

fundamental distinction between one kind of symptom and the other is scarcely to be assumed. If the individual symptoms are so unmistakably dependent on the patient's experience, it remains possible that the typical symptoms may go back to an experience which is in itself typical – common to all human beings. Other features which recur regularly in neuroses may be general reactions which are imposed on the patients by the nature of their pathological change, like the repetitions or doubts in obsessional neurosis. In short, we have no grounds for premature despair; we shall see what remains to be seen.

A quite similar difficulty faces us in the theory of dreams. I could not deal with it in our earlier discussions on dreams. The manifest content of dreams is of the greatest diversity and individual variety, and we have shown in detail what one derives from this content by means of analysis. But alongside of these there are dreams which equally deserve to be called 'typical', which happen in everyone in the same way, dreams with a uniform content, which offer the same difficulties to interpretation. They are dreams of falling, flying, floating, swimming, of being inhibited, of being naked and certain other anxiety-dreams – which lead, in different people, now to this and now to that interpretation, without any light being thrown on their monotony and typical occurrence. But in these dreams too we observe that this common background is enlivened by additions that vary individually; and it is probable that, with a widening of our knowledge, it will be possible, without constraint, to include these dreams too in the understanding of dream-life which we have acquired from other dreams.¹

1. [See the section on 'typical' dreams in *The Interpretation of Dreams* (1900a), Chapter V (D).]

LECTURE 18

FIXATION TO TRAUMAS –
THE UNCONSCIOUS

LADIES AND GENTLEMEN, – In my last lecture I expressed a desire that our work should go forward on the basis not of our doubts but of our discoveries. We have not yet had any discussion of two of the most interesting implications that follow from our two sample analyses.

To take the first of these. Both patients give us an impression of having been 'fixated' to a particular portion of their past, as though they could not manage to free themselves from it and were for that reason alienated from the present and the future. They then remained lodged in their illness in the sort of way in which in earlier days people retreated into a monastery in order to bear the burden there of their ill-fated lives. What had brought this fate upon our first patient was the marriage which she had in real life abandoned. By means of her symptoms she continued to carry on her dealings with her husband. We learnt to understand the voices that pleaded for him, that excused him, that put him on a pedestal and that lamented his loss. Although she was young and desirable to other men, she had taken every precaution, real and imaginary (magical), to remain faithful to him. She did not show herself to strangers and she neglected her personal appearance; furthermore, once she had sat down in a chair she was unable to get out of it quickly,¹ she refused to sign her name, and she could not make any presents, on the ground that no one ought to receive anything from her.

The same effect was produced on the life of our second patient, the young girl, by an erotic attachment to her father which had started during the years before her puberty. The

1. [This symptom is further described and explained in Freud's other account of the case (1907b).]

conclusion she herself drew was that she could not marry as long as she was so ill. We, however, may suspect that she had become so ill in order not to have to marry and in order to remain with her father.

We cannot dismiss the question of why, in what way and for what motive a person can arrive at such a remarkable attitude to life and one that is so inexpedient – assuming that this attitude is a general characteristic of neuroses and not a special peculiarity of these two patients. And in fact it is a general feature, of great practical importance, in every neurosis. Breuer's first hysterical patient [p. 296 above] was similarly fixated to the period when she was nursing her father in a serious illness. In spite of her recovery, in a certain respect she remained cut off from life; she remained healthy and efficient but avoided the normal course of a woman's life.¹ In every one of our patients, analysis shows us that they have been carried back to some particular period of their past by the symptoms of their illness or their consequences. In the majority of cases, indeed, a very early phase of life is chosen for the purpose – a period of their childhood or even, laughable as this may sound, of their existence as an infant at the breast.

The closest analogy to this behaviour of our neurotics is afforded by illnesses which are being produced with special frequency precisely at the present time by the war – what are described as traumatic neuroses. Similar cases, of course, appeared before the war as well, after railway collisions and other alarming accidents involving fatal risks. Traumatic neuroses are not in their essence the same thing as the spontaneous neuroses which we are in the habit of investigating and treating by analysis; nor have we yet succeeded in bringing them into harmony with our views, and I hope I shall be able at some time to explain to you the reason for this limitation.² But in one respect we may insist that there is a complete agreement between them. The traumatic neuroses give a clear indication

1. [Anna O. was never married.]

