LECTURE 17

THE SENSE OF SYMPTOMS

LADIES AND GENTLEMEN, – In the last lecture I explained to you that clinical psychiatry takes little notice of the outward form or content of individual symptoms, but that psychoanalysis takes matters up at precisely that point and has established in the first place the fact that symptoms have a sense and are related to the patient's experiences. The sense of neurotic symptoms was first discovered by Josef Breuer from his study and successful cure (between 1880 and 1882) of a case of hysteria which has since become famous. It is true that Pierre Janet brought forward the same evidence independently; indeed, the French worker can claim priority of publication, for it was only a decade later (in 1893 and 1895), while he was collaborating with me, that Breuer published his observation. In any case it may seem a matter of some indifference who made the discovery, for, as you know, every discovery is made more than once and none is made all at once. And, apart from this, success does not always go along with merit: America is not named after Columbus. The great psychiatrist Leuret[1] gave it as his opinion, before Breuer and Janet, that even the delusional ideas of the insane would certainly be found to have a sense if only we understood how to translate them. I must admit that for a long time I was prepared to give Janet very great credit for throwing light on neurotic symptoms, because he regarded them as expressions of *idées inconscientes* which dominated the patients. But since then he has expressed himself with exaggerated reserve, as if he wanted to admit that the unconscious had been nothing more to him than a form of words, a makeshift, *une façon de parler* – that he had meant nothing real by it [1913]. Since then I have ceased to understand Janet's writings; but I think he has unnecessarily forfeited much credit.

1. [François Leuret (1797–1851). (Leuret, 1834, 131.)]

Thus neurotic symptoms have a sense, like parapraxes and dreams, and, like them, have a connection with the life of those who produce them. I should now like to make this important discovery plainer to you by a few examples. I can indeed only assert, I cannot prove, that it is always and in every instance so. Anyone who looks for experiences himself, will find convincing evidence. But for certain reasons I shall choose these examples from cases not of hysteria but of another, highly remarkable neurosis which is fundamentally very much akin to it and about which I have a few introductory remarks to make.

This neurosis, known as 'obsessional neurosis', is not so popular as the universally familiar hysteria. It is not, if I may express myself thus, so obtrusively noisy, it behaves more like a private affair of the patient's, it dispenses almost entirely with somatic phenomena, and creates all its symptoms in the mental sphere. Obsessional neurosis and hysteria are the forms of neurotic illness upon the study of which psychoanalysis was first built, and in the treatment of which, too, our therapy celebrates its triumphs. But obsessional neurosis, in which the puzzling leap from the mental to the physical plays no part, has actually, through the efforts of psychoanalysis, become more perspicuous and familiar to us than hysteria, and we have learnt that it displays certain extreme characteristics of the nature of neurosis far more glaringly.

Obsessional neurosis is shown in the patient's being occupied with thoughts in which he is in fact not interested, in his being aware of impulses in himself which appear very strange to him and in his being led to actions the performance of which give him no enjoyment, but which it is quite impossible for him to omit. The thoughts (obsessions) may be senseless in themselves, or merely a matter of indifference to the subject; often they are completely silly, and invariably they are the starting-point of a strenuous mental activity, which exhausts the patient and to which he only surrenders himself most unwillingly. He is obliged against his will to brood and speculate as though it were

a question of his most important vital problems. The impulsions which the patient is aware of in himself may also make a childish and senseless impression; but as a rule they have a content of the most frightful kind, tempting him, for instance, to commit serious crimes, so that he not merely disavows them as alien to himself, but flies from them in horror and protects himself from carrying them out by prohibitions, renunciations and restrictions upon his freedom. At the same time, these impulses never – literally never – force their way through to performance; the outcome lies always in victory for the flight and the precautions. What the patient actually carries out – his so-called obsessional actions – are very harmless and certainly trivial things, for the most part repetitions or ceremonial elaborations of the activities of ordinary life. But these necessary activities (such as going to bed, washing, dressing or going for a walk) become extremely tedious and almost insoluble tasks. In different forms and cases of obsessional neurosis the pathological ideas, impulsions and actions are not combined in equal proportions; it is the rule, rather, that one or other of these factors dominates the picture and gives its name to the illness, but the common element in all these forms is sufficiently unmistakable.

