable labour, from the home where women were generally confined. (3)

It is possible to regard the hysterics as heroines then, as women who shared the suffragettes' cause, the dramatic rise in their number, coinciding with the nascent campaign for women's rights. Social conditions, one might say, cause women to become mad. But it is not a simple matter, for in a patriarchal system, the dice are already loaded against women, so that madness itself also serves to connote their submissive role. One should remain aware of the ways in which patriarchal discourse constructs woman as mad, against man's rationality, according to a set of binary oppositions set up between the male and the female which reaches far into our discursive practice, and serves to reinforce a hierarchy in which women remain inferior to men (Cixous & Clément).

Another reading of the reasons behind the growth of hysteria, one which may coexist with the feminist one, involves the therapist rather than the patient. Jan Goldstein, in an article entitled "Anticlericalism and the Diagnosis of Hysteria" describes the context of republican and anticlerical politics which formed an integral part of French neurology in the second half of the 19th century. Charcot and several of his students and colleagues, most

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3 See for example Elaine Showalter's, The Female Malady, especially chapter 6, "Feminism and Hysteria: the Daughter's Disease"; Also, Helen Cixous and Catherine Clement's La Jeune Née, about the Dora case, as examples of books dealing with hysteria as a feminine protest.

notably Bourneville, were closely allied with republican politicians such as Gambetta. Their positivist scientific stand connoted a mistrust of the teachings of the Catholic church, and a rebellion against the political influence it had exercised up until the 1880's. In turn, the Paris Prefect of Police maintained a spy in the medical faculty between 1873 and 1876, and Charcot was deliberately overlooked for the Chair of Psychiatry in 1876, the post going instead to Ball, a man much more moderate in his views. (Goldstein, 222-232).

In the 1880's with Gambetta gaining political power, anticlericalism took on both legitimacy and momentum. Charcot's detailed descriptions of hysterical attacks were applied in a kind of retrospective diagnosis, to both witches and saints from past centuries. The material evidence was easily provided by court transcripts from sorcery trials, books on witchcraft like the famous 16th century Malleus Maleficarum, or by artwork, such as the Gorgons from Notre-Dame's façade, for example. (4) Charcot and his colleagues took the stand, which the Nancy people equally shared, although they spent less energy expanding upon it, that witches who were tortured and burned at the stake in past centuries were hysterics whose symptoms conformed exactly to those of their patients. The Beatific visions of saints, and miraculous healings could also be

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4 See for example, Charcot and Richer's Les Démoniaques dans l'art; and the collection of books which Bourneville edited under the heading of "Bibliothèque diabolique".

dismissed in a similar manner. In a sense this positivistic redefinition of the supernatural into the scientifically understandable, which French neurologists were engaged in, was an active political statement, and hysteria was in this context more than just a disease. It was a tool used for a political end. Charcot's, and to a certain extent Bernheim's positivist conception of the disease was thus overdetermined by their position within the French political spectrum, just as Freud's social situation in Vienna was bound to have an effect on his scientific endeavors.

II. The Discourse of Hysteria: Theory and Treatment.

Woven from the socio-political context, a tight fabric of themes, strategies and theoretical positions came to delimit the topic of hysteria as a fin-de-siècle neurological disturbance. Disentangled, each one of these reveals a particular facet of the discourse of hysteria, as expressed in the work of the people engaged in its treatment. The following chapter represents an effort to identify the main discursive strands defining hysteria, through a perusal of a representative selection from the theoretical and clinical writings of both Charcot and Bernheim, as well as those of a few of their most important colleagues. These discursive strands would come to be, ultimately, the basis of Freud's case studies of hysterics.

The basic issues confronting the scientists who attempted to treat neurological disturbances in the late 19th century were the following. Whether hysteria involved in fact, consciousness or unconsciousness as distinct or interchangeable states; whether it was allied to sickness or health, madness or sanity; whether it represented a reality or an illusion and whether that illusion was to be called malingering, hallucination or fantasy. These were topical problems, part of the Cartesian philosophical heritage, which recognized the dual nature of human beings, and they played a particularly prominent part in 19th century scientific reflection on hysteria.

It is a matter of common sense to observe that states of disturbance, whether physical or mental, are defined as such against a certain conception of normalcy. The organism in health is "true" to itself and the French term for madness, "aliénation", implies the distancing from this state which occurs in illness. One very important symptom of hysterical disturbance provided a choice port of entry into the new/old problem of the "stranger within one's own soul", illustrating the point with great clarity. It was the case of dual or even multiple personalities manifesting themselves in the behaviour of patients. The symptom would range from distinct, fully-fledged personalities alternating randomly, to the "uncharacteristic" conduct of the afflicted people, which is surely an important defining feature of "mental alienation".

However, it was understood that the pathological condition involved in the splitting of the personality of the hysteric only exaggerates what had already been recognized as normal for all humans. The continuous link between illness and health had, a couple of decades previously been readily conceded for the body by Dr. Bernard. The prominent physician defined physical illness as an exaggeration of the very conditions which constituted health. Exactly the same idea could be applied to the mind, as Pierre Janet, a philosopher and psychologist working at la Salpetrière readily pointed out (Janet 1889, p.5).

Georges Guillon, a laboratory chief at la Salpetrière, offered the following contextualisation of the issue of dual personalities. Interestingly, it shows the extent to which these problems were actually out in the open, far more so than we would tend to believe in our Freudian era, looking back at the pre-Freudian "dark ages". "Ce n'est pas seulement dans le sommeil hypnotique que l'on observe un dédoublement de l'individu en deux personnes différentes. La plupart des psychologues admettent qu'il existent en nous pas seulement, ainsi que le disait Goethe -"deux âmes habitent dans ma poitrine" -- deux personnes distinctes mais bien un grand nombre de personnalités diverses variant "suivant l'age, les divers devoirs de la vie, les événements, les excitations du moment" (Greisinger). Ces sous-personnalités, pour employer l'expression adoptée par M. Paulhan, résultent de tendances diverses s'associant ou se repoussant les unes les autres suivant les lois de l'activité mentale, constituent par leur ensemble la personnalité complète". (Charcot 1893, 179-180).

However, what was never really in doubt was the need for one all-encompassing well-integrated personality presiding over the fractions. One central control (or will) over the diverse factions and fractions of personalities was thought necessary in order for an adequate functioning of the organism. Havoc in general, and the case of the pathological double or multiple personality in particular, occurred precisely when this control could not be maintained

or was given up. Control was at its weakest in states such as sleep, emotional upheaval and hypnosis, when rationality no longer holds sway.

When subjects had lost control over themselves, they were easily suggestible. In the act of either the therapeutic or evil, criminal relationship, the central control, the will, was weakened and room was made for the will of another. Bernheim writes of diverse degrees of suggestibility. "Sans doute l'impressionabilitè est variable. Les gens du peuple, les cerveaux dociles, les anciens militaires, les artisans, les sujets habitués à l'obéissance passive m'ont paru, ainsi qu'à M. Liébeault plus aptes à recevoir la suggestion, que les cerveaux raffinés, préoccupés, qui opposent une certaine résistance morale, souvent inconsciente" (Bernheim 1886, 5). Bernheim divides people into those who are easily swayed and those who are not. In so doing he seems to be upholding the theory of degeneration, which clearly maintains that the hysteric, by virtue of her constitution is weaker-willed, of a lesser moral fibre, hence her illness. The hysteric's innate weakness would make her suggestible. However, Bernheim adds to Charcot's theory of inherited hysteria, the need to take into consideration the environmental, learned element, i.e. "les gens habitués à l'obéissance passive". This already shows that Bernheim laid much greater stock than Charcot on the possibility of an outer influence reacting with the

illness. Indeed he made this idea, in the form of the therapeutic relationship, the cornerstone of his theory.

Thinkers with lesser ties with medicine, such as Janet, who had research facilities at la Salpêtrière, but whose basic training was in philosophy, and Paulhan, a philosopher with no medical connections at all, were wrestling with just such issues in their writings. They were studying the way control of the self could best be understood and exercised. Paulhan's vision of the human being, the physical and psychic indistinguishable, was one of an intricate balance of parts: "un ensemble d'organes reliés et mis en harmonie par un de ces organes, le système nerveux" (Paulhan 1901, 4). Understanding the world involved reproducing on the outside the relationship which existed on the inside "L'harmonie qui existe en lui, il l'étend dans le monde" (Paulhan 1901, 7). The fragmentation was recognized, but the hierarchy of control was still deemed crucial. (1)

Janet dealing with the exact same issue as Paulhan, that of control and harmony within the self, speaks of the capacity for synthesis. This is opposed to psychological automatism, the mere receptiveness to external phenomena, "sensations, images, souvenirs qui emplissent la conscience" (Janet 1889, 219). Synthesis, the ability to compose these impressions into "une idée nouvelle et complexe, celle d'une nouvelle personnalité" (Janet 1889, 219) denotes health.

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1 Of course Freud's concept of the ego, follows directly in that line, but in his theory, the ego's control is precarious at best as it must attempt to conciliate two demanding masters, the id and the superego.

Synthesis refers to the subject's ability to sort out and order, memories and sensations, without losing control. "Il y a une faiblesse morale particulière consistant dans l'impuissance qu'a ce sujet faible de rèunir, de condenser ces phènomènes psychologiques, de se les assimiler" (Janet 1889, 454). Contrary to the healthy, the ill person cannot "à cause d'une faiblesse morale particulière de la faculté de synthèse, se réunir en une seule perception, en une seule conscience personnelle" (Janet 1889, 362).

The question of the relative value of strength and weakness runs parallel to the issue of the control over the self which both Janet and Paulhan are exploring. To achieve synthesis is good, and therefore healthy; lack of synthesis is bad and signifies illness. These notions of strength and weakness, with all their Darwinian "survival of the fittest" connotations, were themselves part of the fin-de-siècle scientific and philosophical context, affected by the sense of inevitability, which belief in heredity causes. In Mythologies de l'hérédité, Jean Borie has explained the ideological role that the topos of heredity played in 19th century France as a controlling device. "Le caractère commun aux mythologies de l'hérédité est d'être peu favorable à l'exercice d'une liberté effective de l'individu" (Borie, 18). According to one's antecedents, one is locked into a pattern of strength or weakness, health or illness, with very little hope of breaking out of it. Strength leads to

greater strength, weakness to greater weakness, as in the related topos of degeneration.

Racist and sexist connotations are an integral part of this latter issue, since degeneration encouraged divisions between people which would inevitably fall into stereotypy (2) . "Toutes les races y sont sujettes. Dans la race blanche, les Israëlites payent à l'hystérie le plus lourd tribut". (Gilles de la Tourette 1891, 119). The ambiguous position of male hysteria was a result as well of a belief in heredity and degeneration. It was a condition which was more and more recognized to occur but persistently surrounded by discursive strategies aiming to minimize its impact on the ruling classes. Working class men, of a weaker "moral" type than their bourgeois brothers, were more likely to be affected by hysteria, as well as, naturally, the aforementioned Jews. Gilles de la Tourette quotes a Polish neurologist: "A Varsovie, les hystériques mâles sont presque tous des Isréalites" (Gilles de la Tourette 1891, 119).

But another discursive construct coexisted with this explanation of the hereditary transmission of strengths and weaknesses, including hysteria. The topos of "influence" acted as an alternative explanation to heredity. Indeed it functioned almost as an anti-heredity. Here, the emphasis is no longer on the chain linking generations of ancestors to their descendants, but rather, establishes the parallel,

2 Lombroso's research into the criminal type, which included classifying people according to shapes of their cranium is one example of scientific work spawned by degeneration theories.

perhaps even opposing configuration: the pairing of those exerting influence with those having influenced: magnetizer/magnetized, hypnotist/somnambulist, therapist/patient.