2. [Traumatic neuroses are mentioned again on pp. 428–9 below.]

that a fixation to the moment of the traumatic accident lies at their root. These patients regularly repeat the traumatic situation in their dreams;¹ where hysteriform attacks occur that admit of an analysis, we find that the attack corresponds to a complete transplanting of the patient into the traumatic situation. It is as though these patients had not finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been dealt with; and we take this view quite seriously. It shows us the way to what we may call an *economic* view of mental processes.² Indeed, the term 'traumatic' has no other sense than an economic one. We apply it to an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances of the manner in which the energy operates.

This analogy is bound to tempt us to describe as traumatic those experiences too to which our neurotic patients seem to be fixated. This would promise to offer us a simple determinant for the onset of neurosis. Neurosis could then be equated with a traumatic illness and would come about owing to inability to deal with an experience whose affective coloring was excessively powerful. And this indeed was actually the first formula in which (in 1893 and 1895) Breuer and I accounted theoretically for our new observations.³ A case like that of the first of the two patients in my last lecture – the young married woman separated from her husband – fits in very well with this view. She had not got over the failure of her marriage and remained attached to that trauma. But our second case – that of the girl with a fixation upon her father – shows us already that the

1. [This particular point played a part in Freud's first discussion of the 'compulsion to repeat' a few years later. See *Beyond the Pleasure Principle* (1920g).]

2. [Freud returns to this later (pp. 401–2).]

3. [See, for instance, the Breuer and Freud 'Preliminary Communication' (1893a), and in particular the last two paragraphs of Section II.]

formula is not sufficiently comprehensive. On the one hand, a little girl's being in love like this with her father is something so common and so frequently surmounted that the term 'traumatic' applied to it would lose all its meaning; and, on the other hand, the patient's history showed us that in the first instance her erotic fixation appeared to have passed off without doing any damage, and it was only several years later that it re-appeared in the symptoms of the obsessional neurosis. Here, then, we foresee complications, a greater wealth of determinants for the onset of illness; but we may also suspect that there is no need to abandon the traumatic line of approach as being erroneous: it must be possible to fit it in and subsume it somewhere else.

Here once more, then, we must break off the course we have started on. For the moment it leads no further and we shall have to learn all kinds of other things before we can find its proper continuation.¹ But on the subject of fixation to a particular phase in the past we may add that such behaviour is far more widespread than neurosis. Every neurosis includes a fixation of that kind, but not every fixation leads to a neurosis, coincides with a neurosis or arises owing to a neurosis. A perfect model of an affective fixation to something that is past is provided by mourning, which actually involves the most complete alienation from the present and the future. But even the judgement of a layman will distinguish sharply between mourning and neurosis. There are, on the other hand, neuroses which may be described as a pathological form of mourning.²

It may happen, too, that a person is brought so completely to a stop by a traumatic event which shatters the foundations of his life that he abandons all interest in the present and future and remains permanently absorbed in mental concentration upon the past. But an unfortunate such as this need not on that

1. [The subject is taken up again in Lecture 22.]

2. [See on this Freud's metapsychological paper 'Mourning and Melancholia' (1917e [1915]). A short reference to melancholia appears in Lecture 26, pp. 477-8 f. below.]

account become a neurotic. We will not attach too much value to this one feature, therefore, in characterizing neurosis, however regularly present and however important it may usually be.

Let us turn now to the second of the discoveries which follow from our analyses; in its case we need not fear having to make a subsequent qualification of our views. I have described to you how our first patient carried out a senseless obsessional action and how she reported an intimate memory from her past life as having some connection with it: and how afterwards I examined the connection between the two and discovered the intention of the obsessional action from its relation to the memory. But there is one factor which I have entirely neglected, though it deserves our fullest attention. However often the patient repeated her obsessional action, she knew nothing of its being derived from the experience she had had. The connection between the two was hidden from her; she could only quite truthfully reply that she did not know what it was that was making her carry out her action. Then suddenly one day, under the influence of the treatment, she succeeded in discovering the connection and reported it to me. But she still knew nothing of the intention with which she was performing the obsessional action - the intention of correcting a distressing portion of the past and of putting her beloved husband in a better light. It took a fairly long time and called for much labour before she understood and admitted to me that such a motive alone could have been the driving force of her obsessional action.

