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The Talking Cure

The idea that it is legitimate for one person—a counselor or therapist—to help relieve the mental distress of another person—a client or patient—by talking with them about their problems is pretty much taken for granted today, and psychotherapy has been enshrined in Western culture. While there are a few critics who have critiqued the very legitimacy of psychotherapy in the not-too-distant past (e.g., Masson, 1994), the debate about the therapeutic enterprise has largely died down and psychotherapy has become embedded in contemporary culture. It all began with the case—and the active assistance—of one very exceptional woman, the famous Anna O. The case of Bertha Pappenheim (Anna O. was the pseudonym given to Pappenheim) “ranks as the founding case of psychoanalysis” (Gay, 2006, p. 63). Her centrality in the birth of talk therapy, her exceptional character, and her noteworthy life continues to be of great importance to understanding not only the origins of therapeutic work but also its workings today. We review who she was and why she was so important to the development of Freud’s ideas, before going on to examine her contemporary importance.

The First Client: Bertha Pappenheim

To begin, we must reemphasize that Pappenheim was never Freud’s patient. She was the patient of a senior colleague of Freud’s, Josef Breuer. Breuer treated Pappenheim from 1880 to 1882, and discussed the case with Freud. Freud became intensely interested in it, and he and Breuer spoke many times and at length about Pappenheim’s treatment. Pappenheim’s

case, as described by Breuer, was ultimately published in a book, *Studies on Hysteria*, together with cases that Freud described (Breuer & Freud, 1893–1895/1955).

TREATMENT SUMMARY FOR BERTHA PAPPENHEIM

- Josef Breuer, an older colleague of Freud's, treated her from 1880 to 1882.
- She is considered the founding patient of psychoanalysis, even though she wasn't treated by Freud. Freud first learned of the case in November 1882. He is very curious about it and asks Breuer about it constantly. They have many discussions about Pappenheim's case.
- She called her treatment the "talking cure" and sometimes "chimney-sweeping."
- Her case was published, with Breuer and Freud as the authors, in *Studies in Hysteria*, 1893–1895.
- Pappenheim is described as being extremely bright and talented—but it is her less intelligent brother who is sent to University.
- It was her duty to nurse, day and night, her sick father.
- She develops strange symptoms—a severe thirst (with a corresponding inability to drink water); facial tics; hallucinations; coughs.
- Breuer listens to her, spending over a thousand hours with her during the course of treatment, according to some sources. Unsurprisingly, Pappenheim develops a deep attachment to him, including romantic and erotic feelings.
- Breuer terminates treatment abruptly; Pappenheim's condition deteriorates.
- Pappenheim goes to the Bellevue Clinic in Switzerland, a private sanatorium, and underwent more "treatment"—electrotherapy, massage, rest cure, hydrotherapy.
- Pappenheim gradually improves, likely due to her increased sense of agency and her accomplishments in literary and philanthropic endeavors. She goes on to become an influential social worker and advocate for women's rights.
- Debate continues about the relative merits of Breuer's treatment of Pappenheim. From a common factors perspective, Breuer (1) paid attention to Pappenheim, (2), engaged her in a warm and supportive relationship, and (3), activated hope/placebo factors through his encouragement and support.

What could have interested Freud so much about Pappenheim's case that he kept pestering Breuer to talk about it and to write up a case report on it? Freud's letters to his eventual wife, Martha, describe his excitement discussing cases with Breuer, saying that they ate meals together in their shirt sleeves and had "a lengthy medical conversation on moral insanity and nervous diseases and strange case histories" (E. Freud, 1960/1992, p. 41), one of the more strange being Pappenheim's. For to be sure, Pappenheim's case held many interesting, even exotic aspects. Pappenheim began nursing her father (he had tuberculosis) in July of 1880; she was 21. Over the course of caring for him, she began to develop general weakness, anemia,

Intensive, Ongoing Treatment

and an aversion to eating; eventually she developed a nervous cough, which brought Breuer into the picture for the first time in late November. She took to her bed in December; at this point, symptoms started to proliferate. She developed squints and facial tics, headaches, paralytic, and periods of dissociation and altered consciousness. Breuer began to explore these symptoms and to develop a rudimentary method of working with them. Freud's (1909–1910/1961) summary in *Five Lectures* (which condenses and simplifies the complex treatment history) shows his view of Pappenheim's difficulties and Breuer's stumbling attempts to help her: Patient becomes confused and enters a trance-like state; patient mutters a few key words; doctor deepens trance-like state and repeats the key words; patient relates daydreams centering around a young girl caring for her sick father; doctor brings patient back to normal state; patient expresses relief and is improved; wash, rinse, and repeat.

