
The Ghost of Anna O

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Abstract

The origin of the Freudian notion of 'the unconscious' is examined through the history of 'Anna O' (Bertha Pappenheim) and the early mistakes of Josef Breuer and Sigmund Freud are highlighted. The theory of the unconscious, based on the idea of repression and conversion, is rejected as a mistake, caused by diagnostic error and the myth of 'hysteria'. With reference to the developmental theory of Daniel Stern and the brain research of Joseph LeDoux, an alternative view of the unconscious is approached.

1. *The origin of the modern psychoanalytic idea of the unconscious—the Freudian myth—Anna O, Charcot and Hysteria.*

The common idea of the unconscious emerged in the writing of Sigmund Freud and Josef Breuer, in their *Studies in Hysteria*, which appeared in 1895, preceded by a preliminary paper in 1893. It is based on an enormous misconception. The idea rested on Breuer's treatment of a woman known as 'Anna O'. We later knew her, through Ernest Jones' revelation in his Freud biography, as Bertha Pappenheim. Later she emerged as a politically active woman with an intense interest in the lack of preparation for real life in the education of young middle-class women, whom she thought had a responsibility in society far beyond their duties as wives and mothers.

So, I am going to briefly go over some old stuff here. The main sources are not psychotherapists, but historians (Ellenberger, 1970; Masson, 1984; Micale, 1989, 1990a, 1990b, 1993a, 1993b; Micale and Porter, 1994; Sulloway, 1979; Thornton, 1976; Webster, 1995).

As a young woman, Fraülein Pappenheim suffered from a distressing assortment of symptoms that brought her, in the year 1881, to the prominent researcher and neurologist Josef Breuer.¹

1. Breuer had been jointly responsible in 1868 for the discovery of the role played by the vagus nerve in the breathing reflex—still known as the Herring-Breuer reflex, and in 1873 for the discovery of the role played by the by semicircular canals in balance. He was a prominent and brilliant researcher.

While nursing her father who was suffering from a subpleuritic tubercular abscess, she first developed a severe cough, then rigid paralysis of right side extremities, a convergent squint, double vision, a left side occipital headache, disturbances in hearing and sporadic deafness, and lapses of consciousness or, as she called them, “absences”. She would stop in middle of a sentence, repeat her last words, pause and continue, apparently without awareness of what she had done. As her spells of confusion became more severe, she suffered from violent outbursts, throwing cushions, shouting abusively and tearing buttons from her clothes. She had hallucinations and disorders of speech, periodically losing the ability to speak her native German and using English without realising what she was doing.

Breuer diagnosed ‘hysteria’, a frequently reported condition which, it was thought, could mimic almost any physical symptom. After he had stopped seeing her, Breuer discussed the case with Freud during the following year, 1882. Freud later connected this story with what he subsequently learned during his studies with Jean Martin Charcot² at the Salpêtrière in Paris in 1885.

During the 1870s Charcot had become interested in a ward full of women suffering from ‘hystero-epilepsy’³. Symptoms included convulsions, contractures, losses or distortions of neurological functioning for which no organic explanation was then available, chorea-form movements, somnambulisms, and amnesiac fugues.⁴

Recent reviews of Charcot’s case histories confirm our suspicions that these were all neurological symptoms. The majority were suffering from various forms of epilepsy—temporal and frontal lobe lesions (Webster, 1995: 52–102) that did not cause *grand mal* seizures and were impossible to diagnose with the resources available at the time.⁵ Charcot was looking for a hypothetical

2. Charcot was another prominent anatomical researcher. He detected excessive uric acid in cases of gout, recognised the lobular structure of the lung, liver and kidney, introduced routine temperature taking in everyday hospital practice, attempted, correctly, to differentiate multiple sclerosis from Parkinson’s disease and, with another, pieced together almost the entire pathology of MS. He described the changes in the spinal cord characteristic of poliomyelitis. Motor neurone disease is still called Charcot’s disease in Europe. In short, Charcot was an expert on degenerative diseases of the spinal cord.

3. In 1882, with the establishment of an outpatient department at Salpêtrière, he encountered a new group of patients—men who had had accidents or fights. Because the symptoms were similar, Charcot again diagnosed hysteria.

4. Note—the patients involved in Charcot’s much quoted experiments with hypnotism and the transfer of symptoms were patients who regularly experienced convulsive seizures.