The link with the scene after her unhappy wedding-night and the patient's affectionate motive constituted, taken together, what we have called the 'sense' of the obsessional action. But while she was carrying out the obsessional action this sense had been unknown to her in both directions - both its 'whence' and its 'whither'. [Cf. p. 325 below.] Mental processes had therefore been at work in her and the obsessional action was the effect of them; she had been aware of this effect in a normal mental

fashion, but none of the mental predeterminants of this effect came to the knowledge of her consciousness. She behaved in precisely the same way as a hypnotized subject whom Bernheim had ordered to open an umbrella in the hospital ward five minutes after he woke up. The man carried out his instruction when he was awake, but he could produce no motive for his action. [Cf. p. 132 above.] It is a state of affairs of this sort that we have before our eyes when we speak of the existence of *unconscious mental processes*. We can challenge anyone in the world to give a more correct scientific account of this state of affairs, and if he does we will gladly renounce our hypothesis of unconscious mental processes. Till that happens, however, we will hold fast to the hypothesis; and if someone objects that here the unconscious is nothing real in a scientific sense, is a makeshift, *une façon de parler*, we can only shrug our shoulders resignedly and dismiss what he says as unintelligible. Something not real, which produces effects of such tangible reality as an obsessional action! [Cf. above, p. 296.]

And we meet with what is in essence the same thing in our second patient. She had made a rule that the pillow must not touch the back of the bedstead, and she had to obey this rule though she did not know where it came from, what it meant or to what motives it owed its power. Whether she herself regarded the rule as a matter of indifference, or whether she struggled against it or raged against it or decided to transgress it – none of this made any difference to her carrying it out. It had to be obeyed, and she asked herself vainly why. We must recognize, however, that these symptoms of obsessional neurosis, these ideas and impulses which emerge one knows not whence, which prove so resistant to every influence from an otherwise normal mind, which give the patient himself the impression of being all-powerful guests from an alien world, immortal beings intruding into the turmoil of mortal life – these symptoms offer the plainest indication of there being a special region of the mind, shut off from the rest. They lead, by a path that cannot be missed, to a conviction of the existence of the unconscious in

the mind; and that is precisely why clinical psychiatry, which is acquainted only with a psychology of consciousness, can deal with these symptoms in no other way than by declaring them to be signs of a special sort of degeneracy. Obsessional ideas and obsessional impulses are not, of course, themselves unconscious, any more than the performance of obsessional actions escapes conscious perception. They would not have become symptoms if they had not forced their way into consciousness. But their psychical predeterminants which we infer by means of analysis, the connections into which we insert them by interpretation, are unconscious, at least until we have made them conscious to the patient by the work of analysis.

If, now, you consider further that the state of affairs which we have established in our two cases is confirmed for every symptom of every neurotic illness – that always and everywhere the sense of the symptoms is unknown to the patient and that analysis regularly shows that these symptoms are derivatives of unconscious processes but can, subject to a variety of favourable circumstances, be made conscious – if you consider this, you will understand that in psychoanalysis we cannot do without what is at the same time unconscious and mental, and are accustomed to operate with it as though it were something palpable to the senses. But you will understand as well, perhaps, how incapable of forming a judgement on this question are all those other people, who are only acquainted with the unconscious as a concept, who have never carried out an analysis and have never interpreted dreams or found a sense and intention in neurotic symptoms. To say it for our ends once again: the possibility of giving a sense to neurotic symptoms by analytic interpretation is an unshakeable proof of the existence – or, if you prefer it, of the necessity for the hypothesis – of unconscious mental processes.

But that is not all. Thanks to a second discovery of Breuer's, which seems to me even more significant than the other [p. 296] and which he shared with no one, we learn still more of the connection between neurotic symptoms and the unconscious.