It is his understanding of this other system of filiation which permits a historian such as Ellenberger to write of Janet, hypnotizing a woman who had at a previous point in her life been privy to an old-style magnetizing session, as tapping into knowledge of the past, since she would reproduce for him her "magnetic crises" (Ellenberger, 339). This establishes an alternative destiny for the patient, but one just as deterministic, since she experiences another type of branding, this time not through the accidents of birth but through the therapeutic relationships she might have contracted. (3) Bernheim for example writes of having no trouble identifying hysterics who might have passed through the wards of la Salpêtrière, for they appear to him to be the only ones conforming in their fits to the pattern of hysterical attacks which Charcot writes about (Bernheim 1886, 95). The effects, therapeutic or otherwise, positive or negative, of such an inevitable bond are bound to be marked, sometimes even spectacular. It is not surprising that two members of the Nancy school, Beaunis, a criminal lawyer, and Liégeois, a

3 This sense of therapeutic filiation is still a part of psychoanalysis. The issue of one's training analyst can become a matter of prestige. Being able to claim a direct analytic descendence from Freud or from Lacan, for example, is a quasi-guarantee of professional success.

neurologist, were mainly interested in discussing the role of suggestion in crime, speculating on whether one could be driven against one's will by someone else to commit illicit acts. Bernheim himself wrote extensively on the topic, which was moreover one of journalistic topicality. In De la suggestion, he discusses famous crimes of the decade, for example, "l'affaire Chambige" which also served as inspiration for a best-selling novel by Paul Bourget, Le Disciple. A young clerk was accused of hypnotizing a respectable housewife (4) and enticing her in her altered state into a passionate affair. This culminated in a suicide pact which left her dead and him wounded but fit enough to stand trial and face sentencing to hard labour (Bernheim 1891, 153-154).

The conflict between heredity and environmental influence can readily be seen in studies of families being carried out at that time in more than one country. One of the most famous of these studies was the survey by Richard Dugdale of the Juke family, A Study in Crime, Pauperism, Disease and Heredity, which traced the descendents of six convicts over several generations and found among them a preponderance of thieves, imbeciles and hysterics. Yet despite the fact that this study was undertaken with the intent of proving the effects of degeneration, the effects of economic deprivation had to be taken into account to a certain extent. Dugdale's position was to accept as cause

4 In Bourget's novel, a young private tutor seduces an aristocratic young lady.

the effects of heredity balanced by environment (Carlson, 132-133).

Notwithstanding the famous rivalry between the Paris and Nancy schools one begins to see that in actual fact, the heredity and influence explanations functioned side by side. In Charcot's discourse on hysteria one finds in conjunction with examples of how the disease is transmitted and inherited, discussions of the influence of example and of the environment on the disease. If a mother has fits and her daughter follows in her path, it becomes difficult to assess which is the part due to heredity, and which to influence. Reinforcement may come as well in more indirect ways, as in the case of a young boy who had a fit every evening at the same time, and whose father anxiously anticipated the event, watch in hand, by his bedside (Charcot 1887, 94-95).

The key for the therapist lay in replacing one influence by another, to get the hysteric to submit to a will greater than her destiny, the therapist's own will. This is a tell-tale sign of the hubris of mastery, and of the hierarchy of power which articulates the conception of hysteria. The mandate is to install a revolution in the mind of the patient, to replace one order of things by another -- a state of things remarkably close to Bernheim's openly assumed position. "Elle se montre plus souple, devient obéissante, et de l'obéissance à la guérison il n'y a pas loin" (de la Tourette 1898, p.171). Charcot illustrates this point very eloquently by quoting a young hysterical patient

of his, a young provincial girl. She was severely anorexic, and her despairing parents pleaded Charcot to save her. His only recommendation: that they bring her to a hydrotherapeutic establishment in Paris and leave her, ceasing all communication with her. She soon started to eat again. She explained her change of heart in the following way: "Tant que papa et maman ne m'ont pas quittée, en d'autres termes tant que vous n'avez pas triomphé -- car je savais que vous vouliez me faire enfermer -- j'ai cru que ma maladie n'était pas sérieuse, et comme j'avais horreur de manger, je ne mangeai pas. *Quand j'ai vu que vous étiez le maître, j'ai eu peur,* et malgré ma répugnance, j'ai essayé de manger et cela est venu peu à peu" (emphasis Charcot's) (Charcot 1887, p.243). (5)

What clearly emerges here is the relative position of Charcot and his patient: he has power and she does not. This is the proposition which underwrites the other divisions between them: her hereditary antecedents are bad, his are good; he and his line can exert curing influence, she and her parents can do nothing but aggravate the situation unable to break out of the circle of illness and weakness.

However, it remains true that in their differing emphasis on heredity on the one hand, and influence on the other, the Paris and Nancy schools were proposing two partly

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5 Forrester, in Language and the Origins of Psychoanalysis also quotes this passage as an example of Charcot's mastery, which enables the neurologist to effect "a cure by suggestion", through the strength of his "impressive presence articulated on the absence of her parents" (Forrester 10-11).

conflicting therapies for neurotic illness. They also parted ways in evaluating their prospects of achieving a cure. Bernheim, whose approach highlighted a concern with influence was much more optimistic than Charcot. The Nancy school's accounts of cures effected was sometimes quite impressive. Bernheim tells of months, sometimes years of illness and suffering being wiped out in very few well-applied hypnotic sessions (Bernheim 1886, 305-315; 1891, 294-301).

Charcot whose conception of neurosis was mainly based on the heredity/degeneration factor, laid lesser stress on the effects of influence, and was therefore inherently pessimistic regarding the possibility of cure. He warned against setting one's hopes too high in matters of nervous disease, and all the more so in connection with hysteria, an illness in which factors of heredity held according to him, particular sway, and whose cure was thus only to be tentatively aspired for. Gilles De la Tourette's writes pessimistically on the prospects for a cure of the condition of "congenital" neurasthenia, or nervous exhaustion as opposed to true neurasthenia, where the cause of the fatigue could be identified and, eventually eliminated. (6) De la Tourette's remarks on the other, more problematic kind of neurasthenia, are equally valid for hysteria. "Le système

6 A businessman who exhausted himself by building up his own company from scratch rather late in life, is provided as an example of true neurasthenia. His condition was eased when he accepted to rest in the country while putting his affairs in the hands of a trusted manager (Gilles de la Tourette 1898, 116-118).

nerveux congenitalement touché, n'offre que peu de ressources réactionnelles dans un sens favorable à la guérison...Il n'est pas en notre pouvoir de regénérer un état mental congénitalement faible et déprimé, lorsqu'il n'est pas perverti...Les sujets restent toujours des invalides au moral sinon au physique" (Gilles de la Tourette 1898, 121).

Indeed, the quest for a cure, although never openly abandoned altogether, (neurology was after all a subdiscipline of medicine, a field whose explicit mandate was nothing less than to combat illness), was perceived at la Salpêtrière as an enterprise undertaken against the severest odds and at most, merely hoped for. So curing had to avail itself of the only remaining possibilities in view of the inexorable laws of heredity: the understanding of the structures of the illness itself. To achieve this, symptoms had to be shown to have a material basis. This of course required certain careful strategies in the case of hysteria, which as we have seen involved physical symptoms having had no ostensible physical basis.

Charcot and his colleagues sought to classify and to explain these phantom hysterical symptoms in the most thorough manner possible. They engaged in a positivistic description of symptoms, striving towards an identification of a clear link between neurological affliction and the nervous system. This was not without problems, "ce vaste appareil" (Gilles de la Tourette 1898, 155) still held out

the neurologist was the continued search for the precise physical cause having a specific effect on the suffering body. Now in this respect, hysteria was problematic. "Malheureusement, à ce point de vue, l'hystérie fait encore partie du domaine des névroses, c'est-à-dire de ces maladies *sine materia* ou au moins dont 'la matière' est encore à déceler" (Gilles de la Tourette 1898, 154). The materiality of the disease was then suggested by Charcot to be provided by the brain itself, a statement which considerably mitigated the apparently revolutionary nature of a famous statement of his which de la Tourette duly cites, "il faut prendre l'hystérie pour ce qu'elle est, c'est-à-dire pour une maladie purement psychique par excellence" (Gilles de la Tourette 1898, 155).

The materiality of hysteria was thus not to be found in the body, at least not yet, or not directly. In a masterly closure, Charcot restored a positivistic grounding to hysteria by perceiving regularity in the hitherto disorderly hysterical attack. He divided it into four phases which recur in every patient: 1) éliptoïde, 2) grands mouvements (contradictoires, illogiques), 3) attitudes passionnelles (logiques), 4) délire terminal. (Charcot 1887, 15). Charcot understood that a perceived lack of coherence in a disease would rob it of its legitimacy: "quelques-uns même ne voient dans plusieurs de ces affections qu'un assemblage de phénomènes bizarres, incohérents, inaccessibles à l'analyse et qu'il faudrait mieux-peut-être reléguer dans la catégorie

de l'incognocible. C'est l'hystérie qui est surtout visée par cette description" (Charcot 1887, 14). His rigorous classifying system rescued hysteria from the realm of the unknowable. In so doing, he tamed it, and by extension, the hysterical patient, just as surely as if he had found the exact lesion in her nervous system which corresponded to every one of her symptoms.

When writing about his hysterical patients, Charcot systematically searched for, a) their hereditary antecedents -- these were necessarily there if not always successfully identified, and b) the actual exciting cause of the onset of the disease in each particular case. It was understood however, that "la cause primordiale de l'hystérie, (...) est l'hérédité, que celle-ci soit similaire: mère hystérique, fille hystérique, qu'elle agisse par transformation: le ou les générateurs ou leurs ascendants étant atteint d'une affection nerveuse autre que l'hystérie elle-même" (Gilles de la Tourette 1891, 37). Statistics were brought to bear as proof. De la Tourette concluded that children of hysterics were twelve times more likely to contact the disease than not. (Gilles de la Tourette 1891, 37). Charcot's affirmations could be quite forceful at times: "en matière de pathologie nerveuse, il n'y a pas de génération spontanée et que rien ne vient de rien, il y a ses antécédents pathologiques (...). L'hérédité est intéressante, car elle nous ramène toujours au même principe; elle nous prouve que l'hystérie ne vient pas seule, comme un champignon" (Charcot

1888, 100-101). Heredity thus explains and tames hysteria just as Charcot's classifying system does. Charcot and his colleagues were able to understand exactly where it came from ("ne vient pas seule"), and to keep it thus at bay, reinforcing by yet another means the division of power: those prone to hysteria, and those not.

As for the exciting cause, it was of lesser interest. In the case history of a young hysterical girl whose symptoms consisted of her being radically unmanageable, prone to nasty pranks such as pulling the bedcovers off her chronically ill father, as well as being afraid of needles and broken glass, Charcot berates the parents for persistently offering him theories as to the possible exciting cause of their child's illness. "Il semble qu'il y ait chez les parents une sorte d'instinct qui les pousse à mettre ces faits singuliers sur le compte d'une cause fortuite et de se soustraire ainsi à l'idée de la fatalité héréditaire. La véritable cause cependant est là, dans l'hérédité." (Charcot 1888, 296). The exciting cause was recorded in every case history whenever possible, as an aid to achieve a positivist closure, to help tie up all lose ends. The specific details of each exciting cause were not particularly significant, but what their recording did achieve was the completion of the clinical picture. This applies to the Nancy practitioners just as well. Janet remains the one exception, as he did consider exciting

causes to be more than mere data. His case shall be discussed below.

This one scenario tamed the concept of hysteria by making it into a necessary byproduct of heredity and introducing a pessimism concerning its cure, but a greater optimism as to the possibility of identifying its form. A different strategy, however, as we have mentioned, consists in taking another route, and to concentrate mainly on the act of curing. This would be made possible through belief in another kind of positivistic "given". As the belief in the irreversible and inexorable quality of heredity was the cornerstone of Charcot's camp, the universal suggestibility of humanity was the cornerstone of Bernheim's. The antecedents, perhaps not in fact but certainly in spirit, for this position were to be found in no less than the magnetic idea of the universal fluid circulating between all things. Bernheim believed that everyone was to a degree, potentially suggestible. This was a point severely contested, indeed mocked, by Charcot referring to "récents travaux", which implied that "quatre-vingt dix pour cent parmi vous messieurs seraient plus ou moins hypnotisables. Le bon sens comme l'observation vulgaire protestent contre de telles allégations; qu'il se trouve bien parmi vous un ou deux névropathes, je le veux bien, mais 90 pour cent je ne le crois guère. On n'hypnotise pas tous les sujets indifféremment et dans le sommeil hypnotique qui n'est pas le sommeil naturel, on ne peut

rapporter tous les phènomènes indistinctment à la suggestion. La suggestion par l'abus du terme est devenue une sorte de *Deus ex machina* dont il faut beaucoup se défier" (Charcot 1893, 170-171).