Pappenheim and Breuer remained locked in this pattern for nearly two years; by some accounts Breuer spent over 1,000 hours with his young patient, identifying symptoms, working to release the emotion that had been pent up, usually as the result of an upsetting event, and moving on to new symptoms when the old ones had been dealt with. Pappenheim developed symptoms that were of great clinical interest, such as hallucinations—imagining that her fingers were snake heads—and unusual disturbances of language—at times being unable to speak her native German and instead speaking and writing in English, Italian, and French. She developed terrible thirsts, but could not bear to touch a glass of water to her lips, and for stretches of time subsisted on fruit. And, in a truly odd twist, in the second year of her treatment she began to tell Breuer that she was actually living both in the present and exactly one year earlier.

It appeared that the symptoms that Pappenheim was displaying could be linked to traumatic scenes that she experienced. In the first place, caring for her dying father was the ongoing traumatic backdrop. It is hard for us, in these days of modern, sanitized medicine and skilled nursing care, to imagine what it must have been like to care for a person who suffered from tuberculosis in the 1800s. Anyone who has read classic novels of the period can call to mind scenes in which a tubercular patient coughs up blood into a basin held by a caregiver. These scenes made up Pappenheim's normal day; she held the basin. So it was no wonder that the stories that she repeated when she was "subject to conditions of 'absence,' of confusion, of delirium, and of alteration of her whole personality" (Freud, 1909–1910/1961, p. 5) began with the story of a girl who was caring for

her sick father; this was the fundamental and ongoing crisis that she was experiencing on a day-to-day basis.

Delving into her symptoms—the thirst, her facial tics, the vision where her “fingers turned into little snakes with death’s heads” (Freud, 1909–1910/1961, p. 11)—seemed to show that they originated in situations in which Pappenheim experienced, but suppressed, significant emotions. The thirst, accompanied by a horror of drinking, appeared to be linked to a scene where she saw the lap-dog of her maid/servant drink out of a glass of water, but suppressed her disgust out of politeness. Freud, quoting from *Studies on Hysteria*, the book he coauthored with Breuer, says that when Breuer was able to induce Pappenheim to repeat this story while she was in hypnotic state, she “asked for something to drink, drank a large quantity of water without any difficulty, and awoke from her hypnosis with the glass at her lips; and thereupon the disturbance vanished, never to return” (Freud, 1909–1910/1961, p. 9).

Freud goes on to discuss the implications suggested by Pappenheim’s case: it seems to suggest that “our hysterical patients suffer from reminiscences” and that “their symptoms are residues” and “symbols of particular (traumatic) experiences” (Freud, 1909–1910/1961, p. 12). It is like, he says, walking in a city and coming across the statues of kings or memorials to great, tragic events that a people have experienced; these statues and memorials commemorate important and history-shaping events. In a similar way, symptoms such as Pappenheim’s seem to serve as reminders of past, tragic events. The difference is that most passersby in a city go about their daily business, walking past the memorials with hardly a backward glance, intent on their day-to-day life; neurotics, by contrast, not only remember these past events, but “they still cling to them emotionally; they cannot get free of the past and for its sake they neglect what is real and immediate” and “this fixation of mental life to pathogenic traumas is one of the most significant and practically important characteristics of neurosis” (Freud, 1909–1910/1961, p. 13).

Furthermore, it would seem that improvement could be brought about by releasing the emotion that had been stirred up, but suppressed, by the initial traumatic event. Her thirst had been caused by a traumatic experience viewing a dog. Her nightmarish visions seemed to originate in the day-mare of treating her sick father. However, her odd experience of living both in the present and exactly 1 year in the past made things more difficult. In the beginning of her treatment, she could simply tell Breuer about her daydreams or her hallucinations and she would be cured. As they entered their second year, Pappenheim had to recall, in exact reverse order, each time the symptom had appeared, a kind of super-duper release of emotions with a chronological twist. To return to the tour metaphor, it was as if Pappenheim not only had to show Breuer the monument, but also had to

Catharsis and Hypnotism

take him back with her on every trip she had made to the monument, until they reached the original time when the monument had been erected.

Returning to Freud’s simplified version for the sake of clarity—Breuer helped Pappenheim recall her symptoms which then brought her relief—we can clearly see the cathartic cure at work, the idea that therapeutic healing can be accessed by reexperiencing and expressing emotion that had been stirred up by a powerful event but suppressed or not fully worked through. Catharsis has a long history in the Western tradition of philosophy and is particularly associated with Aristotle. In Aristotle’s view, catharsis is “a beneficial transformation of painful emotions, through the absorbed contemplation of a powerfully moving artwork, into a key component of a satisfying unified experience” (Halliwell, 2005, p. 44). As a theory, it has been applied to artistic expression—poetry, music, painting, and tragedy—as well as more recently to therapeutic expressions of feelings. As Ellenberger (1970) relates, catharsis had been employed for some time in the early 1800s by mesmerists who, under the cloak of arcane ideas like subtle fluids and electromagnetic attraction, had actually been discovering how to establish a hypnotic relationship by developing rapport with their patients. Interest in mesmerism waxed and waned during the 1800s, but catharsis had returned as a topic of interest in the 1880s; this was due in part, interestingly enough, to a book written by Jacob Bernays, the uncle of Freud’s wife, on Aristotelian catharsis. Thus at the time of Pappenheim’s treatment, “catharsis was one of the most discussed subjects among scholars and was the current topic of conversation in Viennese salons” (Ellenberger, 1970, p. 484).