Not only is the sense of the symptoms regularly unconscious, but there is an inseparable relation between this fact of the symptoms being unconscious and the possibility of their existing. You will understand me in a moment. I follow Breuer in asserting that every time we come upon a symptom we can infer that there are certain definite unconscious processes in the patient which contain the sense of the symptom. But it is also necessary for that sense to be unconscious in order that the symptom can come about. Symptoms are never constructed from conscious processes; as soon as the unconscious processes concerned have become conscious, the symptom must disappear. Here you will at once perceive a means of approach to therapy, a way of making symptoms disappear. And in this way Breuer did in fact restore his hysterical patient – that is, freed her from her symptoms; he found a technique for bringing to her consciousness the unconscious processes which contained the sense of the symptoms, and the symptoms disappeared.

This discovery of Breuer's was not the result of speculation but of a fortunate observation made possible by the patient's co-operation.¹ Nor should you torment yourselves with attempts at understanding it by tracing it back to something already known; you should recognize in it a new fundamental fact, by whose help much else will become explicable. Allow me, therefore, to repeat the same thing to you in another way.

The construction of a symptom is a substitute for something else that did not happen. Some particular mental processes should normally have developed to a point at which consciousness received information of them. This, however, did not take place, and instead – out of the interrupted processes, which had been somehow disturbed and were obliged to remain unconscious – the symptom emerged. Thus something in the nature of an exchange has taken place; if this can be reversed the therapy of the neurotic symptoms will have achieved its task.

1. [Breuer's description of the occurrence will be found in his case history of Anna O. in *Studies on Hysteria* (1895d).]

This discovery of Breuer's is still the foundation of psychoanalytic therapy. The thesis that symptoms disappear when we have made their unconscious predeterminants conscious has been confirmed by all subsequent research, although we meet with the strangest and most unexpected complications when we attempt to carry it through in practice. Our therapy works by transforming what is unconscious into what is conscious, and it works only in so far as it is in a position to effect that transformation.

And now I must quickly make a short digression, to avoid the risk of your imagining that this therapeutic work is accomplished too easily. From what I have so far said a neurosis would seem to be the result of a kind of ignorance – a not knowing about mental events that one ought to know of. This would be a close approximation to some well-known Socratic doctrines, according to which even vices are based on ignorance. Now it would as a rule be very easy for a doctor experienced in analysis to guess what mental impulses had remained unconscious in a particular patient. So it ought not to be very difficult, either, for him to restore the patient by communicating his knowledge to him and so remedying his ignorance. One part at least of the symptom's unconscious sense could be easily dealt with in this way, though it is true that the doctor cannot guess much about the other part – the connection between the symptoms and the patient's experiences –, since he himself does not know those experiences but must wait till the patient remembers them and tells them to him. But even for this a substitute can in some instances be found. One can make inquiries about these experiences from the patient's relatives and they will often be able to recognize which of them had a traumatic effect, and they can even sometimes report experiences of which the patient himself knows nothing because they occurred at a very early period of his life. Thus, by combining these two methods, we should have a prospect of relieving the patient of his pathogenic ignorance with little expense of time or trouble.

If only that was how things happened! We came upon dis-

coveries in this connection for which we were at first unprepared. Knowledge is not always the same as knowledge: there are different sorts of knowledge, which are far from equivalent psychologically. 'Il y a fagots et fagots', as Molière has said.¹ The doctor's knowledge is not the same as the patient's and cannot produce the same effects. If the doctor transfers his knowledge to the patient as a piece of information, it has no result. No, it would be wrong to say that. It does not have the result of removing the symptoms, but it has another one – of setting the analysis in motion, of which the first signs are often expressions of denial. The patient knows after this what he did not know before – the sense of his symptom; yet he knows it just as little as he did. Thus we learn that there is more than one kind of ignorance. We shall need to have a somewhat deeper understanding of psychology to show us in what these differences consist.² But our thesis that the symptoms vanish when their sense is known remains true in spite of this. All we have to add is that the knowledge must rest on an internal change in the patient such as can only be brought about by a piece of psychological work with a particular aim. We are faced here by problems which will presently be brought together into the *dynamics* of the construction of symptoms.

