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I Preliminary Communication (1893)

On The Psychical Mechanism of Hysterical Phenomena: Preliminary Communication from Studies on Hysteria

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I On The Psychical Mechanism of Hysterical Phenomena: Preliminary Communication (1983)[1]

I

A CHANCE observation has led us, over a number of years, to investigate a great variety of different forms and symptoms of hysteria, with a view to discovering their precipitating cause —the event which provoked the first occurrence, often many years earlier, of the phenomenon in question. In the great majority of cases it is not possible to establish the point of origin by a simple interrogation of the patient, however thoroughly it may be carried out. This is in part because what is in question is often some experience which the patient dislikes discussing; but principally because he is genuinely unable to recollect it and often has no suspicion of the causal connection between the precipitating event and the pathological phenomenon. As a rule it is necessary to hypnotize the patient and to arouse his memories under hypnosis of the time at which the symptom made its first appearance; when this has been done, it becomes possible to demonstrate the connection in the clearest and most convincing fashion.

This method of examination has in a large number of cases produced results which seem to be of value alike from a theoretical and a practical point of view.

They are valuable theoretically because they have taught us

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1 As explained above in the preface to the first edition, this first chapter had appeared originally as a separate paper in 1893. It was reprinted not only in the present book, but also in the first of Freud's collected volumes of his shorter works, Sammlung kleiner Schriften zur Neurosenlehre (1906). The following footnote was appended to this latter reprint: 'Also printed as an introduction to *Studies on Hysteria*, **1895**, in which Josef Breuer and I further developed the views expressed here and illustrated them by case histories.']

that external events determine the pathology of hysteria to an extent far greater than is known and recognized. It is of course obvious that in cases of 'traumatic' hysteria what provokes the symptoms is the accident. The causal connection is equally evident in hysterical attacks when it is possible to gather from the patient's utterances that in each attack he is hallucinating the same event which provoked the first one. The situation is more obscure in the case of other phenomena.

Our experiences have shown us, however, that the most various symptoms, which are ostensibly spontaneous and, as one might say, idiopathic products of hysteria, are just as strictly related to the precipitating trauma as the phenomena to which we have just alluded and which exhibit the connection quite clearly. The symptoms which we have been able to trace back to precipitating factors of this sort include neuralgias and anaesthesias of very various kinds, many of which had persisted for years, contractures and paralyses, hysterical attacks and cpileptoid convulsions, which every observer regarded as true epilepsy, *petit mal* and disorders in the nature of *tic*, chronic vomiting and anorexia, carried to the pitch of rejection of all nourishment, various forms of disturbance of vision, constantly recurrent visual hallucinations, etc. The disproportion between the many years' duration of the hysterical symptom and the single occurrence which provoked it is what we are accustomed invariably to find in traumatic neuroses. Quite frequently it is some event in childhood that sets up a more or less severe symptom which persists during the years that follow.

The connection is often so clear that it is quite evident how it was that the precipitating event produced this particular phenomenon rather than any other. In that case the symptom has quite obviously been determined by the precipitating cause. We may take as a very commonplace instance a painful emotion arising during a meal but suppressed at the time, and then producing nausea and vomiting which persists for months in the form of hysterical vomiting. A girl, watching beside a sick-bed in a torment of anxiety, fell into a twilight state and had a terrifying hallucination, while her right arm, which was hanging over the back of her chair, went to sleep; from this there developed a paresis of the same arm accompanied by contracture and anaesthesia. She tried to pray but could find no words; at length she succeeded in repeating a children's

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prayer in English. When subsequently a severe and highly complicated hysteria developed, she could only speak, write and understand English, while her native language remained unintelligible to her for eighteen months.[1]—The mother of a very sick child, which had at last fallen asleep, concentrated her whole will-power on keeping still so as not to waken it. Precisely on account of her intention she made a 'clacking' noise with her tongue. (An instance of 'hysterical counter-will'.) This noise was repeated on a subsequent occasion on which she wished to keep perfectly still; and from it there developed a *tic* which, in the form of a clacking with the tongue, occurred over a period of many years whenever she felt excited.[2]—A highly intelligent man was present while his brother had an ankylosed hip-joint extended under an anaesthetic. At the instant at which the joint gave way with a crack, he felt a violent pain in his own hip-joint, which persisted for nearly a year.—Further instances could be quoted.