5. The lumbar puncture was not invented until 1891, and was not used in anything like the way it is used today; x-rays were only discovered in 1895 and the EEG was invented in 1929 and was not in general use until the 1940s.

lesion in the brain. He was right about that, but wrong about hysteria.⁶

By Charcot's definition, hysteria was caused by trauma, by which he meant *physical* trauma. Breuer developed a technique of associating each of Bertha's symptoms with an *emotionally* traumatic memory, and found that the symptoms eased with talking about the event in question. This he called the 'cathartic method'. It was to become, in the hands of Sigmund Freud, the first method of psychoanalysis, and is still current in psychotherapeutic practice today.

Based on Breuer's experience with Anna O and Charcot's ideas about hysteria, Freud began to formulate his theory of the unconscious. He applied this theory to a series of cases he saw between his return from Paris in the mid 1880s and the publication of *Studies in Hysteria* in 1895. In this work, Breuer and Freud claimed that Anna O had been cured by Breuer's 'cathartic method'. By this time, the theory of the unconscious was, to all intents and purposes, complete.

The Unconscious, Repression and Conversion

This, very briefly, is Freud's theory.

1. An emotional event leads to a quantity of *excitation*.⁷
2. This excitation seeks discharge. However, if the excitation is the consequence of an unacceptable cause, particularly, in late Victorian women, a sexual event, or even a sexual thought,⁸ it cannot be discharged in the normal way. In this case, the excitation is *converted* to another channel and trapped in a body part, creating the symptom.
3. This occurs because something is unacceptable to the ego (a term used by Charcot) and is therefore repressed.

6. The concept of 'hysteria' and its lack of any real clinical foundation, is described in a number of penetrating historical analyses (Astbury 1996; Micale 1989, 1990a, 1990b, 1993; Micale and Porter 1994; Thornton 1976).

7. One cannot read these old accounts without being aware of the current mores among upper middle class society where any kind of 'excitation' might be considered a bad thing.

8. Freud himself commented that these sexual 'frights' were often "astonishingly trivial". "In one of my women patients, it turned out that her neurosis was based on the experience of a boy ... stroking her hand ... and, at another time, pressing his knee against her dress ..." (Webster, 1995: 203)

In October 1895, in a letter from Freud to his friend, Willhelm Fleiss (quoted in Webster, 1995: 200), we have a clear statement of the sexual aetiology of hysteria and the sexual determinants of repression.^{9, 10}

We return to Bertha Pappenheim with the work of the historian Henri Ellenberger, who published, in 1972, an account of his detective work concerning the famous case. Finding a photograph of her in a biography, thought to have been taken in 1882, he obtained the original from the author. The date was clearly visible, but the name and address of the photographer indistinct. Enlisting the aid of the Montreal police, who examined the photograph under special lights, the word “Konstanz” was made out. This led him to a sanatorium in Kreuzlingen, on the shores of Lake Konstanz in Switzerland, where he found case notes pertaining to the treatment of Bertha Pappenheim in 1882—the year after she had seen Breuer.

The Kreuzlingen case notes describe trances, hallucinations, convulsions, severe facial neuralgia, recurring loss of ability to speak German and also, not mentioned in Breuer’s or Freud’s accounts, a severe addiction to morphine, prescribed by Breuer. *Anna O was not cured* as Freud and Breuer claimed 14 years later.

Today, we would not for a moment doubt that Bertha Pappenheim suffered from a neurological disorder. A series of papers, several by neurologists, have variously diagnosed sarcoid, encephalitis, meningitis and temporal lobe epilepsy. The best guess is a localised infection or a lesion in the frontal lobe, just above the sylvan fissure—Broca’s area—associated with language, and with the usual involvement of the adjacent motor cortex that occurs in such cases. Allowing for the difficulty associated with retrospective diagnosis after 100 years, there is still a consensus that she was very ill.

9. The controversy over the ‘Seduction Hypothesis’ (Masson, 1984) arises out of this, but is beyond the scope of this short paper. Note that Webster casts doubt on Masson’s hypothesis that Freud abandoned the seduction theory because he could not tolerate the idea of child sexual abuse. Webster suggests that Freud looked for, but did not find the evidence he needed. Among the evidence he cites is the following, from the Standard Edition, Vol 2: 154, taken from Freud’s notes about the treatment of ‘Elizabeth von R’:

I no longer accepted her declaration that nothing had occurred to her, but assured her that something *must* have occurred to her ... perhaps she thought her idea was not the right one. This, I told her, was not her affair ... Finally I declared that I knew very well that something *had* occurred to her and that she was concealing it from me; but she would never be free from her pains so long as she concealed anything.

10. The emphasis on sex was a movement away from Charcot. It could be claimed that it was also a powerful reason for Freud’s later popularity, particularly in America.