I must ask now, Gentlemen, whether what I am saying to you is not too obscure and complicated. Am I not confusing you by so often taking back what I have said or qualifying it – by starting up trains of thought and then dropping them? I should be sorry if that were so. But I have a strong dislike of simplifying things at the expense of truthfulness. I have no objection to your receiving the full impact of the many-sidedness and complexity of our subject; and I think, too, that it does no harm if I tell you more on every point than you can at the moment make use of. I am aware, after all, that every listener or reader puts what is presented to him into shape in his mind, shortens it and simplifies it, and selects from it what

1. [*Le médecin malgré lui*, Act I, Scene 5.]

2. [Freud returns to this question in Lecture 27, p. 488 below.]

he would like to retain. Up to a certain point it is no doubt true that the more there is at one's disposal the more one is left with. Permit me to hope that, in spite of all the trimmings, you have clearly grasped the essential part of what I have told you – about the sense of symptoms, about the unconscious and about the relation between them. No doubt you have also understood that our further efforts will lead in two directions: first towards discovering how people fall ill and how they can come to adopt the neurotic attitude to life – which is a clinical problem; and secondly towards learning how the pathological symptoms develop from the determinants of the neurosis – which remains a problem of mental dynamics. There must moreover be a point somewhere at which the two problems converge.

I will not go into this any further today. But since we still have some time to spare. I should like to direct your attention to another characteristic of our two analyses, which, once again, it will only be possible to appreciate fully later on – to the gaps in the patients' memories, their amnesias. As you have heard [p. 321], the task of a psychoanalytic treatment can be expressed in this formula: its task is to make conscious everything that is pathogenically unconscious. You will perhaps be surprised to learn, then, that this formula can be replaced by another one, its task is to fill up all the gaps in the patient's memory, to remove his amnesias [cf. also p. 237]. This would amount to the same thing. We are thus implying that the amnesias of neurotic patients have an important connection with the origin of their symptoms. If, however, you consider the case of our first analysis you will not find this view of amnesia justified. The patient had *not* forgotten the scene from which her obsessive action was derived; on the contrary, she had a vivid recollection of it; nor did anything else forgotten play a part in the origin of the symptom. The position with our second patient (the girl with the obsessional ceremonial), though less clear, was on the whole analogous. She had not

really forgotten her behaviour in earlier years – the fact that she had insisted on the door between her parents' bedroom and her own being left open and that she had driven her mother out of her place in her parents' bed; she remembered this very plainly, even though with hesitation and unwillingly. The only thing we can consider striking is that the first patient, in carrying out her obsessional action on countless occasions, had never *once* noticed its resemblance to her experience on her wedding-night, and that the memory of it did not occur to her when she was directly asked to look for the motives of her obsessional action. And the same thing applies to the girl, whose ceremonial and its causes were moreover connected with a situation which was identically repeated every evening.¹ In both these cases there was no true amnesia, no missing memory; but a connection had been broken which ought to have led to the reproduction or re-emergence of the memory.

A disturbance of memory of this kind is enough for obsessional neurosis; but the case is different with hysteria. As a rule the latter neurosis is marked by amnesias on a really large scale. In analysing each separate hysterical symptom one is usually led to a whole chain of impressions of events, which, when they recur, are expressly described by the patient as having been till then forgotten. On the one hand, this chain reaches back to the earliest years of life, so that the hysterical amnesia can be recognized as an immediate continuation of the infantile amnesia which, for us normal people, conceals the beginnings of our mental life. [Cf. p. 236 above.] On the other hand, we learn with astonishment that even the patient's most recent experiences can be subject to forgetting, and that the occasions which precipitated the outbreak of the illness or led to its intensification are in particular encroached upon, if not completely swallowed up, by amnesia. It regularly happens that important details have disappeared from the total picture of a recent recollection of this sort or that they have been replaced by falsifications of memory. Indeed it happens with

1. [I.e. her father and mother sleeping together.]

almost equal regularity that certain memories of recent experiences only emerge shortly before the end of an analysis – memories which had been held back till that late moment and had left perceptible gaps in the continuity of the case.