Charcot was driven by his theoretical distinction between good and bad hereditary antecedents, which as we have seen divided people so clearly: he and his learned colleagues were surely on one side, the patients on another. Charcot had to draw a sharp line between neurosis and normalcy, even though in other contexts he and his colleagues may have admitted that this line was blurred. The division is furthermore safeguarded by the equally clear distinction made between hypnotism and sleep. Charcot resorts to the rhetorical device of drawing his learned colleagues and students into the debate personally by showing how their own sanity or normalcy might be put in question by the recent theories of the opposing Nancy camp. The capability of responding to hypnosis is in itself felt to be a sign of neurosis, inherited, and thus not a universal trait.

The Nancy camp on the other hand, held on the whole, a more universalist position on the human psyche, and did not draw such a sharp distinction between health and neurosis. Their affiliation was traceable after all to the parallel theoretical construct of influence, and was only indirectly affected by the segregation imposed by theories of heredity. Magnetism, as we recall, posed no distinctions, erected no

sharp barriers, as the fluid circulated between all things, and moreover under ideal conditions, it circulated evenly.

Liébeault, was the oldest of the Nancy practitioners, and closest to Mesmer not only chronologically, but through his theoretical position as well. He writes of the mental state of attentiveness, "l'attention", which provides a key to the adequate functioning of the human organism. But, he asserts, "l'attention ne reste pas toujours parfaitement équilibrée, elle a aussi la propriété sous l'influence d'une excitation ou de la pensée, de se transporter sur une faculté cérébrale ou sur un organe de la vie de relation aux dépens des autres facultés ou des autres organes auxquels elle était distribuée et de s'y accumuler (...). L'attention, en s'accumulant ainsi, à la manière d'un fluide, peut exagérer tour a tour l'action propre à chaque organe. (Liébeault 1866, 11-12; 1889, 6). Expanding upon the teachings of the magnetists, whose conception of the magnetic fluid was still very materialistic, Liébeault believed, more abstractly, that an even distribution of a mental force, its good balance, was the key to health. This was the natural state of things, attainable by all, which made health itself universally accessible. In this context an "excitation" caused this natural balance to be perturbed, and provoked the state of illness. It is interesting to note the sharp difference of opinion with the Charcot camp which, as we recall, held that an "excitation", the exciting cause

served to disrupt in the predisposed individual the precariously held balance of health. This, in Charcot's opinion would return the hereditarily predisposed individual to a natural state of illness.

For Bernheim, whose writing and practice brought Liébeault's position up to date, there was to be no question as to the universal suggestibility of people. He established as one of the bases of suggestibility the quality of credulity, "la crédibilité" defined after Durand de Gros as "la capacité de croire sur parole, sans avoir à exiger de preuves". Bernheim then established most forcefully this quality as one of the cornerstones of civilization, without which "pas d'éducation, pas de tradition, pas d'histoire, pas de transactions, point de pacte social" (Bernheim 1886, 145).

Indeed, our childhood upbringing, something which we must all submit to, is specifically referred to as a sort of "suggestion à l'état de veille", the force of which marks us for life. "Les hommes mûrs dont l'expérience personnelle a plus tard affranchi le cerveau conservent souvent en dépit de toute leur indépendance d'esprit, de toute leur libre raison, un vieux fond d'idées dont ils ne peuvent plus se départir, parce qu'elles sont incarnées dans leur cerveau à la faveur d'une longue suggestion antérieure bien que ces idées semblent jurer avec les allures nouvelles de leur état psychique" (Bernheim 1886, 176-177). However, we may recall that Bernheim also believed in differing degrees of

suggestibility among people. As we have seen, he constructed an opposition between "cerveaux dociles", easily suggestible, and "cerveaux raffinés", better able to resist suggestion (Bernheim 1886, 5). This opposition refers back to the hierarchy of power. Bernheim would without doubt have considered himself among the "cerveaux raffinés" rather than the "cerveaux dociles".

But suggestible we all were and shall remain. And this theoretically universal suggestibility itself would be for the Nancy camp, the key to a cure, which thus remains a possibility for every patient. Indeed seen in this light of the cure the effect of the theoretical opposition between Paris and Nancy was indeed of considerable significance. The cure, if one is to take as a basis Bernheim's accounts of his cases and that of his associates, would appear far easier to achieve and spectacular in its manifestation than Charcot believed. Yet despite these material and theoretical differences, it is interesting to observe how close Bernheim and Charcot managed to come in practice, in their actual behaviour towards their patients, the habitus of mastery, which the strong automatically wield vis-à-vis the weak, the therapist vis-à-vis the patient.

The differences between Paris and Nancy were at the same time irreconcilable and trivial, depending on the view one takes. This attests to the hegemony of social discourse, whose pull comes to be felt in this common space between the two theories. The inevitable bottom line, however, becomes

the issue of mastery, of the power relationship between the patient ill, and having no sense of control, or the knowledge about the self which comes with that sense of control, and the therapist not ill, in control and knowing. This relationship is played out over and beyond "details", vital from one angle, trivial from the other, such as the inexorable sway of heredity, or the status of hypnosis, whether its value lay in therapy or diagnosis.

Janet entered this common middle ground of therapeutic mastery, and shifted it ever so slightly in the direction Freud's work would take, towards a greater input on the part of the patient (7). Janet, as Breuer had done with Anna O. in the early 1880s, did stumble upon the curative value of the patient's narrative. However Janet's strategy was to get the whole story out of the patient, and then apply suggestion to change its outcome, which returns in the end to absolute mastery.

The following is a representative example of Janet's technique. The root of a patient's hysterical blindness in one eye was traced back to being forced to sleep as a child with another child suffering from impedigo on one side of its face. Janet's tactic was to bring his patient back to that point in time by using hypnosis, and convince her that

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7 In later years, this of course became a hotly contended area. Janet protested vigorously at the International Congress of Medicine of 1913, claiming that it was he who really discovered the method of the cathartic cure, and that Freud never acknowledged his debt properly (Ellenberger, 344). But of course, the points on which their methods may have converged are only part of the Freudian system, and not significant on their own.

the sick child which had frightened her was really healthy and benign (Janet 1889, p.439-440). This is, clearly, quite different to the strategies of Freud and Breuer. Janet was really trying to remake the memories, whereas the other two were precisely trying to allow the expression of these unpleasant memories (8). Furthermore, in what was to become the art of psychoanalytic interpretation, Freud was eventually to seek to uncover their "true" or original meaning, and reveal this to the patient. It was this last step which would cause the cure to take place. But Janet nevertheless did approach the issue of the patients' recollection differently from most of his contemporaries. Charcot, for example, was content simply to note sometimes that his patients were reliving traumatic memories in their deliria, without taking the matter any further.

Janet's writings of that time were also remarkable for providing a proto-account of his patient's transference, both positive and negative. He made his observations in a study of hysterics suffering from aboulia, or loss of will. He saw that several women were growing strongly attached to the attending therapist. "Celui qui s'occupe d'elles n'est plus à leurs yeux un homme ordinaire; il prend une situation prépondérente auprès de laquelle rien ne peut entrer en balance" (Janet 1892, 158). But here again he showed a

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8 It must be said however, that Freud did use the method of altering, or even wiping out unpleasant memories in his treatment of Frau Emmy. However, he did take notice of the important fact that the memories had to be completely expressed in order for the technique to work.

mixture of blindness and insight in terms of the direction Freud was able to take such notions. Janet sought to distinguish his patients' attachment to him from the "passions magnétiques" of old, which his critics were bound to bring up. He pointed out that there were many different varieties of that attachment, including perhaps erotic feelings but also fear and aversion, or even filial respect. "Ce serait le fait d'un observateur bien superficiel que de donner à cette passion une origine vulgaire et de la rattacher à un besoin érotique " (Janet 1892, 159). Janet seemed to treat this strange phenomenon the same way as Charcot did hypnosis, considering it simply as a further symptom. "Il faut reconnaître qu'il y a là un sentiment pathologique des plus curieux" (Janet 1892, 160).

Meanwhile Charcot, despite a turning of the critical tide against him in favour of Bernheim, held on to a positivist description of neurosis, which ultimately could not help but negate the possibility of solid common ground between health and illness. It is understandable in this light how it was that the Ecole de Paris evolved in the direction of an ever increasing somatisation of neurology, which safeguarded tangible hereditary divisions, against questionable psychic influences. In a sense, it was Charcot who was striving to achieve an epistemological break as he endeavoured to resolve the old mind/body split once and for all in favour of the body in his barely wavering stand on hypnosis. We may recall at this point, the intensity of the

anticlericalist, antispiritualist efforts of Charcot and his school.

However, some aspects of Charcot's position on hysteria would appear on the surface, at least, to contradict his favouring of somatic explanations. He and his followers were most insistent on denouncing theories of old which linked hysteria with genitality, which in the scientific discourse primarily meant female genitality. A crusade was waged against the linking of hysteria to female sexual organs. The idea was still widespread in neurology, and often resulted in various barbarisms being perpetrated against female patients, including ovarectomies, a treatment, which, Gilles de la Tourette informs us, "Charcot n'hésitait pas à qualifier d'immorale" (Gilles de la Tourette 1898, 181). (9)

Charcot himself, however did not always see hysteria as independant from the ovaries. In his earlier texts, the ovarian region was still considered as a prime "zOne hystérogène", or a region of the body whose manipulation would provoke or forestall an attack in the hysteric. It is quite interesting to behold the moment of conversion away from this opinion in his writings. Work with male hysterics showed him that more often than not, pressure applied to the corresponding region of their abdomens would result in quite

9 The case histories Jeffrey Masson collected in A Dark Labyrinth, constitute a chilling example of the mistreatment female patients suffered sometimes in the hands of fin-de-siècle therapists. We are however aware of the axe Masson had to grind in terms of his views of Freud's abandonment of the seduction theory, which in Masson's view constituted in itself an abusive act against female patients, on par with the castrations and other outrages he describes in his book.

a similar effect. This led Charcot to move the seat of the disease away from the internal organs, towards the surface of the body, and eventually towards a still-to-be-defined portion of the nervous system, the exclusive characteristic of neither men nor women (Gilles de la Tourette 1891, 96). In Charcot's view hysteria could thus maintain a purer link with the body, a link not distorted by the intrusion of the concept of the sexed body. The veritable campaign waged at la Salpêtrière to make male hysteria acknowledged was one aspect of this. A good part of the third volume of Leçons sur les maladies du système nerveux, (10) was devoted to showing how hysteria did in fact occur in males, and in certain cases even more frequently than in females.

However, the logical extension of Charcot's preoccupation with breaking the old link between hysteria and the genitals was the campaign he waged even against the conception of hysteria as somehow linked with sexuality. This, as we recall was a recurring theme in the history of the disease from Graeco-Roman times, and still part of the popular discourse on hysteria. Yet Charcot in the great majority of his writings downplayed this factor greatly. (11) Indeed there seems to have been a deliberate attempt to minimize the sexual deprivation factor in the aetiology of

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10 The same work, incidentally, which Freud was to translate into German, shortly after his stay at la Salpêtrière.

11 We may well share the astonished surprise of Freud, who responded "Well but if he knows that, why does he never say so?" to Charcot's now famous quip "Mais dans des cas pareils, c'est toujours la chose génitale... toujours... toujours... toujours". (S.E. XIV, 14).

hysteria, even in the case of nuns, despite the fact that, as we have seen, both the Paris and Nancy schools were actively exploring the link between hysteria and religion. Gilles de la Tourette, while discussing a hysterical nun patient flatly denied the sexual roots of her disorder, putting it into a broader, politically more strategic context. "Le seul fait de s'astreindre à ces pratiques de dévotion excessives, de s'enterrer pour ainsi dire en pleine vie derrière les grilles d'un cloître était attentatoire aux lois naturelles et dénotait chez les sujets une hérédité névropatique certaine. Point n'est besoin alors d'invoquer la privation de relations sexuelles, trop souvent indiquées à tort pour expliquer la genèse des epidémies d'hystérie dans les couvents" (Gilles de la Tourette 1891, 114). So, in a master stroke, the degeneracy factor, far more reliable than the accidents of sexual fulfillment, is brought forward to embrace the very institutions of the Catholic clergy.