Yet Freud came to be dissatisfied with the hypnotic technique and the cathartic method that seemed to be suggested by Pappenheim’s case and Breuer’s work with her. He objected for several reasons. The first was a practical one: he could put only a few of his patients into a deeply hypnotic state and found hypnosis to be “a temperamental, and one might almost say, a mystical ally” (Freud, 1909–1910/1961, p. 20). Put simply, he was lousy at it. Now we might respect Freud for his honesty, but this isn’t much of a reason in and of itself. There are other, better reasons that he abandoned hypnosis.

The Psychoanalytic Cure

To understand these reasons, we need to briefly consider what Freud eventually proposed putting in place of hypnosis and the cathartic cure. His proposal constitutes the heart of the psychoanalytic cure—what

Listening to Pappenheim With Sympathy and Interest

These are important theoretical developments that we return to in the course of our discussion, but let us return to our focus on Pappenheim's case. Her clinical manifestations were naturally of interest to Freud, yet he had seen these kinds of florid symptoms before. There certainly were intriguing theoretical issues suggested by Breuer and Pappenheim's cathartic cure, but these bore fruit later. What really interested Freud at the time was his insight that something new was going on, and that insight, stated in the simplest of terms, was that *Breuer was listening to Pappenheim*. Instead of the common approach at the time, which was to dismiss anything said by patients that exhibited psychological distress as hysterical nonsense, Breuer "gave her both sympathy and interest, even though, to begin with, he did not know how to help her" (Freud, 1909–1910/1961, p. 7). This sympathy and interest, this "benevolent scrutiny" (p. 7) was striking to Freud and in *Five Lectures* and elsewhere (e.g., *An Autobiographical Study*) he returns to it with a palpable sense of wonder, despite the intervening years.

This point bears emphasizing, because it is easy, in discussing Freud, to become lost in the critiques and countercritiques that attend his ideas and famous cases such as Pappenheim's. These perspectives add richness, but the primary importance of the case of Anna O., both for Freud and for contemporary practice, is that it pointed out a different way of dealing with mental illness, a way that focused on listening to a person in the context of a warm, empathic relationship. Freud was struck by Breuer's report of this exceptional woman, "bubbling over with intellectual vitality" who possessed a "powerful intellect" and "sympathetic kindness" (Breuer & Freud, 1893–1895/1955, p. 21) and by Breuer's obvious care and concern for a "hysterical" woman, a kind of attitude that went against the grain of treatment at the time.

Pappenheim's Contemporary Importance

We haven't just learned about a troubled person in some far-off time and place; we have learned about a person who has the characteristics of clients that one meets today. She had a number of complex psychosocial stressors. She was struggling with unhealthy societal restrictions, just as many—if not all—of the clients we see today struggle with unhealthy societal constraints, unhelpful messages about sex and gender, race and ethnicity, youth and age, spirituality, and so on. Some of these restrictions are blatant and overt: sexism, racism, and other problems that deny people equitable access to resources and that have severe impacts on their psychological functioning.

psychoanalysis tries to do and how it tries to accomplish it, and as such is referred to a number of times in the text. Instead of trying to discharge emotion from a past event using a tool such as hypnosis, he proposed to "uncover repressions and replace them by acts of judgment which might result either in accepting or in the condemning of what had formerly been repudiated. I showed my recognition of the new situation by no longer calling my method of investigation and treatment *catharsis* but *psych-analysis*" (Freud, 1925/1959, p. 30).

ONE-SENTENCE SUMMARY OF FREUD'S AIM IN PSYCHOANALYTIC TREATMENT

The aim of psychoanalysis is to bring unconscious material to conscious awareness and to strengthen the Ego so that it can make rational judgments about this material.

Later, we consider in greater detail what he meant by repression, and what might constitute the kinds of things that a person might wish to repudiate, but for now, let us understand Freud's rejection of hypnosis in the following way: hypnosis was difficult to accomplish, and, as he found out, not necessary. More important, putting people into hypnotic states robbed them of conscious, rational awareness of what was troubling them. They might reveal their deepest anxieties and fears while under hypnosis—they might, as it were, show you around the village square of their mind and show you the sights—but when they woke from a hypnotic state, they would have no memory of the tour they had just conducted.