Certainly this is a crazy illness. The most extravagant psychiatric imagination would not, I think, have succeeded in constructing anything like it; and if one did not see it before one every day one would never bring oneself to believe in it. Do not suppose, however, that you will help the patient in the least by calling on him to take a new line, to cease to occupy himself with such foolish thoughts and to do something sensible instead of his childish pranks. He would like to do so himself, for he is completely clear in his head, shares your opinion of his obsessional symptoms and even puts it forward to you spontaneously. Only he cannot help himself. What is carried into action in an obsessional neurosis is sustained by an energy to which we probably know nothing comparable in normal mental life. There is only one thing he can do: he can make displacements, and ex-

changes, he can replace one foolish idea by another somewhat milder, he can proceed from one precaution or prohibition to another, instead of one ceremonial he can perform another. He can displace the obsession but not remove it. The ability to displace any symptom into something far removed from its original conformation is a main characteristic of his illness. Moreover it is a striking fact that in his condition the contradictions (polarities) with which mental life is interlaced [cf. p. 342 f. below] emerge especially sharply differentiated. Alongside of obsessions with a positive and negative content, *doubt* makes itself felt in the intellectual field and little by little it begins to gnaw even at what is usually most certain. The whole position ends up in an ever-increasing degree of indecision, loss of energy and restriction of freedom. At the same time, the obsessional neurotic starts off with a very energetic disposition, he is often extraordinarily self-willed and as a rule he has intellectual gifts above the average. He has usually reached a satisfactorily high level of ethical development; he exhibits over-conscientiousness, and is more than ordinarily correct in his behaviour. You can imagine that no small amount of work is needed before one can make one's way any distance into this contradictory hotch-potch of character-traits and symptoms. And to begin with we aim at nothing whatever else than understanding a few of the symptoms and being able to interpret them.

Perhaps you would like to know in advance, having in mind our earlier talks, what attitude contemporary psychiatry adopts towards the problems of obsessional neurosis. But it is a meagre chapter. Psychiatry gives names to the different obsessions but says nothing further about them. On the other hand it insists that those who suffer from these symptoms are 'degenerates'. This gives small satisfaction; in fact it is a judgement of value – a condemnation instead of an explanation. We are supposed to think that every possible sort of eccentricity may arise in degenerates. Well, it is true that we must regard those who develop such symptoms as somewhat different in their nature

from other people. But we may ask: are they more 'degenerate' than other neurotics – than hysterical patients, for instance, or those who fall ill of psychoses? Once again, the characterization is evidently too general. Indeed, we may doubt whether there is any justification for it at all, when we learn that such symptoms occur too in distinguished people of particularly high capacities, capacities important for the world at large. It is true that, thanks to their own discretion and to the untruthfulness of their biographers, we learn little that is intimate about the great men who are our models; but it may nevertheless happen that one of them, like Émile Zola, may be a fanatic for the truth, and we then learn from him of the many strange obsessional habits to which he was a life-long victim.[1]

Psychiatry has found a way out by speaking of '*dégénérés supérieurs*'. Very nice. But we have found from psychoanalysis that it is possible to get permanently rid of these strange obsessional symptoms, just as of other complaints and just as in people who are not degenerate. I myself have succeeded repeatedly in this.

I shall give you only two examples of the analysis of an obsessional symptom: one an old observation which I cannot find a better one to replace, and another recently met with. I limit myself to this small number, because it is impossible in such reports to avoid being very diffuse and entering into every detail.

A lady, nearly thirty years of age, who suffered from the most severe obsessional manifestations and whom I might perhaps have helped if a malicious chance had not brought my work to nothing – I may be able to tell you more about this later on – performed (among others) the following remarkable obsessional action many times a day. She ran from her room into another neighbouring one, took up a particular position there beside a table that stood in the middle, rang the bell for her housemaid, sent her on some indifferent errand or let her go