However it was an ambiguous position to take. It was politically useful, although deliberately blind, considering the overtly sexual behavior of many hysterics during their attacks. The name of the last phase of the attack "attitudes passionnelles", spoke in itself of repeated scenarios of sexual deliria, mostly containing elements of a traumatic nature. Sexuality thoroughly permeated Charcot's hysteria, but he saw it as a deceptive symptom at par with her "fake" paralysis. In his extensive treatise devoted specifically to hysteria, Gilles de la Tourette, makes this point clearly.

He defends hysterical women from charges of lasciviousness, by making them guilty of the opposite, frigidity, "Le dérèglement des sens est, chez elle, psychique et non physique. The hysteric is "plutôt froide physiquement", and even more: "L'acte sexuel a été pour l'hystérique plus qu'une désillusion. Elle ne le comprend pas, il lui inspire des répugnances insurmontables" (Gilles de la Tourette 1891, 518). This involved an express denial of what her gestures, her lips were saying, or at least a denial of their significance. And Charcot, when told by the mother of a young hysteric that she sees a frightful bearded man, replies, "Il y a peut-être là-dessous une histoire qu'il est inutile d'approfondir en ce moment". (Charcot 1892, 104).

A final relevant point in the issue of diverging attitudes to hysteria is that regarding malingering, or whether the hysteric is to be believed or not. Malingering tended to confuse two separate issues, that of the genuineness of the symptoms and that of the falsity of the patient's utterances. Charcot is generally regarded as a scientist who restored dignity and respectability to the hysteric, and this is partially true. In response to the general attitude which declared that because hysterical symptoms had no physical basis, they were deliberate lies, Charcot set out to prove the contrary. Thus he describes in some of his case studies, intricate mechanical contraptions which put the newest technology into the service of scientific truth. For example, he uses a respiratory machine

to measure the amount of effort a girl exerts supporting a one kilogramme weight on her hysterically contracted appendage. The control subject is a strong male assistant of Charcot who artificially maintains a similar contraction. He soon huffs and puffs while her breathing remains regular. The verdict is passed: she cannot be malingering. (Charcot 1892, 97-117).

Yet despite declaring the hysteric's symptoms to be genuine, it is clear that Charcot still regards her utterances with great suspicion. "Le besoin de mentir, tantôt sans interêt, par une sorte de culte de l'art pour l'art, tantôt en vue de faire sensation, d'exciter la pitié est chose vulgaire, en particulier dans l'hystérie" (Charcot 1887, 16-17). A glance at the manner in which he interviews his patients is also instructive. Always sure of the status of his own knowledge and mastery, he has a very clear notion of what he wants to be hearing.

"Ch: Avez-vous des accès de vomissement?

Mal: J'en ai continuellement.

Ch: vous exagérez toujours.

(Other questions of Charcot follow)

Mal: Oui, parce que...

Ch: Je ne vous demande pas de théories. Voyez comme il n'est pas toujours facile d'interroger les malades. Ils vous servent souvent une quantité de faits inexacts ou d'interprétations dont on ne sait que faire." (Charcot 1887, 322-323).

Similarly Liégeois, who was as we recall a lawyer by training, was especially prone to condemning the malingering hysteric, more so than his medical colleagues. He may have recognized the existence of her hallucinations, but his tone of moral condemnation is nevertheless evident as he lists a series of famous cases where miscarriages of justice were carried out or just narrowly averted due to hysterics' false accusations, usually of a sexual nature (Liégeois, see esp. pp.468-472).

It is thus clear that all schools reached a consensus, disregarding unanimously what the hysteric said. This of course feeds into the issue of power and mastery. In the example quoted above Charcot continues in the following manner, "il faut savoir les conduire par les bons chemins de l'observation simple et désintéressée" (Charcot 1887, 322-323). And he makes this comment despite at other times saying that it is counterproductive to actually "guide" patients.

Similarly, in another case, he leads his patient to conform to his own theoretical model of the disease, the four stage of hysteria he had so carefully described. He had already identified from the mother's description of the patient's attack, phase two (grands mouvements) and phase three (attitudes passionnelles). He offers the mother a description of phase one, the "période éliptoide", in the guise of a question: "au moment où elle tombe, avant qu'elle

se morde et se roule, n'est-elle pas d'abord raide pendant un instant, puis agitée d'un tremblement?

Mère: oui, souvent mais pas toujours." And Charcot is quick to declare that the cycle is complete. He is in this case especially triumphant because this is the girl's first visit to his clinic, she has had ostensibly no previous contact with his regular hysterics. Charcot is still obviously smarting from Bernheim's accusations that all one finds at la Salpêtrière is a sort of "hystérie de culture", and is pleased that with this fresh patient, he is able to answer the charges. (Charcot 1892, pp.103-104; Bernheim 1891, p 168).

In essence, the common attitude of all therapists was to consider the patient herself of little account. On the one hand, it was conceded that the malingering hysteric, often could not help what she was doing because she had fallen prey to her own hallucinations. This was, as we recall, the manner in which the behaviour of past witches and saints was being explained by the new insights provided by neurology. But simultaneously, a picture of the hysteric as malingerer continued to coexist with this more generous caracterisation. Hysterics were not to be trusted, believed or listened to, as in the cases of Charcot and Bernheim. And in the rare cases when they were listened to, as with Janet, nothing prevented the therapist from transforming their stories at will. It can be observed that in the end, despite the belief in the inevitable sway of heredity, which should,

in theory disculpate the ill, and in the universal susceptibility of humans to suggestion and influence, value judgements and a sense of hierarchy were implicit in the therapeutic attitude of all practitioners.

III. The Narrative of Hysteria: Freud's Early Case Histories and Epistemological Change.

As we have seen, two principal discursive topoi, relating to the effects of heredity and to those of influence, affected the theory and treatment of hysteria. These topoi also ran through a series of lesser themes defining the disease, themes such as sexuality, malingering, the continuity or opposition between madness and health, between states of consciousness and unconsciousness, and reality and illusion. The two main topoi were not, however, demarcated by easy divisions clearly separating scientific camps or individual thinkers. Rather, heredity and influence were both subservient to the greater principle of the power relation between therapist and patient, founded on the difference between the strong and the weak, and which ensured ultimately the mastery of the former over the latter.

It is interesting to investigate where Freud stands relative to the principle of therapeutic mastery, and to discover whether his work reveals to us, in this respect, any appreciable difference. It is in this fundamental perspective that change, however minimal, might affect the course of knowledge. We will look for evidence of a possible alteration in the attitude towards mastery, in the case histories of hysterics which Freud wrote after coming into contact with the theories of Charcot and Bernheim. Case

histories are a particularly apt place to conduct such a search, for they function as a forum for the expression of the theoretical positions of their writers. More importantly, they also allow for a glimpse at the therapeutic relationship, as they are after all, about the treatment of particular patients. In this capacity, they provide a record of the hierarchy of power playing itself out between patient and therapist. Of course, we are aware that the ground rules from the outset favour the latter, since he is the one recording the encounter, actually weaving the narrative of what has happened. But the question we are now addressing is whether and how the ideal of mastery, assumed in Charcot's positivist description of symptoms rooted in the inherited hysterical disposition, or in Bernheim's equally positivist description of his alleviation of troubling symptoms, applies to Freud.

A well known proposition by Kluckhohn and Myers in the field of personality psychology describes three levels of generality in the study of lives as scientifically useful "exempla". To be scientifically sound, case histories should express simultaneously 1) what is true of all human beings, 2) What is true of groups of human beings (sex, race, social class, culture, historical periods, occupation), 3) what is true of individual human beings. (Runyan, 7). I believe these criteria to be implicitly at work in Freud's case histories, including those of hysterics. It might be argued that levels two and three

ultimately get downplayed or distorted, in favour of level one which consists in the construction of a theory. But case histories, much as historical writing, involve a reconstruction and interpretation of a small number of "real" events in a subject's life which surround a specific problem, in this case, hysteria. They also include another set of events, those surrounding the treatment of that problem, the therapeutic, psychoanalytic encounter. And traces of the actual encounter, the practice, never vanish altogether from the universalizing theory. Levels two and three colour level one distinctively.

Furthermore, case histories are arguing a specific scientific point for their authors. As such, they always require a judicious selection of useful material. Bromley writes that this selection follows a "quasi-judicial procedure. A case study presents a theory about how and why a person behaved as he or she did in particular circumstances, and this theory needs to be tested by collecting evidence and formulating arguments relevant to the claims put forward in the theory" (Runyan, 189). Therefore the form, the structure, of the case history itself is important as the vehicle for the argument, as that which organizes in a coherent manner the material selected. The case history must be constructed in order to convince. It must possess the aura of truth. (1)

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1 Freud was quite aware of the similarity between psychoanalytic and legal inquiry. See "Psycho-analysis and the Establishment of Facts in Legal Proceedings", S.E. IX, 97-115.

The form best suited to the argument presented in case histories, and adhered to by both judicial and psychiatric case histories in the 19th century as nowadays, is the narrative. Freud's case histories are extreme examples of this, to the point that their author felt compelled to justify the fact they read like short stories (Freud, S.E. II, 160; S.E. VII, 9). In recent criticism of the Dora case, Steven Marcus describes it as a masterpiece of modernist fiction, and Neil Hertz draws direct parallels between Freud's narrative technique and Henry James' in What Maisie Knew (Marcus, 56-91; Hertz, 221-242).

Moreover an analogy with historical writing, which also follows a narrative form, would be well taken because both the writing of history and the writing of case histories makes use of "real events", and constrains them into a form which necessarily puts an artificial beginning, middle and end onto something theoretically infinitely expandable. Hayden White has expounded much upon the value of narrativity in historical writing, as something which confers "seriousness and objectivity" to actual occurrences. This may seem, at first, a paradox, since the usual association of narrative is with fictional, not with real events. White compares modern historical writing with "primitive" forms such as the annal and the chronicle, perhaps more suited to the chaos of events "either as mere sequences without beginning or end or as sequences of beginnings that only terminate and never conclude" (White

1980, 27). The historian's role is to impose a form, which would make what she or he writes about superior to mere events, and enable her or him to close their sequence, and thus transform events into events-with-a-meaning. This "demand for closure in the historical story is a demand [...] for moral meaning, a demand that sequences of real events be assessed as to their significance as elements of moral drama" (White 1980, 24). To narrativize reality by categorizing it, classifying, dividing and imposing limits onto it, is a characteristic of sense-making. White hints that this serves as our defence against unbearable chaos (White 1980, 24) (2).

Theory must provide that final moral meaning in the case of the psychoanalytic case history, because the therapy itself is as chaotic as history would be in its "prenarrativized" state. "Everything that has to do with the clearing-up of a particular symptom emerges piecemeal, woven into various contexts, and distributed over widely separated periods of time" (Freud, S.E. VII, 12). But the theory itself is reducible to a micro-narrative: a tale of an ever-receding return to the origins, which ultimately serves the purpose of proving the universal applicability of psychoanalytic knowledge.

When one reads Studies in Hysteria, one becomes aware that Freud's discourse does not differ sensibly from that of his contemporaries. The vocabulary of his knowledge is

2 Quite in accordance with certain psychoanalytic, mainly Kleinian, positions.

similar to the one we have described in the works of Charcot, Janet, Bernheim and others. All of them, when discussing hysteria deal with issues such as the split nature of consciousness, suggestibility, the physical and the psychic, sexuality, heredity, moral strengths and weaknesses. We have seen how the description and the treatment of hysteria, whether by Charcot, Bernheim or Janet, in such diverse, even conflicting ways, and seemingly emphasizing areas so different that their views become logically incompatible, actually share a common pursuit, a hidden implicit meaning in the ideology of control. This is what transpires in the philosophy of the human psyche of Paulhan and Janet, in their notion of the integrated self essentially ruling over the splintered sub-personalities. This is what underlies Bernheim's treatment by suggestion, in as much as it endeavors to replace the deficient weak "controlling powers" of the affected patient, by the superior, well integrated ones of the therapist. This is the meaning of Charcot's insistence on the inevitability of the hereditary destiny, over which, only he might have an effect, either by the strength of his presence or through the thoroughness of his descriptions.