Instead, Freud developed a method of getting at those underlying issues, which was psychoanalysis itself—making available to our conscious awareness those wishes and urges that we might demonstrate while in a hypnotic state such as Pappenheim experienced so that we can make rational judgments about them—to say no to them, to sublimate them (turn these unacceptable wishes and urges into something productive), or to say yes to them and indulge in them (which is the point of the "horse of Schilda" story in *Five Lectures*). Thus in Pappenheim's case, the critique made from a psychoanalytic perspective is that the cathartic cure that Breuer employed did not help her come to rational awareness of the difficulties that were besetting her and was thus unable to help her make better (i.e., conscious and rational) decisions about them.

in my own experience working in community mental health clinics, many of the clients were so dreadfully lacking in basic resources—jobs, money, education—that it could seem at times that the work that I was doing was a mere Band-Aid. Rappenheim came from a wealthy family, but she was denied access to education and career due to her gender; clients who are seen in contemporary clinical practice may have more equal access to these goods regarding gender, but large barriers remain for large segments of our population due to other factors.

Additionally, Rappenheim displayed a complex clinical picture of possible organic illness and possible iatrogenic (treatment-caused) factors. While modern medicine might have been able to rule out issues such as a seizure disorder, it is also quite possible that it might have failed to add much to the conversation. Suffice it to say that were Rappenheim to be seen today, there may not have been any additional insight into how to describe the complex interplay between her biological and psychological statuses.

She also appeared to have a history of poor medication management and possibly inept psychotherapy. De Paula Ramos (2003) forcefully makes the case that many of Rappenheim's symptoms can be explained by the fact that Breuer prescribed morphine and chloral hydrate at high levels; Breuer periodically tried to wean her off these medications but failed and had to continue prescribing them, which created a rollercoaster of withdrawal and toxicity that most probably contributed to her symptoms.

Quick Clinical Vignette

Enough Medications to Choke a Horse

Rappenheim's case reminds me of a client of mine, Grace, who I cared for in the context of a residential treatment program. As the director of the program, I occasionally took over direct care duties when my staff was unavailable, and when I would administer Grace's medications to her, I would feel queasy at the size, variety, and quantity of the pills that she took—some appeared large enough to literally choke a horse. She took the medications for mood and for her persistent florid symptoms of psychosis—as well as medications to combat the significant side effects from her medications, side effects that included tardive dyskinesia, which can manifest as “abnormal twisting and rocking movements of the body and restless...movements of the feet” (Moncrieff, 2013, p. 77). Grace had other serious medical issues, many of which could have been caused by and/or exacerbated by her many medications, issues such as weight gain, high blood pressure, diabetes, and heart disease.

It was, unfortunately, extremely hard to assess whether her medications in fact helped her—when her psychiatrist changed her medications, Grace would appear to improve, but after a week or two, the symptoms would return with a vengeance. Grace was one of the most heroic people I've ever met. Even when

she was in the midst of the most severe psychotic episodes, she would pause and ask me how my daughter was doing. When the staff would sit with her and try to get her to draw (an activity that she enjoyed and that seemed to calm her), Grace would ask me if I thought my daughter would like it. Grace died in her early fifties from heart failure; her life was both tragically foreshortened (those diagnosed with schizophrenia die on an average of 15 to 20 years earlier than the general population [Tandon, Nasrallah, & Keshavan, 2009]) as well as marred regarding her quality of life. The takeaway is that, like in Rappenheim's case, psychotropic medications continue to be potentially helpful and potentially harmful. While mood may be regulated and psychotic symptoms may be dampened, there are significant side effects that can seriously impact a client's quality of life.

Was Rappenheim also the victim of poor counseling? If so, she wasn't the last one to have suffered from this malady. We clinicians hear stories of botched treatment, misguided interventions, and ethical misconduct. One client I saw told me that she had slept with every counselor that she ever had prior to me; I was able to help her break that streak, but the damage that she had sustained from her prior (mis)treatment was appalling. Clinicians, when they are honest with themselves, admit their own treatment blunders (though for most of us, thankfully, they are not such blatant violations of ethical codes). We have been inattentive, said hurtful things without meaning to, and been blindsided by our own biases and prejudices. We have no indications that Breuer acted unethically, but his treatment of her was a haphazard, do-it-yourself kind of affair, and though Rappenheim seemed to get immediate relief from seeing Breuer, the question remains whether his treatment was ultimately therapeutic for her. Rappenheim, with all these variables in play—psychosocial stressors, societal barriers, and biological and treatment questions—was hard to figure out, just like so many of the clients we see in clinical practice.