1. E. Toulouse, *Émile Zola, enquête médico-psychologique*, Paris, 1896

without one, and then ran back into her own room. This was certainly not a very distressing symptom, but was nevertheless calculated to excite curiosity. The explanation was reached in the most unequivocal and unobjectionable manner, free from any possible contribution on the doctor's part. I cannot see how I could possibly have formed any suspicion of the sense of this obsessional action or could have offered any suggestion on how it was to be interpreted. Whenever I asked the patient 'Why do you do that? What sense has it?' she answered: 'I don't know.' But one day, after I had succeeded in defeating a major, fundamental doubt of hers, she suddenly knew the answer and told me what it was that was connected with the obsessional action. More than ten years before, she had married a man very much older than herself, and on the wedding-night he was impotent. Many times during the night he had come running from his room into hers to try once more, but every time without success. Next morning he had said angrily: 'I should feel ashamed in front of the housemaid when she makes the bed,' took up a bottle of red ink that happened to be in the room and poured its contents over the sheet, but not on the exact place where a stain would have been appropriate. I could not understand at first what this recollection had to do with the obsessional action in question; the only resemblance I could find was in the repeated running from one room into the other, and perhaps also in the entrance of the housemaid. My patient then led me up to the table in the second room and showed me a big stain on the tablecloth. She further explained that she took up her position in relation to the table in such a way that the maid who had been sent for could not fail to see the stain. There could no longer be any doubt of the intimate connection between the scene on her wedding-night and her present obsessional action, though all kinds of other things remained to be learnt.

It was clear, in the first place, that the patient was identifying herself with her husband; she was playing his part by imitating his running from one room into the other. Further, to carry on

the analogy, we must agree that the bed and the sheet were replaced by the table and the tablecloth. This might seem arbitrary, but surely we have not studied dream-symbolism to no purpose. In dreams too we often find a table which has to be interpreted as a bed. Table and bed[1] together stand for marriage, so that the one can easily take the place of the other.

It already seems proved that the obsessional action had a sense; it appears to have been a representation, a repetition, of the significant scene. But we are not obliged to come to a halt here. If we examine the relation between the two more closely, we shall probably obtain information about something that goes further – about the intention of the obsessional action. Its kernel was obviously the summoning of the housemaid, before whose eyes the patient displayed the stain, in contrast to her husband's remark that he would feel ashamed in front of the maid. Thus he, whose part she was playing, did not feel ashamed in front of the maid; accordingly the stain was in the right place. We see, therefore, that she was not simply repeating the scene, she was continuing and at the same time correcting it; she was putting it right. But by this she was also correcting the other thing, which had been so distressing that night and had made the expedient with the red ink necessary – his impotence. So the obsessional action was saying: 'No, it's not true. He had no need to feel ashamed in front of the housemaid; he was not impotent.' It represented this wish, in the manner of a dream, as fulfilled in a present-day action; it served the purpose of making her husband superior to his past mishap.

Everything I could tell you about this woman fits in with this. Or, more correctly speaking, everything else we know about her points the way to this interpretation of what was in itself an unintelligible obsessional action. The woman had been living apart from her husband for years and was struggling with an intention to obtain a legal divorce. But there was no question of her being free of him; she was forced to remain faithful to

1. [The English phrase is 'bed and board', which is itself a translation of a law-Latin term for marriage.]

him; she withdrew from the world so as not to be tempted; she exculpated and magnified his nature in her imagination. Indeed, the deepest secret of her illness was that by means of it she protected her husband from malicious gossip, justified her separation from him and enabled him to lead a comfortable separate life. Thus the analysis of a harmless obsessional action led directly to the inmost core of an illness, but at the same time betrayed to us no small part of the secret of obsessional neurosis in general. I am glad to let you dwell a little on this example because it combines conditions which we could not fairly expect to find in every case. Here the interpretation of the symptom was discovered by the patient herself at a single blow, without any prompting or intervention on the analyst's part; and it resulted from a connection with an event which did not (as is usually the case) belong to a forgotten period of childhood, but which had happened in the patient's adult life and had remained undimmed in her memory. All the objections which criticism is normally in the habit of raising against our interpretation of symptoms fall to the ground in this particular case. We cannot hope always to have such good luck.[1]

And one thing more. Were you not struck by the way in which this unobtrusive obsessional action has led us into the intimacies of the patient's life? A woman cannot have anything much more intimate to tell than the story of her wedding-night. Is it a matter of chance and of no further significance that we have arrived precisely at the intimacies of sexual life? No doubt it might be the result of the choice I have made on this occasion. Do not let us be too hasty in forming our judgement, and let us turn to my second example, which is of quite a different kind – a sample of a very common species, a sleep-ceremonial.