One of Bernheim's cases is quite telling in this respect. He tried suggestion bearing upon the moral sense of one of his patients, the goal being that she should give up her loose ways, as well as her physical symptoms. It proved fruitless as she soon fell in with bad individuals whose

influence counteracted Bernheim's. What emerges however, is the patient's ultimate, and permanent lack of control. Bernheim's therapy never did involve giving her power over herself, restoring her "synthesizing" (to use Janet's term) capacities. "Elle était suggestible pour tous et par tous" (Bernheim 1886, 320). Once suggestible, always suggestible; once a patient always a patient. This comes very close indeed to the inevitability of the heredity theories, and is identical to Charcot's view of the permanence of the hysterical state, whether present in a mere disposition towards it, as in the hysterical taint, or the hysterical type, or in the fully fledged enactment of that state, as in the hysterical attack and the hysterical illness.

Ironically, it was Charcot who perhaps took the hysteric more seriously than Bernheim, and in this he lies closer to Freud than his Nancy rival. Charcot realized that in the separate realm of hysteria, she did possess a certain kind of special knowledge, or expertise, filtered though it was, through the knowledge of the therapist-master. He recognized that she owned her own words, spoken in verbal deliria or through the bodily language of her contortions. But this hysterical language was also, of course, made to conform to scientific models of expectation, such as the four stages of hysteria.

It was clear however, that the hysteric provided the raw material for Charcot's theories. She shared the stage with him during the regular expositions in front of the

students. He would have his bevy of "experts": mlle X would be brought on as a particularly good example, a veritable spokesperson for this particular kind of hysterical symptom; M... for that type of disorder... The hysteric could indeed speak, she was even heard. But still she was far from listened to, for her expressiveness, her special kind of knowledge, of experience, of being the best, most typical representation of various forms of the disease was necessarily mediated by the superior knowledge of Charcot. The hysteric did have stories to tell, but these, heard but not understood, were just more symptoms for Charcot to categorize. In an early case, Charcot describes a hysteric whose attack consisted in reliving a series of frights she had had, over and over again. Her story certainly was heard, as it was recorded in the case, but it was marginalized in Charcot's telling. He considered it as just another symptom, relegated to the sidelines, and she, the teller, reduced to pointless repetition, symptomatic hysterical babble. And the reliving, the telling of her tale, was repeated day after day, much as another hysteric's contraction or spasm, bringing her no relief (Charcot 1872, 303).

As we pointed out, Janet was the first to recognize the curing potential of the telling of the hysterical tale. But the patient's story was told only to be replaced in the end by his own. The hysteric's knowledge still had no effect on the therapist's knowledge. It is the contention of this thesis that the great innovation of Breuer, and then Freud,

was that they considered and recorded that hysterical knowledge differently, and thus altered the course of the therapeutic relationship of mastery.

As is well known in the history of psychoanalysis, Breuer's telling Freud of the strange case of his patient Anna O. was a highly significant moment. Breuer's case study of this patient would open Studies in Hysteria. Anna O. suffered from a particularly complex case of hysteria, with multiple symptoms, including a seeming splitting of her personality, hallucinations, various disturbances of the senses including severe "functional disorganization of her speech". Part of her symptoms consisted of her falling into a hypnoid state in the late afternoon, from which she would wake up and complain as best she could of something tormenting her. After Anna O. had been totally unable to communicate for two weeks, Breuer made a first crucial breakthrough by gaining an insight into the "psychical mechanism of the disorder" (S.E. II, 25). "As I knew, she had felt very much offended over something and had determined not to speak about it. When I guessed this and obliged her to talk about it, the inhibition which had made any other kind of utterance impossible as well, disappeared" (S.E. II, 25). Breuer had made contact with Anna O.; he had intruded into her story, broken the isolation of her narrative which, without this outside intervention, was bound to repeat itself ad infinitum like that of the women of la Salpêtrière. After this decisive point, whenever she

would be in her hypnoid state, Anna O. would ramble on in a way reminiscent of what later came to be referred to as free association.

This talking would take the form of narratives, stories having as their starting point a girl at a sickbed. But the stories had direct bearing on Anna O.'s own life as she herself had nursed her sick father. It was his death which changed the course of her illness, precipitating the split in her consciousness. "Hysterics suffer mainly from reminiscences". (S.E. II, 7).

Before falling ill, Anna O. had been given to the habit of "systematic daydreaming" (S.E. II, 22), constructing tales in her head, a habit which, in the case history, is related to "the incubation of her illness". This implies a predisposition, that already familiar concept, to hysterical illness. Daydreaming was an alternate state, a splitting of the personality, and as such, the key not only to the patient's illness but also to her cure. Anna O. told tales in her hypnoid state and Breuer heard her much as Charcot and his assistants heard the deliria of her co-sufferers. But unlike Charcot, Breuer actually lent a sympathetic listening ear to her. He saw that her talking was more than a curious pathological trait, and this, together with his listening to her, actually afforded her a systematic cure.

Anna O. herself would call this new procedure "the talking cure" (S.E. II, 30). But why did it work? As we have seen, the process of cure only started when Breuer attempted

seen, the process of cure only started when Breuer attempted an interpretation and interfered. Every act of narration requires a "narrataire", an addressee, with whom shared social conventions make mutual understanding possible. Without that adressee, something of a different order would be going on, which is akin to a private language, or more to the point, the "mad babble" of the irrecuperably "other". Breuer's lending an ear to his patient implied that he understood her idiosyncratic language, the gap between them was bridgeable, and furthermore that his patient was worth listening to.

Breuer writes of instances when he would not be by Anna O.'s side, and when she would suffer the effects of her narration which had no outlet, no ear. At other times, he would have to make an effort to elicit the words which would sometimes dry up (S.E. II 30-31). Unquestionably, there was communication between them, as Freud refers to the proto-transference/coutertransference which caused Anna O.'s desire for Breuer, and his consequent fright and flight. (S.E. XIV, 12).

The patient's talking was not in itself, as we have shown, unusual. The hysterics at la Salpêtrière were often reported, and observed, in this act of talking, which never was considered as anything other than a symptom among others, to be submitted along with other symptoms, to the descriptive machinery. The rapport established between Breuer and Anna O. was also, after all, something quite

common, lurking dangerously in the background of magnetism, and part of the therapeutic style of suggestion. However, at the point of Breuer's lucky first interjection, there seemed to have occurred a fortuitous juxtaposition of the two strategies, listening to the tale as symptom, and engaging in a rapport with the patient. Out of this juxtaposition, a therapeutic communication was established between Breuer and Anna O. However the therapeutic rapport still centered on the alleviation of physical symptoms. The Anna O. case makes this quite clear, as it lists methodically ailment after ailment, removed one by one by this "chimney-sweeping" or "talking cure" as she called it, or "the cathartic cure" as he did.

The second case of Studies in Hysteria, Frau Emmy Von N., was Freud's first instance of putting to use Breuer's method. This patient's symptoms were milder than Anna O.'s. Indeed she could go about her daily occupations, which included running the business which her husband had left her. Nevertheless, she was racked by various pains, curious tics, and her symptoms included as well a form of splitting of consciousness, manifested by her suddenly breaking off in the middle of an apparently normal conversation with an anxious cry of "keep still! Don't say anything! Don't touch me!", whence "she was probably under the influence of some recurrent hallucination of a horrifying kind and was keeping the intruding material at bay with this formula" (S.E. II, 49).

In his treatment of Frau Emmy, Freud was very much under the influence of Bernheim's teaching. During that time he worked on a German translation of De la suggestion, and travelled to Nancy to observe the therapeutic methods of that school. This case is still one of straightforward symptom elimination, through the dual method of first eliciting from the patient the stories which lay behind the symptoms, which consisted as in Anna O.'s case of a network of memories. The second step involved eliminating the affecting power of these memories through suggestion. With shades of Janet's methods, Freud, upon hearing Emmy's narratives, proceeded with suggestions that they either be wiped out of the patient's memory, or that they at least cease to bother her, be stripped of their affective and affecting content and so become changed through the direct action of the therapist. This afforded Frau Emmy some instant symptomatic relief, providing, and herein lay an important connection for Freud, that she had beforehand expressed all of the pathogenic connections surrounding one particular symptom/memory cluster.

Indeed, the Anna O. case had shown that symptoms were connected to memories, but now this second case made totally clear for the first time that the correlation was not simply one to one, and that it involved a rather more complicated puzzle for the interpreter/listener to unravel. Frau Emmy revealed that there was actually a stratification of memories.

It can be pointed out that an inkling of this was already present in the Anna O. case. Breuer was able to make his patient think about all the separate instances when a particular symptom had occurred, going back to the original occasion. For example, in reference to disturbances of hearing, Breuer and Anna O. explored the connected incidents: "Not hearing when someone came in, while her thoughts were abstracted. 108 separate instances of this, mentioning the persons and circumstances, often with dates. First instance: not hearing her father come in." (S.E. II, 36). But it was only in Frau Emmy's case that the connection between the completeness of the narrative and the quality of the cure was made explicit. Two of her symptoms included stammering and clacking when she was afraid. She told of two major traumatic instances of fright, one of feeling unable to keep still by her daughter's sickbed, the other at being nearly killed by out-of-control horses. These two major frights were subsequently associated to any other fright and "were eventually linked up with so many traumas, had so much reason for being reproduced in memory, that they perpetually interrupted the patient's speech for no particular cause, in the manner of a meaningless tic." (S.E. II, 93). It was in the nature of the cathartic method to find the meaning which lay behind apparent meaninglessness, and therefore effect a cure.

However, a complete cure was not immediately forthcoming in this particular groundbreaking case. Freud

explains this, reinforcing the need for not leaving any gaps, by the fact that the complete explanation could not be reached, the catharsis not having extended to "the secondarily associated" traumas. In a footnote to this passage Freud makes a clear plea for completeness and unprejudiced attention. "I may here be giving an impression of laying too much emphasis on the details of the symptoms and of becoming lost in an unnecessary maze of sign-reading. But I have come to learn that the determination of hysterical symptoms does in fact extend to their subtlest manifestations and that it is difficult to attribute too much sense to them" (S.E. II, 93).

In effect this is the embryo of an alternate system of joint narrative construction. It is an endeavor which is only possible with patient and therapist working in harmony. The patient's role is to provide the tale, duly prompted by the therapist who elicits it from her, down to its "details" which are seemingly irrelevant until he provides the proper place for them. It is not the easiest of collaborations, and here we can evoke the familiar hegemonic belief in therapeutic mastery which must interfere with any attempt at partnership. A real struggle would sometimes take place between Freud and Frau Emmy "who clung so obstinately to her symptoms" (S.E. II, 99) and her memories and would refuse to elaborate upon them. "She would give me incomplete answers and keep back part of her story until I insisted a second time on her completing it" (S.E. II, 98).

But the fact that she did struggle conferred a certain amount of dignity on her. Freud found her unamenable to the kind of "authoritative suggestion" (S.E. II, 99) which supposedly worked with the Nancy hysterics. He always had to give her good reasons to talk. It was necessary to convince her by going into "the psychical history of the origin of a symptom", thus paving the way for a collaboration. She could not be tricked or bullied like Bernheim's or Charcot's patients. Honesty was expected of the therapist, as well as of the patient. It is worth noting that Anna O. as well, was described as being "completely unsuggestible; she was only influenced by arguments, never by mere assertions" (S.E. II, 21).

This new-found grudging respect for the patient was obviously of great significance. It constituted the first step taken towards a realization that the patient's cure depended at least partly on her cooperation, and not solely on the mastery of the therapist. It showed that he did indeed have a chink in his armour, that her words and good-will were necessary to him. But the Dora case also provides an example of the battle of wills which often ensues despite the seeming respect for the patient's words. And the confrontation might become oppressive for the usually female patient, within what is still a patriarchal hegemony of mastery.

Another change observable in the cases is an ambivalence towards heredity. Freud still formally states

that an appropriate hereditary baggage is necessary for the onset of hysteria. Indeed all of the case histories incorporate a discussion of this point. Anna O had a "moderately severe neuropathic heredity" (S.E. II, 21). Frau von N. was undoubtedly a personality with a "severe neuropathic heredity" (S.E. II, 47). Elisabeth had "no appreciable hereditary taint", however her mother suffered for years from an uninvestigated neurotic depression. (S.E. II, 161). The Katharina case was just based on a brief encounter, so information was lacking. As for Dora, the taint is not hard to trace in this story of "the sick daughter (who) has a sick father, who has a sick mistress, who has a sick husband, who himself proposes to the sick daughter as her lover" (Bernheimer and Kahane, p.254). She is a daughter whose mother, in addition, suffered from housewife's neurosis.