We learn something essential—the bedrock of psychoanalysis and all subsequent counseling and psychotherapy—in this inquiry into how to help another human being in clinical practice. We must ask, “Who is this person?” and “What is going on with her?” before we can hope to answer, “How can I help her?” What is noteworthy about Rappenheim's case is that many have tried to figure her out. Breuer tried. Freud tried. Many since have tried, albeit vicariously—one edited collection is plainly titled, *Anna O.: Fourteen Contemporary Interpretations* (Rosenbaum & Muroff, 1984), and *Psychoanalytic Approaches for Counselors* is yet another attempt. It is no easy task; we must listen with sympathy and interest and tact, the quality that Freud prized, paying special attention to her admirable qualities of intellect and character even though, to begin with, we do not know how to help her.

Breuer did try to understand Pappenheim's situation, and in many ways he succeeded in his attempt. The problem is that he didn't credit the importance of what he saw with his own eyes. If one closely reads the first two pages of *Studies on Hysteria* (along with the original case history Breuer wrote on Pappenheim's admission to Bellevue in 1882; see Hirschmuller, 1989) one can find evidence that Breuer knew, at least at the level of description, what was "really going on" with Pappenheim, while simultaneously ignoring the importance of what he was seeing. He says, very directly, that this young woman, "bubbling over with intellectual vitality," was denied outlets for this vitality and instead "led an extremely monotonous existence in her puritanically minded family" (Breuer & Freud, 1893-1895/1955, p. 22). She possessed a "powerful intellect which would have been capable of digesting solid mental pabulum and which stood in need of it though without receiving it after she had left school" (p. 21). She had "great poetic and imaginative gifts, which were under the control of a sharp and critical common sense" (p. 21). He says that she is not religious, yet since she is "the daughter of very orthodox, religious Jews, she has been accustomed to carry out all instructions meticulously for her father's sake" and that "in her life, religion serves only as an object of silent struggles and silent opposition" (Hirschmuller, 1989, p. 277). And, critically, he says that

she embellished her life in a manner which probably influenced her decisively in the direction of her illness, by indulging in systematic day-dreaming, which she described as her "private theatre." While everyone thought she was attending, she was living through fairy tales in her imagination; but she was always on the spot when she was spoken to, so that no one was aware of it. She pursued this activity almost continuously while she was engaged on her household duties, which she discharged unexceptionably. (p. 22)

My reading of Pappenheim's case is that she must have experienced great frustration with Breuer. After all, here was a doctor who took her seriously, who really seemed to understand her situation, who could describe it in such vivid and commonsense terms. He saw that she lived a "very monotonous life, limited entirely to her family" and that she sought "compensation in passionate fondness for her father who spoils her, and by reveling in her highly developed gifts of poetry and fantasy" (Hirschmuller, 1989, p. 277). He saw how smart she was, how passionate, how creative; he also saw how few outlets she had. He saw that she found no solace in the Orthodox Judaism of her father's home, but experienced it as oppressive, which may be unsurprising, as one commentator has

Empathic Listening and Interpretation

And yet this very same doctor, who seemed to understand her so well, most probably did not ask her those questions that would have shown that he was "getting" her, questions like, *So how does it make you feel that you, who are so talented, can't go to university, while your brother can? Oh, the modern clinician moans, to be able to ask her, How do you feel about having to live fairy tales in your imagination while you do housework? To be able to ask, What do you mean by the words "private theatre"?* To ask, *How does it feel to be on the spot? To know that no one else had been aware that, though you were on the spot, your mind was elsewhere?* It must have been excruciating for Pappenheim—passionate, articulate, and verbal—to lack the opportunity to directly express these feelings.

If this sounds traditionally Rogerian rather than traditionally Freudian, it should. A dialectic is often found in counseling programs between Rogers, the empathic listener, and Freud (in this case, Freud/Breuer), the nonempathic interpreter. The idea is that Rogers, the good listener, corrected Freud, the poor listener. Now there is a certain utility in making this generalization, but it is overstated. As we have seen, *the genesis of psychoanalysis emerged not from interpretation, but by listening*. In this earliest phase of prepsychoanalysis, there was little interpretation going on, other than the bare-bones idea of the cathartic cure. Certainly interpretation does appear, in ever-increasing measures, as Freud continues to talk about what happened between Breuer and Pappenheim. Certainly interpretation is a hallmark of Freudian technique, and as such has been vilified as heavy-handed, sexist, clueless, and so on. Certainly Rogers wished to be understood as a kind of anti-Freud. Yet therapy oscillates between listening and interpreting (it can also be seen as the dialectic between acceptance and change, see Linehan, 1993). It is useful for counselors-in-training, who are given a heavy dose of Rogers in courses that teach microcounseling skills, to recognize that Freud, and Breuer before him, listened closely to his patients (the corollary, that Rogers continually interpreted his clients, is a point that cannot be examined at length in this book; suffice it to say that this debate, often happening under the guise of how nondirective a person-centered counselor can be, at the very least admits the use of empathic interpretations [see Kahn, 1999]).