Such restrictions upon the faculty of memory are, as I have said, characteristic of hysteria, in which, indeed, states also arise as symptoms – hysterical attacks – which need leave no trace behind them in the memory. If things are different in obsessional neurosis, you may conclude that what we are dealing with in these amnesias is a psychological characteristic of the change that occurs in hysteria and is not a universal feature of neuroses in general. The importance of this distinction is reduced by the following consideration. We have comprised two things as the 'sense' of a symptom: its 'whence' and its 'whither' or 'what for' [p. 317] – that is, the impressions and experiences from which it arose and the intentions which it serves. Thus the 'whence' of a symptom resolves itself into impressions which came from outside, which were necessarily once conscious and may have since become unconscious through forgetting. The 'whither' of a symptom, its purpose, is invariably, however, an endopsychic process, which may possibly have been conscious at first but may equally well never have been conscious and may have remained in the unconscious from the very start. Thus it is not of great importance whether the amnesia has laid hold on the 'whence' as well – the experiences on which the symptom is supported – as happens in hysteria; it is on the 'whither', the purpose of the symptom, which may have been unconscious from the beginning, that its dependence on the unconscious is founded – and no less firmly in obsessional neurosis than in hysteria.

But in thus emphasizing the unconscious in mental life we have conjured up the most evil spirits of criticism against psychoanalysis. Do not be surprised at this, and do not suppose that the resistance to us rests only on the understandable difficulty of the unconscious or the relative inaccessibility of the

of a conflict which arises over a new method of satisfying the libido [p. 394]. The two forces which have fallen out meet once again in the symptom and are reconciled, as it were, by the compromise of the symptom that has been constructed. It is for that reason, too, that the symptom is so resistant: it is supported from both sides. We also know that one of the two partners to the conflict is the unsatisfied libido which has been repulsed by reality and must now seek for other paths to its satisfaction. If reality remains relentless even though the libido is ready to take another object in place of the one that has been refused to it, then it will finally be compelled to take the path of regression and strive to find satisfaction either in one of the organizations which it has already outgrown or from one of the objects which it has earlier abandoned. The libido is lured into the path of regression by the fixation which it has left behind it at these points in its development.

The path to perversion branches off sharply from that to neurosis. If these regressions rouse no objection from the ego, no neurosis will come about either; and the libido will arrive at some real, even though no longer normal, satisfaction. But if the ego, which has under its control not only consciousness but also the approaches to motor innervation and accordingly to the realization of mental desires, does not agree with these regressions, conflict will follow. The libido is, as it were, cut off and must try to escape in some direction where, in accordance with the requirements of the pleasure principle, it can find a discharge for its cathexis of energy. It must withdraw from the ego. An escape of this kind is offered it by the fixations on the path of its development which it has now entered on regressively — fixations from which the ego had protected itself in the past by regressions. By cathecting these repressed positions as it flows backward, the libido has withdrawn from the ego and its laws, and has at the same time renounced all the education it has acquired under the ego's influence. It was docile so long as satisfaction beckoned to it; but under the double pressure of external and internal frustration it becomes

LECTURE 23

THE PATHS TO THE FORMATION OF SYMPTOMS

LADIES AND GENTLEMEN, — For laymen the symptoms constitute the essence of a disease and its cure consists in the removal of the symptoms. Physicians attach importance to distinguishing the symptoms from the disease and declare that getting rid of the symptoms does not amount to curing the disease. But the only tangible thing left of the disease after the symptoms have been got rid of is the capacity to form new symptoms. For that reason we will for the moment adopt the layman's position and assume that to unravel the symptoms means the same thing as to understand the disease.

Symptoms — and of course we are dealing now with psychical (or psychogenic) symptoms and psychical illness — are acts detrimental, or at least useless, to the subject's life as a whole, often complained of by him as unwelcome and bringing displeasure or suffering to him. The main damage they do resides in the mental expenditure which they themselves involve and in the further expenditure that becomes necessary for fighting against them. Where there is an extensive formation of symptoms, these two sorts of expenditure can result in an extraordinary impoverishment of the subject in regard to the mental energy available to him and so in paralysing him for all the important tasks of life. Since this outcome depends mainly on the *quantity* of the energy which is thus absorbed, you will easily see that 'being ill' is in its essence a practical concept. But if you take up a theoretical point of view and disregard this matter of quantity, you may quite well say that we are *all* ill — that is, neurotic — since the preconditions for the formation of symptoms can also be observed in normal people.

We already know that neurotic symptoms are the outcome