Miss Lucy R., however, had no hereditary taint but was therefore supposed to possess "the proclivity to acquire hysteria", granted "probably a very widespread proclivity" (S.E. II, 122), so that the constraint of heredity is left behind. "Very widespread" precludes the isolating and dividing stance of a theory of heredity. If the proclivity is widespread enough, there could be no sufficient ground for a consecrated difference between "us and them" (3). This

3 Incidentally, it was a similar argument that caused Freud to undermine his own seduction theory. If it was so widespread as to include his own father, and himself it could not possibly be true. "Then the surprise that in all cases, the father, not excluding my own, had to be accused of being perverse -- the realization of the unexpected

argument seems, however, strangely familiar, as we remember Bernheim and Charcot's controversy over the universal applicability of hypnosis. We can recall as well, that heredity was not of the same importance to Bernheim as it was to Charcot. Lantèri-Laura makes the useful point that although Freud never denied the existence of pathological heredity in his patients, he ultimately disregarded it by putting his theories on another register, "un antèrieur uniformément infantile" (Lantèri-Laura, p.65), in other words a universalizing register of common origins.

However, it must be pointed out that Freud does draw a distinct line between the hereditary taint and the moral reprehensiveness commonly associated with it. He makes the point explicitly in the case of Frau Emmy. "We had learnt from our observations on Frau Cecilie M. [another hysterical patient, often mentioned, but not the subject of any case history] that hysteria of the severest type can exist in conjunction with gifts of the richest and most original kind...In the same way Frau Emmy von N. gave us an example of how hysteria is compatible with an unblemished character and a well-governed mode of life" (S.E. II, 103). Freud goes on to talk in glowing terms of her "moral seriousness", "intelligence", "energy" "love of truth" and other qualities. "To describe such a woman as a degenerate would

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frequency of hysteria, with precisely the same conditions prevailing in each, whereas surely such widespread perversions against children are not very probable" (see Freud/Fliess correspondence, september 21, 1897, Masson, ed.,p. 264).

be to distort the meaning of that word out of all recognition" (S.E. II, 104). Freud then offers the distinction of disposition (which he was to describe in the Lucy case as "widespread") as opposed to degeneracy.

Freud's patients seemed to be quite the opposite actually to the "typical" hysteric whose cluster of personality traits has entered the twentieth century scarcely unchanged. "Demanding and manipulative, overcomplaining, over-demonstrative, superficial, hypochondriacal; unduly keen to attract the physician's support, hence dependant,[...] frigidity and exhibitionism in females,[...], attention-seeking behavior, suggestibility, labile and histrionic attitudes, mendacity, self-centeredness, vanity and frigidity, immaturity and dependence" (Mersky, 191).

A different sort of character type emerges from the Studies, almost countering the image of the hysteric of the preceding portrait which moreover, can be read as an exaggerated version of stereotypical femininity. Freud's hysterics are atypical women. Anna O. is "markedly intelligent with an astonishingly quick grasp of things and penetrating intuition [...] She possessed a powerful intellect, with an astonishingly quick grasp of things which would have been capable of digesting solid mental pabulum and which stood in need of it -- though without receiving it after she had left school" (S.E. II, 21). Frau Emmy discharged the duties of running a large business admirably

(S.E. II, 103) though handicapped by "the natural helplessness of a woman". Of Elisabeth: "she was in fact greatly discontented with being a girl. She was full of ambitious plans. She wanted to study or to have musical training, and she was indignant at the idea of having to sacrifice her inclination and her freedom of judgment by marrying (S.E. II, 140). Dora equally conformed to this pattern of strong femininity, possessing "natural gifts and intellectual precocity" (S.E. VII, 140).

These characterisations would seem to fit in well with feminist interpretations of the hysterical protest against patriarchy. In a dialectical reversal, strong women tormented because of the ill-fitting nature of their role in patriarchal society, would regard the act of falling sick as the only "healthy" response they could aspire to. The hysteric could then be perceived in heroic terms, as her noisy attacks and troubling symptoms disrupt the bourgeois family. She "unties familiar bonds, introduces disorder into the well-regulated unfolding of everyday life, gives rise to magic 'n ostensible reason" (Cixous and Clément, 5). We remember that Anna O., having surmounted her hysteria "became" Bertha Pappenheim, renowned feminist and social worker. But preservers of the status-quo have not been daunted. There are those scholars who have argued that Bertha's feminism was nothing but her illness having taken on a different form, any argument against the sexual status-

quo, any attempt to explode the typical, being construed as a perversion of psychic normality. (Kaplan, 101-117).

This connection of hysteria and femininity is illuminated by the category problem of male hysteria. As we have seen, the existence of male hysteria helped Charcot turn hysteria into a more positivistic nervous disorder. However, this existence had to be simultaneously downplayed: most male hysterics were Jews (so not really male); most male hysterics were workers (so used to a subservient place in the hierarchy of power, and thus not really male); and finally the most powerful and completely circular argument: most male hysterics were of a degenerate type anyway because prone to hysteria, and therefore not really male.

Freud's patients were all described as representing a category problem, as well, in that they all offered some kind of a challenge to the female type. Freud, whose method implied an erosion of the ideal of absolute mastery, could not sublimate this problem, as Charcot was able to do with male hysteria, and faced it in an open dialogue/confrontation with his patients. The method of psychoanalysis is largely born out of an encounter with these women, both hysterical and atypical, an encounter, moreover, which does not explicitly or implicitly deny the existence of such women. This implies that psychoanalysis could at least potentially cause a crack to appear in the patriarchal society. And, as mastery was no longer absolute

it could provoke a confrontation between the master and the one subjected to his mastery.

Despite this potential, however, the hegemony of patriarchy was still the system under which Freud worked. He may have been marginalized by his ethnic origins, but as therapist and man (even as Jewish man), he was still master. The tension between Freud and Dora, indeed the tension Freud felt about the entire issue of female sexuality, which he was unable to understand until perhaps the end of his life otherwise than as incomplete male sexuality, bears witness to the uneasy origin of psychoanalysis. Freud gave the hysterical patient the opportunity to sound her voice, but he simultaneously took that opportunity away. His therapy was built upon the necessity of getting her story out, needing that story, but in the end, he appropriated her tale, distorting it out of recognition, as will be seen shortly. But the method itself, given the right socio-discursive context, a different hegemonic configuration, would allow for a true sharing of power, for a joint narrative. Many feminists have recognized this liberating potential of the talking cure, and a powerful dialogue between feminism and psychoanalysis has been ongoing for the past twenty years (4).

But in Freud's time letting the woman's, indeed the patient's narrative participate fully in the construction of

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5 See Jane Gallop, Feminism and Psychoanalysis: The Daughter's Seduction, for a good summary of the cooperation, both uneasy and fruitful, between psychoanalysis and feminism.

the therapeutic encounter and the case history, still belonged to the realm of the unthinkable. Indeed it still is utopian to imagine a time when patient and therapist would truly coauthor the account of their encounter, their status as patient and therapist merged and indistinguishable. This was even more the case in the 1880s and 90s, when Freud was left no choice by the hegemony of power relations but to use all the means at his disposal, all of his authority and his cunning, to wrest the stories and the "secrets" from his patients. He forcefully combated their repression, their resistance to "letting go of their symptoms", which implied a refusal to reveal their secrets to him, as he strove to achieve a complete narrative.

The first two cases, Anna O. and Emmy von N. were basically constructed on a schema of symptom elimination, very close to what was already being done by Freud's French colleagues. The fragmentation of the narrative did not matter very much, since the women's bodies as well were divided into suffering fragments. However, we recall that in the Frau Emmy case, Freud made the important point that every little detail signifies and links up into a larger system of sense-making, the first step towards Freud's later striving for completeness and cohesiveness.

In the case of Lucy, an English governess suffering from a mild case of hysteria, Freud leads his patient through three different levels of awareness, as he takes the narrative to ever increasing stages of completeness. The

avowed aim in this case lay "in compelling the psychical group that had been split off to unite once more with the ego-consciousness" (S.E. II, 124). To do this, Freud had to realize that the different states of his patients were interrelated (since splitting seemed to be at the basis of their disturbances). He saw that there were no real qualitative difference between normal and hypnoid states, for example. This knowledge would have a dual effect: realizing that what was conscious could become unconscious and, most importantly in terms of the cure being aimed for, vice versa.

The abandonment of hypnosis as a method of cure would also directly result from this. Freud had already witnessed Bernheim showing that "the memories of events during somnambulism are only *apparently* forgotten in the waking state and could be reawakened by a mild word of command" (S.E. II, 109). It took little prompting for him to understand that the same would apply to pathogenic memories. They would prove to be retrievable if faced with sufficient insistence. Freud resorted to the pressure technique, which consisted of his applying his hand to the forehead of the patient and exhorting her to remember. This gave a certain additional responsibility to the patient. The one essential condition of hysteria was that an "idea must be *intentionally repressed from consciousness.* " (S.E. II, 116). It follows that since the idea was intentionally

repressed so it would remain in the patient's power to intentionally recall it.

The therapist's role, however, was far from passive. Freud had to provoke the retrieval of memories which would move the narrative to ever greater degrees of completeness, enabling the patient to remember, and share with him memories which were rightfully hers. Freud's strategic interpretations served as prompts in the patient's narrative, moving it to another level, radically altering the nature of the story, like a corner turned abruptly. In the Lucy case, for example, such a moment occurs when Freud suggests to her that she is in love with her employer (S.E. II, 117). After that point "she showed no resistance to throwing light on the origins of this inclination" (of which there had been no explicit indication previously in the text) (S.E. II, 118). But a new resistance, symbolized by a smell of burnt pudding replaces the old one, and is in turn broken by another interpretation of Freud, relating the smell to her employer's violent temper (S.E. II, 119-120), which again releases fresh details of her tale.

But this nevertheless enhances the importance of the part the patient plays: her actual knowledge is necessary for the development of the story. The therapist's interpretations are not suggestions which have to be accepted blindly, or tricks, as in the case of Janet, serving to alter the story. Instead, they function as prompts, releasing the patient to tell what she already

knows, because it has happened in reality (or rather in the reality of fantasy, as this will become increasingly clear in the development of Freud's theory, and is already, as we shall see, easily perceivable in the Dora, and even in the Elisabeth case). When Lucy is confronted with Freud's explanation that she loved her employer, she calmly confirms it, and answers Freud's question as to why she did not admit it previously by the paradox of knowing and not knowing. "I didn't know or rather I did not want to know. I wanted to drive it out of my head and not think it again; and I believe latterly I have succeeded" (S.E. II, 117). This is another path leading back to the old notion of splitting, which Freud, however addresses directly through his interpretations rather than just observing as a characteristic of hysteria.

In Katharina's case, the splitting is between her younger self and her older one. At fourteen she experiences sexual advances from her uncle without fully understanding their nature. Years later, at eighteen, she witnesses that same uncle in a sexual encounter with her cousin. The solution to her problem lay in Katharina establishing "a connection between the new impressions and these two sets of recollections", the uncle's advances towards her, and the uncle in sexual situations with her cousin. As she understood the connection she began "at the same time to fend them off" (S.E. II, 131). Freud suggests a scenario, putting words into her mouth "now he's doing with her what

he wanted to do with me that night and those other times"... He also adds "You're a grown up girl now and know all sorts of things" (S.E. II, 131). "Knowing all sorts of things", refers as well to Katharina's state after hearing Freud's interpretation: she is now able, by retrieving the lost connection, to complete her story.

In the case of Fraulein Elisabeth, a young woman who experienced hysterical pains because she refused to face the fact that she loved her brother-in-law, Freud's process of forcing her to arrive at, and reveal her secret knowledge, is more dramatic in build-up. Freud's first clue that she knew more than she would say came from reading her face. Her expression, one of rapture, did not seem to fit with the pain she asserted she was feeling. Freud concluded that it "was probably more in harmony with the subject matter which lay concealed behind the pain" (S.E. II, 137). This is a forerunner to the clue-gathering method which Freud explains in the Dora case. "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore" (S.E. VII, 77-78).