After reading about Pappenheim's situation, the reader might feel a little discouraged—how could a woman with so many things going against her find success? Her case reminds me of Helen, who was a client I helped care for in a residential setting. Helen would yell at my staff in person and on the telephone, saying particularly nasty and vicious things. She would appear to ask for help, but then reject it when it was offered. Her moods fluctuated wildly, and she often threatened suicide; there was a safety contract in place, but Helen was masterful at evading attempts to help her.

Since Helen was in Dialectical Behavior Therapy (Linehan, 1993) treatment, which is a skills- and mindfulness-based approach aimed at increasing the regulation of emotions, I worked with staff to refocus their efforts on working with Helen to use her skills in managing her distress—as well as protecting themselves. Helen, who had been repeatedly victimized throughout her life (starting at a young age when she had been sexually offered by her mother to men), was adept at finding and exploiting the softest part of a person's defenses. I continually emphasized to my staff that they should only disclose information that they felt could not be used against them; I modeled this in my interactions with Helen. Helen would ask me about my daughter, and I would tease her and say that she knew that was the one thing I would never talk with her about and she should just give up trying, because I could be just as wonderfully stubborn as she was.

Over the course of 3 years, I became quite frankly pessimistic about Helen's future—it didn't seem that she was getting any more able to commit to her life, much less to enjoy it. She went through some major operations and her health was poor. She was focused on moving to another town and another program within our organization, and I wondered how that would help. I eventually took another position and so ended my involvement with her.

Nonetheless, several years later, I was walking down the street in the town where Helen had wanted to move and heard my name being called. I turned to find an attractively dressed, smiling middle-aged woman looking at me expectantly; I had no clue who it was until she said, "It's me, dummy, Helen!"

I was wonderfully astonished at how great she looked and how happy she acted. She told me that she was enjoying living in town, and we chatted amiably for 10 minutes or so and took our leave of one another with undisguised affection. The takeaway is that, like Bertha Pappenheim and Helen, your clients will frequently amaze you by their heroic transformations despite the great odds stacked against them.

Pappenheim's Amazing Transformation

It took a while for Pappenheim to break free as well. This exceptional woman, who herself came up with one of the best and most pithy descriptions of the therapeutic process, describing it in English as the "talking cure," endured

Moreover, it is thus important to note that the prototypical therapy case of Bertha Pappenheim contained both successes in accurate listening—witness Breuer and Freud's eloquent testimony to who Pappenheim was and what she was up against—as well as failures—Breuer's failure to follow up on what Pappenheim was telling him, and Freud's increasing layering of theory that came to obscure the true novelty of the situation. Notably, it contains failures on the part of the clinician to accurately understand data that he himself generated. Breuer's own case notes contain material that he did not follow up on in any practical way; Freud followed this up by neglecting to credit the monumental importance not just of traumatic events, thoughts, and wishes, but of the historical situation that women like Pappenheim were embedded in. This mistake, I believe, continues to be committed with a fair degree of frequency in clinical practice. Sometimes the issue is not a lack of information, it is a surfeit. I have seen clients who had two or three thick binders of treatment history (translation for the modern era: gigabytes rather than the usual kilobytes of data); it was hard to avoid the thought that there had been listening failures, failures that

The Heroic Client

Duncan and Miller (2000) have described the idea of the "heroic client"; this is not some sentimental notion that we should be nice to clients and say impressive things about them. It is the fact that research supports the very commonsense claim that the single most important thing about the therapeutic encounter is the client. It should come as no surprise that the field of counseling and psychotherapy emerged from listening to a very exceptional person. It is no surprise, but the field has been a long time in coming to that realization. Since Freud, and, some would say, due in part to him, the focus has been on the counselor, on theory, and on technique. Yet Freud is not wholly to blame: even Rogers, in the various iterations of his theory—nondirective, client-centered, person-centered—paid a lot of attention to the ideal attributes of the clinician even as his putative emphasis was on the client. Freud did allow his obsession with theory to overgrow the therapeutic couch, and it can take quite a bit of hacking and pruning to find and set free the person underneath (a florid metaphor, perhaps, but this is after all a text about Freud). In general, the obsession with theory and with the counselor have been constraints that the field has only recently begun to break free from.

a rocky road to recovery. Breuer ended treatment with her in 1882, and the end of their relationship is subject to conflicting reports. Breuer reports that it was Pappenheim's wish to end it, and that afterward she traveled for a while, and that "it was a considerable time before she regained her mental balance entirely. Since then she has enjoyed complete health" (Breuer & Freud, 1893-1895/1955, p. 41).