A nineteen-year-old girl, well developed and gifted, was the only child of parents to whom she was superior in education and

1. [Freud had given a shorter account of this case, though with some further details, in his paper on 'Obsessive Actions and Religious Practices' (1907*b*).]

intellectual liveliness. As a child she had been wild and high-spirited, and in the course of the last few years had changed, without any visible cause, into a neurotic. She was very irritable, particularly towards her mother, always dissatisfied and depressed, and inclined to indecisiveness and doubt; finally she admitted that she was no longer able to walk by herself across squares or along comparatively wide streets. We will not concern ourselves much with her complicated illness, which called for at least two diagnoses – agoraphobia and obsessional neurosis – but will dwell only on the fact that she also developed a sleep-ceremonial, with which she tormented her parents. In a certain sense it may be said that every normal person has his sleep-ceremonial or that he has established certain necessary conditions the non-fulfilment of which interferes with his going to sleep; he has imposed certain forms on the transition from the waking to the sleeping state and repeats them in the same manner every evening. But everything that a healthy person requires as a necessary condition for sleep can be understood rationally, and if external circumstances call for a change he will comply easily and without waste of time. A pathological ceremonial, however, is unyielding and insists on being carried through, even at the cost of great sacrifices; it too is screened by having a rational basis and at a superficial glance seems to diverge from the normal only by a certain exaggerated meticulousness. On closer examination, nevertheless, we can see that the screen is insufficient, that the ceremonial comprises some stipulations which go far beyond its rational basis and others which positively run counter to it. Our present patient put forward as a pretext for her nightly precautions that she needed quiet in order to sleep and must exclude every source of noise. With that end in view she did two kinds of things. The big clock in her room was stopped, all the other clocks or watches in the room were removed, and her tiny wrist-watch was not allowed even to be inside her bedside table. Flower-pots and vases were collected on the writing-table so that they might not fall over in the night and break, and disturb her in her

sleep. She was aware that these measures could find only an *ostensible* justification in the rule in favour of quiet: the ticking of the little watch would not have been audible even if it had been left lying on the top of the bedside table, and we have all had experience of the fact that the regular ticking of a pendulum-clock never disturbs sleep but acts, rather, as a soporific. She admitted too that her fear that flower-pots and vases, if they were left in their places, might fall over and break of their own accord lacked all plausibility. In the case of other stipulations made by the ceremonial the need for quiet was dropped as a basis. Indeed, the requirement that the door between her room and her parents' bedroom should stay half-open – the fulfilment of which she ensured by placing various objects in the open doorway – seemed on the contrary to act as a source of disturbing noises. But the most important stipulations related to the bed itself. The pillow at the top end of the bed must not touch the wooden back of the bedstead. The small top-pillow must lie on this large pillow in one specific way only – namely, so as to form a diamond shape. Her head had then to lie exactly along the long diameter of the diamond. The eiderdown (or '*Duchent*' as we call it in Austria[1]) had to be shaken before being laid on the bed so that its bottom end became very thick; afterwards, however, she never failed to even out this accumulation of feathers by pressing them apart.

With your leave I will pass over the remaining, often very trivial, details of the ceremonial; they would teach us nothing new, and would lead us too far afield from our aims. But you must not overlook the fact that all this was not carried out smoothly. There was always an apprehension that things might not have been done properly. Everything must be checked and repeated, doubts assailed first one and then another of the safety measures, and the result was that one or two hours were spent, during which the girl herself could not sleep and would not allow her intimidated parents to sleep either.

The analysis of these torments did not proceed so simply as

1. [The continental quilt, or '*duvet*'.]

that of our earlier patient's obsessional action. I was obliged to give the girl hints and propose interpretations, which were always rejected with a decided 'no' or accepted with contemptuous doubt. But after this first reaction of rejection there followed a time during which she occupied herself with the possibilities put before her, collected associations to them, produced recollections and made connections, until by her own work she had accepted all the interpretations. In proportion as this happened, she relaxed the performance of her obsessional measures, and even before the end of the treatment she had given up the whole ceremonial. You must understand, too, that the work of analysis as we carry it out today quite excludes the systematic treatment of any individual symptom till it has been entirely cleared up. We are, on the contrary, obliged to keep on leaving any particular topic, in the certain expectation of coming back to it again in other connections. The interpretation of her symptoms which I am about to give you is accordingly a synthesis of findings which were arrived at, interrupted by other work, over a period of weeks and months.