So Freud sets himself up in the role of "he that has eyes to see and ears to hear". Freud's strategy is to make the reader share in this ability. This reinforces his authorship (and mastery) at the expense of the patient by dominating the patient, who tries to keep secrets, and whose story it actually is. Hence the following important

interpretation scene from the Elisabeth case. Freud has proceeded as in Lucy's case to the gradual unveiling of the "whole story", in terms of successive retellings incorporating more and more details until completion could be attained. It is quite striking that Elisabeth is the last one conscious of what he is doing. "It had inevitably become clear to me long since what all this was about, but the patient...seemed not to notice the end to which she was steering" (S.E. II, 156). This twists Freud's stand away from the ideal position of shared responsibility between patient and therapist, and back again towards therapeutic mastery. To all intents and purposes, Freud is really saying of his patient: she holds all the clues but cannot make sense of them on her own.

In the Dora case Freud's theoretical apparatus is perfected and therefore his masterful attitude is reinforced. It is important to stress that crucial developments in his theories had occurred in between the Studies, published in 1895 and Dora, written in 1901, but published in 1905. One of these was the abandonment of the seduction theory. This step had the effect of enabling Freud to really integrate into his system the power of fantasy. As is well known, the seduction theory held that hysterical patients had been seduced as children, usually by their parents and that this event had caused their disturbance. Later Freud asserted that the scenes that his patients were reporting as memories were nothing but fantasies.

The seduction theory itself could be regarded from a certain angle as being quite close to the degeneration hypotheses. The children are once again indelibly affected by something pertaining to their parents. But another way of considering the theory is to see it as suggesting that the solution to the patient's problems lies in her own past experience, in the reality of her life, to which only she would have the ultimate key. And this aspect is not forgotten when Freud abandons the seduction theory, and goes on to consider its replacement, fantasy. In the register of fantasy, the patient must assume a superior level of responsibility for her hysteria. The key now lies in the reality of the patient's fantasy life, which comes into conflict with real events, and remakes them. But more importantly, with fantasy, the therapist-interpreter now finds himself on sure ground. In the maze of fantasy life, which is his as well, (for fantasy, the original Oedipal fantasy, is ultimately universally shared), he is the ultimate expert.

This new mastery is well illustrated in the differences between Freud's treatment of Katharina and Dora. Many critics, from Lacan onwards, have commented on Freud's mistreatment of Dora, his unresolved negative countertransference (Bernheimer and Kahane). And Philip McCaffey has contrasted Freud's attitude towards the two girls, pointing out hov much gentler he had been towards Katherina than Dora (McCaffey, 103). I would like to suggest

that this difference is because of the theoretical shift which had occurred between the Studies and Dora. Katharina, like Dora is a young girl who was also disturbed by an advance from an older man (5). But dealing with her before the development of the fantasy theoretical framework, he does not impose forceful interpretations upon her.

With Dora, however, because of his new understanding of fantasy, Freud finds himself at the same time more assured of his position of mastery, and more eager to defend that position. He knows through his theoretical apparatus that it is not Herr K.'s kiss which caused Dora's illness, that it is her *unacknowledged* desire for him (and beyond him, for her father). But he still needs her to know it as well. He finds Dora's refusing to accept his interpretation, and thus holding back the development of the narrative, totally frustrating. The patient is still the one telling the story, aided by the therapist's interpretations, but suddenly those interpretations have become much more forceful than they had been previously. Elisabeth, the keeper of secrets, also treated at about the same time as Katharina, and thus before Dora, springs to mind as another comparison to be made. Freud starts off that case by implying that she knows more than she is willing to tell, perhaps even in her conscious state, an insight which even prompts him not to use hypnosis with her at first. Yet Freud is uniformly patient with Elisabeth, but later cannot forgive Dora for hanging on to

5 Moreover, in a footnote to the Katharina case that man is explicitly identified as her father.

what she knows and refusing to accept what he knows. He angrily denounces Dora for "playing secrets" (S.E. VII, 78).

Freud gives us a clue as to what he perceives to be his challenge as a therapist, when he describes the incompleteness of hysterics' narratives. The first account that they give of their story "may be compared to an unnavigable river whose stream is at one moment choked by masses of rock and at another divided and lost among shallows and sandbanks" (S.E. VII, 16) "It is only at the end of the treatment that we have before us an intelligible, consistent and unbroken case history" (S.E. VII, 18). Several critics (Moi, 181-199: Hertz, 221-242) have pointed out that Freud desperately wanted Dora's secret, so that he may construct that "intelligent, consistent and unbroken case history". This would have consecrated his mastery on the new terms he is in the process of refining. The complete title of the Dora case attests to the fact that the author of "Fragment of an analysis of a case of hysteria" was aware of not having reached that goal.

Dora was caught in the middle of Freud's process of coming to terms with the implications of his theories. With added theoretical refinement, and psychoanalysis better settled into hegemony, Freud's attitude again softened, and he became confident enough in his therapeutic mastery to accept his need to rely on his patients' tales. The ever growing theoretical complexity abstracted the reality of the power relation being played out in the therapeutic

encounter, and the potential for therapist and patient, strong and weak, man and woman, to become more equal. In his only other case history of a woman, "Psychogenesis of a Case of Homosexuality in a Woman", written 20 years later, Freud was able to be kind again to a recalcitrant patient, one moreover, who refused to let go of her secrets, leaving him with yet another fragmented narrative (S.E. XVIII, 145-172). It was a step backwards, perhaps, as hegemony forced Freud back again into a position of confident mastery, but a step forward as well, as his patient was able to chose her silence in relative freedom.

Conclusion: the Freudian Revolution Reassessed.

Our exploration of the way hysteria was treated in the late 19th century, has shown us that at its centre lies the issue of the power relation. This comes as no surprise, given our understanding that the scientific discourse surrounding hysteria was subjected, as any other discourse, to hegemonic constraints and that these constraints essentially served to preserve a certain social distribution of strength and weakness. Accordingly, it was possible to show that all the different elements relevant to the description of hysteria, such as the splitting between consciousness and unconsciousness, the continuity between madness and sanity, the topoi of heredity and suggestibility, were being put to use, albeit in different configurations, by all the scientists concerned with the illness, including Freud. Furthermore it was possible to establish that ultimately, these descriptive components all served to reinforce, in accordance with the requirements of hegemony, the mastery of the therapist over the patient.

It is this last point which enables us to understand how it was within Freud's potential to cause an epistemological revolution. Freud's contribution to change has been shown to lie in an altered therapeutic relationship and thus had a direct bearing on power relations. His method of the talking cure is potentially an empowering one for the patient. It involves the patient and therapist engaging

jointly in a therapeutic endeavor which incorporates the narrativization of relevant parts of the patient's life experience. Freud came to see his patients' repressed memories, and later their unconscious fantasies, as forming a system which not only affected their conscious state, but "made sense" of it. It created in itself, through its own logic, the possibility of understanding happenings in the "real world" which would otherwise be puzzling and/or meaningless.

However, the radical potential of psychoanalysis was never fully actualized, because within a set social configuration, change is always limited by what constitutes socially acceptable discourse or practice. Due to the nature of the social hegemony, a hierarchy of power was reinstalled at the very center of Freud's new therapeutic relationship. The therapist would assume the leading role of the decipherer, which sets off the patient's role of teller as a secondary one. The therapist endowed with a superior power to listen, would be the only one able to interpret appropriately (make sense of) the sense-making of the unconscious, and therefore allow the patient to reach ever-increasing degrees of completeness in her narrative. (1)

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1 It is here that the well-known opposition between Freud's listening ear (after all he needed to listen carefully in order to decipher the symbolic manifestation of symptoms) and Charcot's vision, one might say dramatist's eye (which he required to look at the mise-en-scene of the hysteric's symptom-filled physical presence) would come into play. (Didi-Huberman, in general & esp. 81). Appropriately, the reward and consecration that Freud looked forward to as therapist, was to listen to his patients' story, completed through his efforts. Charcot's was to see a configuration of

But a granting to the patient of some measure of knowledge is still perceivable in Freud's first written case histories of hysterics. The voice of Freud's patients is heard for the first time, in a way that the voice of their sisters at la Salpêtrière and Nancy was not, and they were thus allowed a claim to knowledge and to power. Granted, this voice and this claim was subjugated to those of the therapist who moves their story along in interpretations which are still masterful. Perhaps it was even ultimately discarded in the retelling (after all it was Freud who produced the only text which has been transmitted to posterity), but not before a certain destabilisation or shift had taken place in the hegemony. This destabilisation was stronger in the first pre-theoretical moments, in that primal-scene of psychoanalysis itself, when it was quite impossible to distinguish between Anna O. who talked, Breuer who listened to her and Freud who listened to Breuer. After this, Freud surrounded his therapy with an intricate theoretical apparatus which renewed his position of mastery over the patient, putting him clearly in control of the therapeutic narrative.

The question arises at this point as to whether there is qualitatively any difference in listening to the patient's voice only to squelch it with masterful therapeutic interpretations in the end, as Freud did,

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symptoms, such as a hysterical attack in four regular stages, conforming to his descriptions.

or not listening to it at all, as Charcot and Bernheim had done. I would argue that the difference is indeed a substantial one, for in Freud's therapeutic system, the road towards a greater sharing of power has begun. The patient's input into the cure had become necessary. Given the right socio-discursive situation, one which did not exist in Freud's time and has still not come about, the interaction between patient and therapist, the weak and the strong, might become more equal, resulting in a different, truly co-authored case history.

So the fact that the patients' stories provide the substance constitutes the first potential shift in knowledge and in power relations. The transference/countertransference aspect of the therapeutic relationship constitutes a second, potentially new and liberating element in psychoanalysis. It recognizes that both patient and therapist have an effect on each other. The concept of countertransference, the effect of the patient on the therapist is especially interesting for it shows that a genuine interaction has occurred, even if it is an unequal one in terms of the hierarchy of power. Alongside the therapist's influence on the patient, something of her has affected him as well. This effect is in fact, the unthinkable of Charcot's and Bernheim's discourse, for if followed through to its logical conclusion, it implies an equal ability to influence and to be susceptible to influence on the part of both patient and therapist. Countertransference breaks through in Freud

despite himself, in his sympathy for Elisabeth, and his hostility to Dora. But even when it becomes more fully theorized in later psychoanalytic writings, it is never given its full due. In case histories it is always of a lesser importance than the transference, the effect of the therapist on the patient. It would not be too unrealistic to suspect that in practice, very few, if any, analytic sessions incorporate equally weighted discussions of transference and countertransference, despite the contributions of the Object Relations school of psychoanalysis which does recognize the great importance of the latter concept (Kernberg; Kohon).

François Roustang in Elle ne le lâche plus, presents the interesting argument that the psychoanalytic technique of free-association itself, the injunction to tell all, constitutes a detour, a maze leading away from the actual relationship between therapist and patient. "Ce que Freud veut éliminer par cet allongement, c'est l'affrontement direct avec le patient, l'action directe du médecin" (Roustang, p.133). The theorizing of transference/countertransference, as reliving other real or fantasy relationships, interposing another (or others) between therapist and patient might be seen in this light as well. It can be read as a mystifying glossing over of the actual power relation, therapeutic but also political and sexual, being played out between two people in society. This, in turn, would serve to reinforce and maintain a

beleaguered, by the very implications of Freud's theories, sense of therapeutic mastery.

The consequences of these theories, if taken beyond the limits of the hegemony of the sayable and thinkable, would perhaps lead to a radically altered balance of power, and a case history, where patient and therapist really would share the telling and the writing. Then, transference and countertransference would not just serve as symptoms, but as a true way to shared power.

Bibliography

I. Primary Sources:

Bernheim, Hyppolyte. De la suggestion et de ses applications à la thérapeutique. Paris: Doin, 1886.

----------. Hypnotisme, suggestion, psychothérapie: études nouvelles. Paris: Doin, 1891.

Charcot, Jean Martin. Clinique des maladies du système nerveux. 2 vols. Paris: Alcan, 1892-1893.

----------. Leçons du Mardi faites à la Salpêtrière. Policlinique 1887-1888. Paris: Progrès médical; Delahaye & Lecrosnier, 1888.

----------. Leçons sur les maladies du système nerveux faites à la Salpêtrière. 3 vols. Paris: Progrès médical; Delahaye & Lecrosnier, 1872-1887.

---------- and Paul Richer. Les Démoniaques dans l'art. Paris: Delahaye & Lecrosnier, 1887.