We do know from other sources that Pappenheim's struggle to regain complete health lasted for years after her treatment with Breuer, and included stays in the Bellevue sanatorium in Kreuzlingen, Switzerland. A prime difficulty was the aforementioned fact that she was thoroughly addicted to chloral hydrate and morphine and had to be weaned from these drugs, which again has led one modern commentator to diagnose Pappenheim as suffering from dependence on these drugs, with accompanying mood disorders (De Paul Ramos, 2003). She continued to have difficulties; one of the sources we have about Pappenheim comes from Freud's wife, Martha, who kept in contact with Pappenheim throughout the 1880s and into the 1890s. As late as 1887, "Martha wrote to her mother that Bertha was well during the day but still suffered from hallucinatory states in the evening" (Appignanesi & Forrester, 1992, p. 81).

But slowly she improved. She improved so much that her subsequent life is nothing short of astonishing. Pappenheim went on to have an illustrious career as a social reformer and feminist. In 1888, she moved to Frankfurt and engaged in literary activities, publishing a book of short stories in 1890. She began a career in journalism, and she started to reclaim a sense of her Jewish identity. She established the Jewish Women's Union in 1904; in this role, and as a journalist and the founder of a home for at-risk girls and illegitimate children, she crusaded against the sexual and economic exploitation of women (Appignanesi & Forrester, 1992). She became at the end of her life "a deeply religious, strict, and authoritarian person, utterly selfless and devoted to her task, who had retained from her Viennese education a lively sense of humor, a taste for good food, and the love of beauty" (Ellenberger, 1970, p. 481). She died in 1936, and came to be a revered figure, commemorated in 1954 by the West German government with a postage stamp that bore her image. If the field of counseling and psychotherapy commissioned medals for Heroic Clients, surely Bertha Pappenheim would have been the first recipient.

Primum Non Nocere—Above All, Do No Harm

It might seem odd to counselors-in-training that we are devoting such space to such a problematic case. Wouldn't it be better to talk about a successful

case rather than to one in which therapeutic treatment produced "neither catharsis nor cure" (Ellenberger, 1970, p. 279)? But it is actually entirely correct to do so, both historically and theoretically. Historically, the claim can plausibly be made that Pappenheim's case is not just the founding case of psychoanalysis, it is the founding case of modern counseling and psychotherapy. Simply put, we must study her case because it was the first one that is recognizably a counseling endeavor.

Theoretically, it is important to begin with her case as well. Our field is one in which great harm can be done, and as such we should remember the dictum, *Primum non nocere*, which means First (or Above all) do no harm. *Primum non nocere* has a long if somewhat obscure history (Smith, 2005), and it deserves central billing in any introduction to counseling and psychotherapy. While it must be balanced with other goods such as beneficence, autonomy, fidelity, and justice, and is only one part of a mature model of ethical decision making (Kitchener, 2000), doing no harm, which is termed *nonmaleficence*, is nonetheless a good place to start and to periodically return to. It is difficult to say if Pappenheim's treatment was the cocoon from whence came her colorful career (Appignanesi & Forrester, 1992); what is easier to pick out is that potential and actual harm came from those caregivers who were trying to help her. This is where a book like Masson's (1992) *Against Therapy* come into play, as well as Szasz's (1960) critique of the myth of mental illness, along with other critiques of such professions as social work (Margolin, 1997). They remind us that well-intentioned therapeutic interventions can cause great damage—they *have* caused great damage. It may have become a truism (another bland affirmation, perhaps) to point to the fact that the DSM still listed homosexuality as a diagnosable mental illness until 1973 (which it replaced with Sexual Orientation Disturbance [American Psychiatric Association, 1973], see Bayer, 1981), but it is a truism that should be repeated to every counselor-in-training.

Bertha Pappenheim's story deserves its many retellings. It has a happy ending, but that should not make any of us too comfortable or proud. The merit is hers, not Breuer's or Freud's, certainly not commentators like this one that come so long after the fact. She does us the favor, like all our clients do, of teaching us about what the talking cure does and does not consist of—first and foremost, it consists of listening very closely to a heroic client. This rhetoric—that the client is the teacher who will instruct us, if we are paying attention, how to help them reach their cure—is the best that we know, given the research that we have. A humble attitude—what has been articulated as a position of not-knowing (Anderson & Goolishian, 1992)—is an important way of minimizing harm while attempting to help people.

In the first season of the HBO series *In Treatment*, we are shown the relationship between the psychotherapist Paul Weston and his patient, Laura. Paul has been seeing Laura for around a year when the action begins; in the first episode Laura makes a confession: she is in love with Paul. To be more direct: she is in love with Paul and wants to have sex with him. Paul expresses surprise and then lays down the law: the boundaries are clear and ethically prescribed. He is not an option for her. But despite his clear message, things get a bit messy as treatment progresses.