Our patient gradually came to learn that it was as symbols of the female genitals that clocks were banished from her equipment for the night. Clocks and watches – though elsewhere we have found other symbolic interpretations for them – have arrived at a genital role owing to their relation to periodic processes and equal intervals of time. A woman may boast that her menstruation behaves with the regularity of clockwork. Our patient's anxiety, however, was directed in particular against being disturbed in her sleep by the ticking of a clock. The ticking of a clock may be compared with the knocking or throbbing in the clitoris during sexual excitement.[1] She had in fact been repeatedly woken from her sleep by this sensation, which had now become distressing to her; and she gave expression to this fear of an erection in the rule that all clocks and watches that were going should be removed from her neighbourhood at

1. [Freud had reported a similar connection in his paper on a case of paranoia (1915*f*).]

night. Flower-pots and vases, like all vessels [p. 189], are also female symbols. Taking precautions against their falling and being broken at night was thus not without its good sense. We know the widespread custom of breaking a vessel or plate at betrothal ceremonies. Each man present gets hold of a fragment, and we may regard this as a sign of his resigning the claims he had upon the bride in virtue of a marriage-regulation dating from before the establishment of monogamy.[1] In connection with this part of her ceremonial the girl produced a recollection and several associations. Once when she was a child she had fallen down while she was carrying a glass or china vase and had cut her finger and bled profusely. When she grew up and came to know the facts about sexual intercourse she formed an anxious idea that on her wedding-night she would not bleed and would thus fail to show that she was a virgin. Her precautions against vases being broken thus meant a repudiation of the whole complex concerned with virginity and bleeding at the first intercourse – a repudiation equally of the fear of bleeding and of the contrary fear of not bleeding. These precautions, which she subsumed under her avoidance of noise, had only a remote connection with it.

She found out the central meaning of her ceremonial one day when she suddenly understood the meaning of the rule that the pillow must not touch the back of the bedstead. The pillow, she said, had always been a woman to her and the upright wooden back a man. Thus she wanted – by magic, we must interpolate – to keep the man and woman apart – that is, to separate her parents from each other, not to allow them to have sexual intercourse. In earlier years, before she had established the ceremonial, she had tried to achieve the same aim in a more direct way. She had simulated fear (or had exploited a tendency to fear which was already present) in order that the connecting doors between her parents' bedroom and the nursery should not be shut. This rule had, indeed, been retained in her present

1. [Cf. a reference to 'group marriage' in *Totem and Taboo* (1912–13); *P.F.L.*, **13**, 59–60.]

ceremonial. In that way she gave herself the opportunity of listening to her parents, but in making use of it she brought on an insomnia which lasted for months. Not satisfied with disturbing her parents by this means, she contrived to be allowed from time to time to sleep in her parents' bed between them. The 'pillow' and the 'wooden back' were thus really unable to come together. Finally, when she was so big that it became physically uncomfortable for her to find room in the bed between her parents, she managed, by a conscious simulation of anxiety, to arrange for her mother to exchange places with her for the night and to leave her own place so that the patient could sleep beside her father. This situation no doubt became the starting-point of phantasies whose after-effect was to be seen in the ceremonial.

If a pillow was a woman, then the shaking of the eiderdown till all the feathers were at the bottom and caused a swelling there had a sense as well. It meant making a woman pregnant; but she never failed to smooth away the pregnancy again, for she had for years been afraid that her parents' intercourse would result in another child and so present her with a competitor. On the other hand, if the big pillow was a woman, the mother, then the small top-pillow could only stand for the daughter. Why did this pillow have to placed diamond-wise and her head precisely along its centre line? It was easy to recall to her that this diamond shape is the inscription scribbled on every wall to represent the open female genitals. If so, she herself was playing the man and replacing the male organ by her head. (Cf. the symbolism of beheading for castrating.)

Wild thoughts, you will say, to be running through an unmarried girl's head. I admit that is so. But you must not forget that I did not make these things but only interpreted them. A sleep-ceremonial like this is a strange thing too, and you will not fail to see how the ceremonial corresponds to the phantasies which are revealed by the interpretation. But I attach more importance to your noticing that what was seen in the ceremonial was a precipitate not of a *single* phantasy but of a number of them, though they had a nodal point somewhere, and, further, that the rules laid down by the ceremonial reproduced the patient's sexual wishes at one point positively and at another negatively – in part they represented them, but in part they served as a defence against them.

More could be made, too, of the analysis of this ceremonial if it could be properly linked up with the patient's other symptoms. But our path does not lead in that direction. You must be content with a hint that the girl was in the grip of an erotic attachment to her father whose beginnings went back to her childhood. Perhaps that was why she behaved in such an unfriendly way to her mother [p. 304]. Nor can we overlook the fact that the analysis of this symptom has once again taken us back to a patient's sexual life. We shall perhaps be less surprised at this the more often we gain an insight into the sense and intention of neurotic symptoms.