Freud, Sigmund. "Address to the Society of B'nai Brith" (1941[1926]). Standard Edition of Complete Psychological Works. London: Hogarth Press, 1953-74, vol. XX, 271-274.

----------. "An autobiographical Study"(1925[1924]). Standard Edition XX, 3-74.

----------. "A Case of Successful Treatment by Hypnotism With Some Remarks on the Origins of Hysterical Symptoms Through "Counter Will"" (1893). Standard Edition I, 117-128.

----------. The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887-1904. Jeffrey Masson, ed. Cambridge, Massachusetts; London: Belknap, 1985.

----------. "Femininity" (1933[1932]). Standard Edition XXII, 112-135.

----------. "Fragment of an Analysis of a Case of Hysteria" (1905[1901]). Standard Edition VII, 3-122.

----------. The Interpretation of Dreams (1900). Standard Edition IV & V.

----------. "Observation of a Severe Case of Hemi-Anaesthesia in an Hysterical Male" (1886). Standard Edition I, 23-31.

----------. "On the History of the Psycho-analytic Movement" (1914). Standard Edition XIV, 7-66.

----------. "Psycho-analysis and the Establishment of Facts in Legal Proceedings" (1906). Standard Edition IX, 97-115.

----------. "The Psychogenesis of a Case of Homosexuality in a Woman". Standard Edition XVIII, 145-172.

----------. "Report on my Studies in Paris and Berlin" (1956[1886]). Standard Edition I, 3-22.

----------. "Three Essays on the Theory of Sexuality" (1905). Standard Edition VII, 125-268.

---------- and Joseph Breuer. Studies in Hysteria (1895). Standard Edition II.

Gilles de la Tourette, Georges. Leçons de clinique thérapeutique sur les maladies du système nerveux. Paris: Plon, 1898.

----------. Traité clinique et thérapeutique de l'hystérie. 3 vols. Paris: Plon, 1891. Vol. 2.

Janet, Pierre. L'Automatisme psychologique: Essai de psychologie expérimentale sur les formes inférieures de l'activité humaine. Paris: Doin, 1889.

----------. L'Etat mental des hystériques: les stigmates mentaux. Paris: Rueff, 1892.

Liébeault, Ambroise Auguste. Du sommeil et des états analogues considérés surtout au point de vue de l'action du moral sur le physique. Paris: Masson, 1866.

----------. Le Sommeil provoqué et les états analogues Paris: Doin, 1889.

Liégeois, E. De la suggestion et du somnambulisme dans leurs rapports avec la jurisprudence et la médecine légale. Paris: Doin, 1889.

Paulhan, Frédéric. L'Activité mentale et les éléments de l'esprit. Paris: Alcan, 1889.

----------. Les Phénomènes affectifs et les lois de leur apparition. Essai de psychologie générale. Paris: Alcan, 1901.

II. Secondary Sources:

Ackenknecht, Ezwin H. A Short History of Psychiatry. 1959. New York, London: Hafner, 1968.

Alexander, Franz and Sheldon Selesnick. History of Psychiatry. London: Allen & Unwin, 1967.

Angenot, Marc. Le Cru et le faisandé: sexe, discours et littérature à la Belle Epoque. Bruxelles: Labor, 1986.

----------. "Le discours social: problématique d'ensemble". Cahiers de recherche sociologique 2, (1984), 19-44.

----------. "Lecture intertextuelle d'un texte de Freud". Poétique 56 (1983), 387-396.

Aron, Jean-Paul ed. Misérable et glorieuse: la femme du XIXe siècle. Paris: Fayard, 1980.

Bakan, David. Sigmund Freud and the Jewish Mystical Tradition. Princeton: Van Nostrand, 1958.

Barthes, Roland. "Introduction à l'analyse structurale des récits". Communications 8 (1966), 1-27.

Bernheimer, Charles and Claire Kahane, eds. In Dora's Case: Freud-Hysteria-Feminism. New York: Columbia U.P., 1985.

Borie, Jean. Mythologies de l'hérédité au XIXe siècle. Paris: Galilée, 1981.

Bourdieu, Pierre. La Distinction. Critique sociale du jugement. Paris: Minuit, 1979.

----------. "L'économie des échanges linguistiques". Langue française 34 (1980), 17-34.

----------. Homo Academicus. Paris: Minuit, 1984.

----------. Le Sens pratique. Paris: Minuit, 1980.

Bourget, Paul. Le Disciple. Paris: Plon, 1901.

Carlson, Eric T. "Medicine: Theory and Practice". Chamberlin and Gilman, 121-144.

Chamberlin, Edward and Sander Gilman, eds. Degeneration: The Dark Side of Progress. New York: Columbia U.P., 1985.

Chertok, Léon and Raymond de Saussure. La Naissance du psychanalyste de Mesmer à Freud. Paris: Payot, 1973.

Cixous, Hélène. Portrait de Dora. Paris: Des Femmes, 1976.

----------. and Catherine Clement. The Newly Born Woman. Manchester: Manchester U.P., 1986.

Didi-Huberman, Georges. Invention de l'hystérie: Charcot et l'iconographie photographique de la Salpêtrière. Paris: Macula, 1982.

Dijkstra, Bram. Idols of Perversity: Fantasies of Feminine Evil in Fin-de-Siècle Culture. New York: Oxford U.P., 1986.

Doerner, Klaus. Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry. Oxford: Blackwell, 1981.

Dubois, Jacques. L'Institution de la littérature. Bruxelles: Labor, 1978.

Duchet, Claude, ed. Sociocritique. Paris: Fernand Nathan, 1979

Ellenberger, Henri. The Discovery of the Unconscious. New York: Basic, 1970.

Forrester, John. Language and the Origins of Psychoanalysis. New York: Columbia U.P., 1980.

Foucault, Michel.. Histoire de la folie. Paris: Gallimard, 1972.

----------. Histoire de la sexualité I. La Volonté de savoir. Paris: Gallimard, 1976.

----------. Power\ Knowledge: Selected Interviews and Other Writings, 1972-1977 . New York: Random House, 1980.

Gallop, Jane. Feminism and Psychoanalysis: The Daughter's Seduction. London: Macmillan, 1982.

Gay, Peter. Freud: A Life For Our Times. London; Melbourne: Dent, 1988.

----------. Freud For Historians. New York; Oxford: Oxford U.P., 1985.

Gilman, Sander. "Freud and the Prostitute: Male Stereotypes of Female Sexuality in Fin-de-Siècle Vienna". Journal of the American Academy of Psychoanalysis 9:3 (1981), 337-373.

Glaser, Catherine. "Clinique et roman de la folie (1860-1910)". Unpublished Phd Thesis, McGill University, 1986.

Glenn, Jules. "Freud's Adolescent Patients: Katharina, Dora and the "Homosexual Woman" ". Kanzer and Glenn, 23-47.

Goldstein, Jan. "The Hysterical Diagnosis and the Politics of Anticlericalism in Late Nineteenth Century France". Journal of Modern History 54 (1982), 209-239.

Henry, Michel. Généalogie de la psychanalyse. Paris: P.U.F., 1985.

Hertz, Neil. "Dora's Secrets, Freud's Techniques". Bernheimer and Kahane, 221-242.

Irigaray, Luce. Speculum de l'autre femme. Paris: Minuit, 1974.

----------. Ce sexe qui n'en est pas un. Paris: Minuit, 1979.

Jaccard, Roland, ed. Histoire de la psychanalyse. 2 vols. Paris: Hachette, 1982.

Jones, Ernest. Life and Work of Sigmund Freud. 3 vols. New York: Basic Books, 1953-1957.

Kanzer, Mark and Jules Glenn, eds. Freud and His Patients. New York: Aronson, 1978.

Kaplan, Marion A. "Anna O. and Bertha Pappenheim: an historical perspective". Rosenbaum and Muroff, 101-117.

Kernberg, Otto. Object Relations Theory and Clinical Psychoanalysis. New York: Aronson, 1976.

Klein, Dennis. Jewish Origins of the Psychoanalytic Movement. New York: Praeger, 1981.

Klein, Melanie. The Selected Melanie Klein. Juliet Mitchell, ed. Harmondsworth: Penguin Books, 1986.

Kofman, Sarah. L'énigme de la femme. La femme dans les textes de Freud. Paris: Galilée, 1980.

Kohon, Gregorio, ed. The British School of Psychoanalysis The Independent Tradition. London: Free Association Books, 1986.

Krohn, Alan. Hysteria: the Elusive Neurosis. New York: International U.P., 1978.

Krüll, Marion. Freud and His Father. New York; London: Norton, 1986.

Lantéri-Laura, Georges. Lecture des perversions. Paris: Masson, 1979.

Mahony, Patrick. Freud As a Writer. New York: International U.P., 1982.

Marcus, Steven. "Freud and Dora: Story, History, Case History". Bernheimer and Kahane, 56-91.

Masson, Jeffrey. The Assault on Truth: Freud's Suppression of the Seduction Theory. New York: Farar, Strauss and Giroux, 1984.

----------. A Dark Science. Women, Sexuality and Psychiatry in the Nineteenth Century. New York: Farar, Strauss and Giroux, 1986.

McCaffrey, Philip. Freud and Dora: the Artful Dream. New Brunswick, New Jersey: Rutgers U.P., 1984.

McGarth, William. The Politics of Hysteria: Freud's Discovery of Psychoanalysis. Ithaca: Cornell U.P., 1986.

Mersky, Harold. The Analysis of Hysteria. London: Baillere Tindal, 1979.

Mitchell, Juliet. Psychoanalysis and Feminism. New York: Pantheon, 1974.

----------. and Jacqueline Rose eds. Feminine Sexuality. Jacques Lacan and the Ecole Freudienne. New York; London: Norton, 1985.

Moi, Toril. "Representation of Patriarchy: Sexuality and Epistemology in Freud's Dora". Bernheimer and Kahane, 181-199.

Pederson-Krag, Geraldine. "The Use of Metaphor in Analytic Thinking. Psychoanalytic Quarterly 25 (1956), 66-71.

Pletch, Carl. "Freud's Case Studies". Partisan Review 49 (1982), 101-118.

Postel, Jacques and Claude Quétel, eds. Nouvelle histoire de la psychiatrie. Paris: Privat, 1983.

Rivière, Joan. "A Character Trait of Freud's". Ruitenbeck, 353-356.

Robert, Marthe. From Oedipus to Moses: Freud's Jewish Identity. London: Routledge and Kegan Paul, 1977.

Roustang, Francois. ...Elle ne le lâche plus. Paris: Minuit, 1980.

Ruitenbeck, Hendrik, ed. Freud As We Knew Him. Detroit: Wayne State U.P., 1973.

Runyan, William McKinley. Life Histories and Psychobiography: Explorations in Theory and Method. New York; Oxford: Oxford U.P., 1982.

Schorske, Carl. Fin-de-Siècle Vienna: Politics and Culture. London: Weidenfeld and Nicolson, 1980.

Shafer, Roy. "Narration in the Psychoanalytic Dialogue". Critical Inquiry 7 (1980), 29-53.

Showalter, Elaine. The Female Malady. Women, Madness and English Culture, 1830-1980. New York: Pantheon, 1985.

Stepan, Nancy. "Biological Degeneration: Races and Proper Places". Chamberlin and Gilman, 97-120.

Stengers, Jean and Anne Van Neck. Histoire d'une grande peur: la masturbation. Bruxelle: Ed. de l'Université, 1984.

Sterrenburg, Lee. "Psychoanalysis and the Iconography of Revolution". Victorian Studies 19 (1975), 241-264.

Trillat, Etienne. "Promenade à travers l'histoire de l'hystérie". Histoire, économie et société 4 (1984), 525-534.

Veith, Ilsa. Hysteria: The History of a Disease. 1965. Chicago; London: Phoenix, 1970.

White, Hayden. The Content of the Forms: Narrative Discourse and Historical Representation. Baltimore: Johns Hopkins U.P., 1987.

----------. "The Value of Narrativity in the Representation of Reality". Critical Inquiry 7 (1980), 5-27.

Whyte, Lancelot. L'Inconscient avant Freud. Paris: Payot, 1971.

Willis, Sharon. "A Symptomatic Narrative". Diacritics 13 (1983), 46-60.

Zanusa, Billa. The Young Freud: the Origins of Psychoanalysis in Late Nineteenth Century Viennese Culture. Oxford: Blackwell, 1986.