In other cases the connection is not so simple. It consists only in what might be called a 'symbolic' relation between the precipitating cause and the pathological phenomenon—a relation such as healthy people form in dreams. For instance, a neuralgia may follow upon mental pain or vomiting upon a feeling of moral disgust. We have studied patients who used to make the most copious use of this sort of symbolization.[3] In still other cases it is not possible to understand at first sight how they can be determined in the manner we have suggested. It is precisely the typical hysterical symptoms which fall into this class, such as hemi-anaesthesia, contraction of the field of vision, epileptiform convulsions, and so on. An explanation of our views on this group must be reserved for a fuller discussion of the subject.

Observations such as these seem to us to establish an analogy between the pathogenesis of common hysteria and that of traumatic neuroses, and to justify an extension of the concept of traumatic hysteria. In traumatic neuroses the operative cause of the illness is not the trifling

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1 [This patient is the subject of the first case history; see below, p. 21 ff]

2 [This patient is the subject of the second case history; sec below, p. **48** ff. These episodes are also treated at some length in 'A Case of Successful Treatment by Hypnotism' **(Freud, 1892-93)**, where the concept of 'hysterical counter-will' is also discussed.]

3 [See the account of Frau Cäcilie M., p. **176** ff. below.]

physical injury but the affect of fright—the psychical trauma. In an analogous manner, our investigations reveal, for many, if not for most, hysterical symptoms, precipitating causes which can only be described as psychical traumas. Any experience which calls up distressing affects—such as those of fright, anxiety, shame or physical pain—may operate as a trauma of this kind; and whether it in fact does so depends naturally enough on the susceptibility of the person affected (as well as on another condition which will be mentioned later). In the case of common hysteria it not infrequently happens that, instead of a single, major trauma, we find a number of partial traumas forming a *group* of provoking causes. These have only been able to exercise a traumatic effect by summation and they belong together in so far as they are in part components of a single story of suffering. There are other cases in which an apparently trivial circumstance combines with the actually operative event or occurs at a time of peculiar susceptibility to stimulation and in this way attains the dignity of a trauma which it would not otherwise have possessed but which thenceforward persists.

But the causal relation between the determining psychical trauma and the hysterical phenomenon is not of a kind implying that the trauma merely acts like an *agent provocateur* in releasing the symptom, which thereafter leads an independent existence. We must presume rather that the psychical trauma —or more precisely the memory of the trauma—acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work; and we find the evidence for this in a highly remarkable phenomenon which at the same time lends an important *practical* interest to our findings.

For we found, to our great surprise at first, that *each individual hysterical symptom immediately and permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing its accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words*. Recollection without affect almost invariably produces no result. The psychical process which originally took place must be repeated as vividly as possible; it must be brought back to its *status nascendi* and then given verbal utterance. Where what we are dealing with are phenomena

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involving stimuli (spasms, neuralgias and hallucinations) these re-appear once again with the fullest intensity and then vanish for ever. Failures of function, such as paralyses and anaesthesias, vanish in the same way, though, of course, without the temporary intensification being discernible.[1]

It is plausible to suppose that it is a question here of unconscious suggestion: the patient expects to be relieved of his sufferings by this procedure, and it is this expectation, and not the verbal utterance, which is the operative factor. This, however, is not so. The first case of this kind that came under observation dates back to the year 1881, that is to say to the 'pre-suggestion' era. A highly complicated case of hysteria was analysed in this way, and the symptoms, which sprang from separate causes, were separately removed. This observation was made possible by spontaneous auto-hypnoses on the part of the patient, and came as a great surprise to the observer.[2]