Why did the symptoms ease with Breuer's 'cathartic method'? Because, especially in cases of encephalitis, that is what happens—symptoms come and go. Also, talking with someone who took an interest was undoubtedly a relief for the very sick and distressed Bertha. There was also the morphine, which will take away a lot of symptoms.

As to Freud's cases between 1886 and 1895, there is not space in this short paper to describe each of these. However, in all of these cases of 'hysteria' there was, as we might now suspect, evidence suggesting a physical aetiology, often of a form that contemporary medicine could not diagnose. Because the analyses were lengthy, symptoms did come and go, and Freud might be excused for taking credit for that, though, by Freud's own admission in a series of letters to Fliess in 1896 and 1897, there were no cures. None of them got better with the cathartic method (Webster, 1995: 207).

So much for the misconception—the Freudian myth of the unconscious. I believe, however, that there is a way to conceptualise human unconscious processes that is based on real evidence.

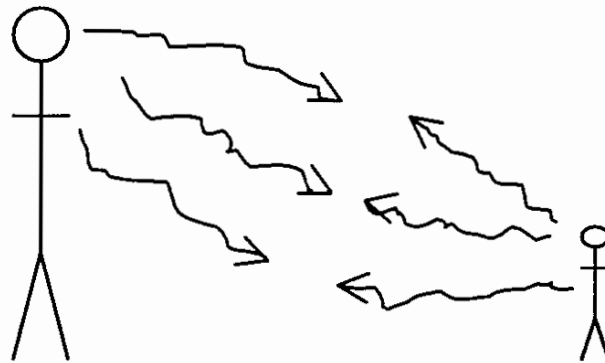
2. *The Real Nature of Human Unconsciousness*

Joseph LeDoux, a psychologist and brain researcher, suggests that the important question is not why something should become unconscious, but why we should be aware of it in the first place (LeDoux, 1996: 42–73). Of all the mechanisms that lead to us becoming aware of a thought or a feeling state, most are and will remain forever beyond our conscious awareness. Consciousness of the self is even more mysterious. We tend to think of 'fragmentation of self' as being abnormal, yet we take for granted thinking, feeling and behaving one way when we are with an intimate partner, another when we meet a colleague, another when we perceive danger, and so on. Fragmentation therefore seems the norm, yet we have an awareness of continuity, of a self that remains constant throughout these changes, a self that transforms only slowly. The person I was thirty years ago seems quite different from the one I am now, yet there is a connection, and the closer we get to the present the greater the similarity. Thus Kim Chernin wrote:

... the sequence of provisional selves through which we pass in the course of our lives, each lived for its season then sloughed off, leaving behind fossil traces (memory), but no immediate, felt sense of the living being who once occupied one's life. ... This sense of fragmentation, this discontinuity, may or may not be a condition peculiar to me. (1995: 10)

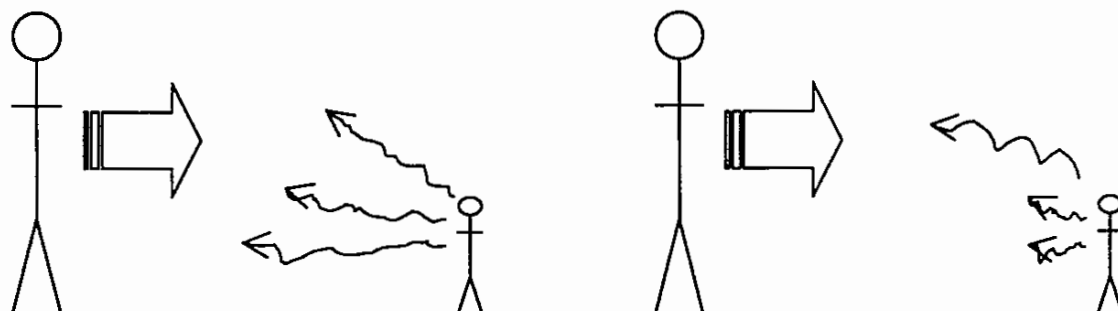
So, rather than think of the presence of a mechanism like *repression*, perhaps we must consider fragmentation, the lack of consciousness of self, and other absences of consciousness as being due to the *absence* rather than the presence of something.

Daniel Stern and his colleagues show us convincingly how we are born giving a fair impression of seeking interaction with others. Far from being autistic, or lost in a symbiosis, we seek contact with the other and are born acting as if we have, at some level, a knowledge of ourselves and of the other. When the other matches us, attunes to us, our responses, our feeling states, felt but *as yet unknown to us*, take form and substance in the relationship. By means of over and over matchings and attunements in the magical world of intersubjectivity we get consensus, affirmation and finally names for the ways we experience the world—in other words, a sense of self, incorporating many emotional states, styles of thinking and behaviours, and a similar sense of the other, and a sense of ourselves *with* the other.