I have shown you, then, on the basis of two chosen examples, that neurotic symptoms have a sense, like parapraxes and dreams, and that they have an intimate connection with the patient's experiences. Can I expect you to believe this extremely important thesis on the evidence of two examples? No. But can you require me to go on giving you further examples till you declare yourselves convinced? No, once more. For, in view of the detailed fashion in which I deal with each single case, I should have to devote a five-hour course of lectures to settling this one point in the theory of the neuroses. So I must be content with having given you a trial proof of my assertion and, for the rest, I refer you to the reports given in the literature of the subject – to the classical interpretations of symptoms in Breuer's first case (of hysteria)[1] to the striking light thrown upon the most obscure symptoms of what is known as dementia praecox by C. G. Jung [1907], at a time when he was merely a psychoanalyst and had not yet aspired to be a prophet, and all the other papers that have since then filled our periodicals.

1. [Included in *Studies on Hysteria* (1895*d*), the case of Anna O.]

There has been no lack of investigations precisely on these lines. The analysis, interpretation and translation of neurotic symptoms proved so attractive to psychoanalysts that for a time they neglected the other problems of neurosis.

If any of you undertakes exertions of this kind, he will certainly gain a powerful impression of the wealth of evidential material. But he will also come up against a difficulty. The sense of a symptom lies, as we have found, in some connection with the patient's experience. The more individual is the form of the symptom the more reason we shall have for expecting to be able to establish this connection. The task is then simply to discover, in respect to a senseless idea and a pointless action, the past situation in which the idea was justified and the action served a purpose. The obsessional action of our patient who ran to the table and rang for the housemaid is a perfect model of this kind of symptom. But there are – and they are very frequent – symptoms of quite another character. They must be described as 'typical' symptoms of an illness; they are approximately the same in all cases, individual distinctions disappear in them or at least shrink up to such an extent that it is difficult to bring them into connection with the patients' individual experience and to relate them to particular situations they have experienced. Let us look once more at obsessional neurosis. The sleep-ceremonial of our second patient already has much that is typical about it, though at the same time it has enough individual traits to make what I might call a 'historical' interpretation possible. But all these obsessional patients have a tendency to repeat, to make their performances rhythmical and to keep them isolated from other actions. The majority of them wash too much. Patients who suffer from agoraphobia (topophobia or fear of spaces), which we no longer regard as obsessional neurosis but describe as 'anxiety hysteria', often repeat the same features in their symptoms with wearisome monotony: they are afraid of enclosed spaces, of large open squares, of lengthy roads and streets. They feel protected if they are accompanied by an acquaintance or followed by a vehicle, and so on. On this

similar background, however, different patients nevertheless display their individual requirements – whims, one is inclined to say – which in some cases contradict one another directly. One patient avoids only narrow streets and another only wide ones; one can go out only if there are few people in the street, another only if there are many. In the same way, hysteria, in spite of its wealth of individual traits, has a superfluity of common, typical symptoms, which seem to resist any easy historical derivation. And we must not forget that it is these typical symptoms, indeed, which give us our bearings when we make our diagnosis. Suppose, in a case of hysteria, we have really traced a typical symptom back to an experience or a chain of similar experiences – a case of hysterical vomiting, for instance, to a series of disgusting impressions – then we are at a loss when the analysis in a similar case of vomiting reveals a series of a quite different kind of ostensibly effective experiences. It looks, then, as though for unknown reasons hysterical patients are bound to produce vomiting and as though the historical precipitating causes revealed by analysis were only pretexts which, if they happen to be there, are exploited by this internal necessity.

So we are now faced by the depressing discovery that, though we can give a satisfactory explanation of the individual neurotic symptoms by their connection with experiences, our skill leaves us in the lurch when we come to the far more frequent typical symptoms. Furthermore, I am far from having made you acquainted with all the difficulties that arise when consistently pursuing the historical interpretation of symptoms. Nor do I intend to do so; for, though it is my intention not to gloss things over to you or conceal them, I cannot throw you into perplexity and confusion at the very beginning of our common studies. It is true that we have only made a beginning with our efforts at understanding the significance of symptoms; but we will hold fast to what we have achieved and pursue our way step by step to a mastery of what we have not yet understood. I will try to console you, therefore, with the reflection that any

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* (1900*a*), 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 (1907*b*).]