We may reverse the dictum '*cessante causa cessat effectus*' ['when the cause ceases the effect ceases'] and conclude from these observations that the determining process continues to operate in some way or other for years—not indirectly, through a chain of intermediate causal links, but as a *directly* releasing cause— just as a psychical pain that is remembered in waking consciousness still provokes a lachrymal secretion long after the event. *Hysterics suffer mainly from reminiscences*.[3]

[PEP] This page can be read in German in GESAMMELTE WERKE Vol 1, Page **85**

[1] The possibility of a therapeutic procedure of this kind has been clearly recognized by Delbœuf and Binet, as is shown by the following quotations: 'On s'expliquerait dès lors comment le magnétiseur aide à la guérison. II remet le sujet dans l'état où le mal s'est manifesté et combat par la parole le même mal, mais renaissant.' ['We can now explain how the hypnotist promotes cure. He puts the subject back into the state in which his trouble first appeared and uses words to combat that trouble, as it now makes a fresh emergence.'] (**Delbœuf, 1889**.)—'… peut-être verra-ton qu'en reportant le malade par un artifice mental au moment même où le symptôme a apparu pour la première fois, on rend ce malade plus docile à une suggestion curative.' ['… we shall perhaps find that by taking the patient back by means of a mental artifice to the very moment at which the symptom first appeared, we may make him more susceptible to a therapeutic suggestion.'] (Binet, **1892**, **243**.)—In Janet's interesting study on mental automatism **(1889)**, there is an account of the cure of a hysterical girl by a method analogous to ours.

[2] [The first event of this kind is reported on p. 34.]

[3] In this preliminary communication it is not possible for us to distinguish what is new in it from what has been said by other authors such as Moebius and Strümpell who have held similar views on hysteria to ours. We have found the nearest approach to what we have to say on the theoretical and therapeutic sides of the question in some remarks, published from time to time, by Benedikt. These we shall deal with elsewhere. [See below, p. **210** *n.*]

[Cf. **Andersson, 1962**, **114** *n.* 3.]

II

At first sight it seems extraordinary that events experienced so long ago should continue to operate so intensely—that their recollection should not be liable to the wearing away process to which, after all, we see all our memories succumb. The following considerations may perhaps make this a little more intelligible.

The fading of a memory or the losing of its affect depends on various factors. The most important of these is *whether there has been an energetic reaction to the event that provokes an affect*. By 'reaction' we here understand the whole class of voluntary and involuntary reflexes—from tears to acts of revenge—in which, as experience shows us, the affects are discharged. If this reaction takes place to a sufficient amount a large part of the affect disappears as a result. Linguistic usage bears witness to this fact of daily observation by such phrases as 'to cry oneself out' ['*sich ausweinen*'], and to 'blow off steam' ['*sich austoben*', literally 'to rage oneself out']. If the reaction is suppressed, the affect remains attached to the memory. An injury that has been repaid, even if only in words, is recollected quite differently from one that has had to be accepted. Language recognizes this distinction, too, in its mental and physical consequences; it very characteristically describes an injury that has been suffered in silence as 'a mortification' ['*Kränkung*', lit. 'making ill'].—The injured person's reaction to the trauma only exercises a completely 'cathartic' effect if it is an *adequate* reaction—as, for instance, revenge. But language serves as a substitute for action; by its help, an affect can be 'abreacted' almost as effectively.[1] In other cases speaking is itself the adequate reflex, when, for instance, it is a lamentation or giving utterance to a tormenting secret, e.g. a confession. If there is no such reaction, whether in deeds or words, or in the mildest cases in tears, any recollection of the event retains its affective lone to begin with.

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[1] ['Catharsis' and 'abreaction' made their first published appearance in this passage. Freud had used the term 'abreaction' previously (June 28, 1892), in a letter to Fliess referring to the present paper (**Freud, 1950a**, Letter 9).]