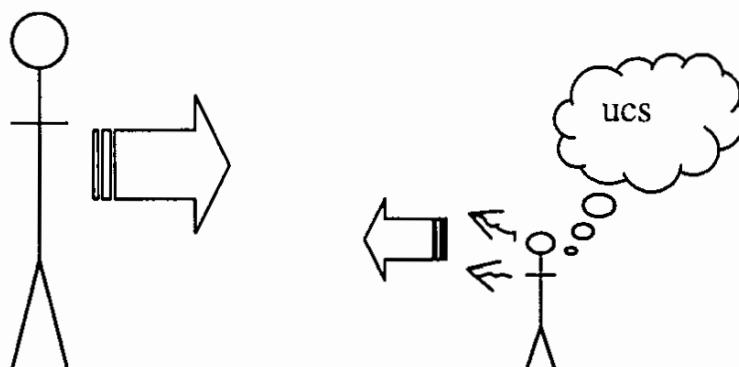


For instance, when a child is sad or upset, perhaps because of some fright, this is taken to the mother and the mother matches the feeling state, with a serious appreciation, approximating the intensity of the feeling and the rhythms of the child's distress. At some point she will name the experience, and later perhaps explain and reassure. The result, over many repetitions, is consciousness of something like, "When I feel like this, it is called 'sad and upset', and it is because I was frightened." In this way, a process that starts as unconscious, merely an emotional state, achieves a conscious form, is named, and a naturally occurring means of expression is affirmed, with modifications according to the way it is expressed and responded to by the other over time. In the future, a variety of stimuli associated with 'fright' will precipitate a similar feeling state and this consciousness and a means of expression, modified *because* of consciousness, will be available.

When this fails, when the attunements are erratic, or skewed, when responses are limited to a few, or when these are punitive, when our experiences and expressions are not affirmed, then their nature is only vaguely felt. With no matching response to assist in naming them, discriminating between them, they remain out of awareness, to some degree at least, unconscious. The way we experience the world and the other remains limited, skewed.



Many possible ways of being are unnamed, unknown, and we experience a generalised region of feeling for which there is no expression. In the example above, if the mother reacts impatiently, or violently, or with disdain or a lack of involvement, so that the intensity and rhythm of the child's expression is not matched, the result will be a confusion, something experienced that has no name, or is perhaps called 'annoying' or 'bad'—something to be avoided in future, then the child's consciousness of the experience will be impoverished. *Something* will be felt, and *some* name will be found for it, but it will not be adequate. At a later time, when the feeling state is precipitated by a stimulus in the environment, neither stimulus nor response will be recognised. If this event occurs often in early life, in response to a number of different kinds of experience—and this is likely, as what I am describing is a *pattern* of interaction—then distressing emotional arousal will be experienced in response to a common array of stimuli.



Thus, we experience an unnamed emotional arousal that occurs often and has a limited means of expression. This is the nature of a symptom. We can understand how it arises from unconscious processes, but without the need for a mysterious mechanism like repression.

We also know that our differentiated sense of self, its continuity, and our ways of being with others can be disrupted by subsequent events—by extremity, loss or trauma. I do not pretend to understand the wonderfully protective mechanism of dissociation, by which means we lose contact with a continuity of self and a physical experience that have become unbearable, but rather than a repressive mechanism, it seems more a disruption, a separation of things that were previously experienced as contiguous. Memory of events and a sense of being, previously indistinguishable, are now quite apart, though usually neither is lost. As Chernin suggests, the old consciousness is remembered, but not identified with. Memory of events depends on many factors, including age, but we know that adult trauma is much more easily remembered than forgotten.

In this way we can conceptualise a real unconscious process, as opposed to the Freudian myth. And this is the mission, the ‘real McCoy’ of psychotherapy. For the antidote is the discovery by attunement, the matching, or *re*-matching, the naming, and the learning of a variety of means of expression for a variety of feeling states.

LeDoux writes:

I conclude with the hypothesis, based on trends in brain evolution, that the struggle between thought and emotion may ultimately be resolved, not simply by the dominance of neocortical cognitions over emotional systems, but by a more harmonious integration of reason and passion in the brain, a development that will allow future humans to better know their true feelings and to use them more effectively in daily life. (1996: 21)

These things are the real stuff, the ‘real McCoy’ of psychotherapy. *The Unconscious* is, well, actually, it’s over.

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