'Abreaction', however, is not the only method of dealing with the situation that is open to a normal person who has experienced a psychical trauma. A memory of such a trauma, even if it has not been abreacted, enters the great complex of associations, it comes alongside other experiences, which may contradict it, and is subjected to rectification by other ideas. After an accident, for instance, the memory of the danger and the (mitigated) repetition of the fright becomes associated with the memory of what happened afterwards—rescue and the consciousness of present safety. Again, a person's memory of a humiliation is corrected by his putting the facts right, by considering his own worth, etc. In this way a normal person is able to bring about the disappearance of the accompanying affect through the process of association.

To this we must add the general effacement of impressions, the fading of memories which we name 'forgetting' and which wears away those ideas in particular that are no longer affectively operative.

Our observations have shown, on the other hand, that the memories which have become the determinants of hysterical phenomena persist for a long time with astonishing freshness and with the whole of their affective colouring. We must, however, mention another remarkable fact, which we shall later be able to turn to account, namely, that these memories, unlike other memories of their past lives, are not at the patients' disposal. On the contrary, *these experiences are completely absent from the patients' memory when they are in a normal psychical state, or are only present in a highly summary form*. Not until they have been questioned under hypnosis do these memories emerge with the undiminished vividness of a recent event.

Thus, for six whole months, one of our patients reproduced under hypnosis with hallucinatory vividness everything that had excited her on the same day of the previous year (during an attack of acute hysteria). A diary kept by her mother without her knowledge proved the completeness of the reproduction [p. 33]. Another patient, partly under hypnosis and partly during spontaneous attacks, re-lived with hallucinatory clarity all the events of a hysterical psychosis which she had passed through ten years earlier and which she had for the most part forgotten till the moment at which it re-emerged. Moreover, certain memories of aetiological importance which dated back

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from fifteen to twenty-five years were found to be astonishingly intact and to possess remarkable sensory force, and when they returned they acted with all the affective strength of new experiences [pp. **178-80**].

This can only be explained on the view that these memories constitute an exception in their relation to all the wearing-away processes which we have discussed above. *It appears, that is to say, that these memories correspond to traumas that have not been sufficiently abreacted*; and if we enter more closely into the reasons which have prevented this, we find at least two sets of conditions under which the reaction to the trauma fails to occur.

In the first group are those cases in which the patients have not reacted to a psychical trauma because the nature of the trauma excluded a reaction, as in the case of the apparently irreparable loss of a loved person or because social circumstances made a reaction impossible or because it was a question of things which the patient wished to forget, and therefore intentionally repressed[1] from his conscious thought and inhibited and suppressed. It is precisely distressing things of this kind

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[1] [This is the first appearance of the term 'repressed' ('*verdrängt*') in what was to be its psychoanalytic sense. The concept, though not the term, had already been used by Breuer and Freud in the joint, posthumously published draft **(1940d)**, which was written in November, 1892, only about a month before the present paper. Freud's own first published use of the word was in the second section of his first paper on defence neurosis **(1895b)**; and it occurs several times in his later contributions to the present volume (e.g. on p. **116**). At this period 'repression' was used as an equivalent to 'defence' ('*Abwehr*'), as is shown, for instance, in the joint Preface to the First Edition (p. **xxix**, above). The word 'defence' does not occur in the 'Preliminary Communication', however. It first appeared in Section I of Freud's first paper on 'The Neuro-Psychoses of Defence' **(1894a)**, and, like 'repression' is freely used by him in the later parts of the *Studies* (e.g. on p. **147**). Breuer uses both terms in his theoretical chapter (e.g. on pp. **214** and **245**).—On some of its earlier appearances the term 'repressed' is accompanied (as here) by the adverb 'intentionally' ('*absichtlich*') or by 'deliberately' ('*willkürlich*'). This is expanded by Freud in one place **(1894a)**, where he states that the act of repression is 'introduced by an effort of will, for which the motive can be assigned'. Thus the word 'intentionally' merely indicates the existence of a motive and carries no implication of *conscious* intention. Indeed, a little later, at the beginning of his second paper on 'The Neuro-Psychoses of Defence' **(1896b)**, Freud explicitly describes the psychical mechanism of defence as 'unconscious'.—Some remarks on die origin of the concept of repression will be found in the Editor's Introduction, p. **xxii**.]

that, under hypnosis, we find are the basis of hysterical phenomena (e.g. hysterical deliria in saints and nuns, continent women and well-brought-up children).

The second group of conditions are determined, not by the content of the memories but by the psychical states in which the patient received the experiences in question. For we find, under hypnosis, among the causes of hysterical symptoms ideas which are not in themselves significant, but whose persistence is due to the fact that they originated during the prevalence of severely paralysing affects, such as fright, or during positively abnormal psychical states, such as the semi-hypnotic twilight state of day-dreaming, auto-hypnoses, and so on. In such cases it is the nature of the states which makes a reaction to the event impossible.

Both kinds of conditions may, of course, be simultaneously present, and this, in fact, often occurs. It is so when a trauma which is operative in itself takes place while a severely paralysing affect prevails or during a modified state of consciousness. But it also seems to be true that in many people a psychical trauma *produces* one of these abnormal states, which, in turn, makes reaction impossible.

Both of these groups of conditions, however, have in common the fact that the psychical traumas which have not been disposed of by reaction cannot be disposed of either by being worked over by means of association. In the first group the patient is determined to forget the distressing experiences and accordingly excludes them so far as possible from association; while in the second group the associative working-over fails to occur because there is no extensive associative connection between the normal state of consciousness and the pathological ones in which the ideas made their appearance. We shall have occasion immediately to enter further into this matter.

It may therefore be said that the ideas which have become pathological have persisted with such freshness and affective strength because they have been denied the normal wearing-away processes by means of abreaction and reproduction in states of uninhibited association.

III

We have stated the conditions which, as our experience shows, are responsible for the development of hysterical phenomena

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that determines whether a hysterical personality manifests itself in attacks, in chronic symptoms or in a mixture of the two.[1]

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It will now be understood how it is that the psychotherapeutic procedure which we have described in these pages has a curative effect. *It brings to an end the operative force of the idea which was not abreacted in the first instance, by allowing its strangulated affect to find a way out through speech; and it subjects it to associative correction by introducing it into normal consciousness (under light hypnosis) or by removing it through the physician's suggestion, as is done in somnambulism accompanied by amnesia.*

In our opinion the therapeutic advantages of this procedure are considerable. It is of course true that we do not cure hysteria in so far as it is a matter of disposition. We can do nothing against the recurrence of hypnoid states. Moreover, during the productive stage of an acute hysteria our procedure cannot prevent the phenomena which have been so laboriously removed from being at once replaced by fresh ones. But once this acute stage is past, any residues which may be left in the form of chronic symptoms or attacks are often removed, and permanently so, by our method, because it is a radical one; in this respect it seems to us far superior in its efficacy to removal through direct suggestion, as it is practised to-day by psychotherapists.

If by uncovering the psychical mechanism of hysterical phenomena we have taken a step forward along the path first traced so successfully by Charcot with his explanation and artificial imitation of hystero-traumatic paralyses, we cannot conceal from ourselves that this has brought us nearer to an understanding only of the *mechanism* of hysterical symptoms and not of the internal causes of hysteria. We have done no more than touch upon the aetiology of hysteria and in fact have been able to throw light only on its acquired forms—on the bearing of accidental factors on the neurosis.

VIENNA, *December* 1892

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[1] [A preliminary draft of this discussion on hysterical attacks, written in November, 1892, was published posthumously **(Breuer and Freud, 1940)**. The subject was dealt with much later by Freud in a paper on hysterical attacks **(1909a)**.]