In Treatment is more than just good television. Though it possesses drawbacks, it nonetheless is a big improvement over many other television and movie portrayals of psychotherapy. Paul Weston knows that the "true vehicle of therapeutic influence" (Freud, 1909-1910/1961, p. 57) is the transference relationship between counselor and client. Transference—"a degree of affectionate feeling (mingled, often enough, with hostility)" (p. 56) that the client feels toward the counselor—re-enacts that client's past relationship history. When Laura falls in love with Paul, Paul suggests that the intimacy of the therapeutic encounter stimulates powerful emotions, and that as a result of this, she is transferring feelings from past relationships into the therapeutic relationship with him.

Quick Clinical Vignette

Sometimes, a Brother Is Just a Brother

In considering transference and countertransference, one must be aware that in the treatment encounter there is typically a complex mixture of relatively more accurate and reality-based responses versus relatively less accurate and less reality-based responses on the part of both client and counselor. As an example, I was referred a client whose presenting issue was a series of sexual encounters with married men. As a heterosexual, married male, I carefully prepared myself for our first session. I spoke with my supervisor about the possibility that the client might choose to act seductively with me; I also spoke with my supervisor about how I might caringly and ethically respond, should the client do so.

Susie turned out to be a strikingly attractive, intelligent, and funny woman. She was married to Jeffrey (who was aware that she was in treatment with me and who was unstinting in his support of Susie), had two small children, and was open and articulate in describing her situation. She thought that her status as a sexual abuse survivor played a part in both her problems with alcohol and with her sexual encounters. At the end of the session, she paused and said, "You know, you remind me of my brother."

I was uncertain how to interpret her remark; given the circumstances, I brought up Susie's remark in supervision, and we agreed that I should remain open yet vigilant.

As we have already seen in our discussion of Bertha Rappenheim and her treatment provider, Josef Breuer, powerful feelings arose in the first therapeutic relationship. Just how powerfully they were manifested is illustrated in what happened at the end of treatment. We know that Breuer spent an enormous amount of time with Rappenheim; we know that even when she was most downhearted, she took pleasure in his company. We also know that the ending of their relationship was very hard on Rappenheim and that the termination was very poorly executed (Breuer abruptly referred her and then fled on vacation with his wife). We know that throughout the treatment, both Rappenheim and Breuer acted in ways that suggested that there were other qualities to their relationship than those assumed to be typical between a doctor and a patient. It's likely that Rappenheim had fallen in love with Breuer—transference—and it is equally likely that Breuer entertained feelings toward Rappenheim as well—countertransference—even if he never overtly acted on their feelings. In their relationship we see a great example of everything that Freud said about these mutually occurring phenomena. Unfortunately, therapeutic use was not made of these feelings, and we find yet more cautionary evidence from the first psychoanalytic case that should make us yet more careful in our clinical practice.

Several sessions passed, and Susie remained the same—funny, kind (to everyone except herself), and engaging. Then, after a few months, Susie greeted me in the waiting room with, "Hey, I want you to meet my brother. Don't you guys look alike?"

Her brother and I could've been twins. Walking with Susie back to my office, we marveled at the resemblance.

Susie's treatment continued to progress extremely well; in fact, her progress was close to ideal—slow, steady, and enduring. Her drinking decreased, her self-esteem improved, and she stopped having sexual encounters outside her marriage. So what about her remark? I came to believe that it was primarily a statement of fact—we did look very much alike. Seeing me, she immediately thought of her brother.

But I also think that her statement meant something more. We usually think that it is the counselor who needs to manage unruly feelings in session. Yet I believe that Susie was the one who made her treatment more effective by telling herself and telling me that our relationship was going to be intimate but fraternal. In effect, she set the bounds for the treatment alliance, making it as powerful and helpful as a relationship between brother and sister can be—but also clearly articulating the normative boundaries for this relationship. The takeaway? Susie's case furnished an important reminder that, in considering the real and imagined process and content of the therapeutic relationship, look to the client's lead.

A skeptic might break in and say, You have shown erotic elements in (1) a television show about psychotherapy and (2) in the first official psychoanalytic case. Surely these elements aren't as important in modern clinical practice? And even if they occasionally exist, why focus on these extreme manifestations of erotic attraction? Isn't the therapeutic relationship more characterized by less extreme characteristics, like warmth, friendliness, and liking (on the positive end) and mild irritation, impatience, and dislike (on the negative end)?

In my experience, and I believe in the experience of most practitioners, it is true that therapeutic relationships are generally much less intense than either Paul's relationship with Laura, or Breuer's relationship with Rappenheim. I have genuinely liked, esteemed, and respected my clients (on the positive end) and occasionally disliked, wondered about, and been irritated by my clients (on the negative end). A few provoked stronger negative feelings; a few caused stronger positive feelings, and the solutions to these potentially unmanageable feelings were the same: consult with colleagues and address these issues in supervision.

And what have my clients thought and felt about me? My best guess is probably pretty much the same as how I felt about them—the vast majority liked or disliked me in varying measures. I don't remember clients who powerfully disliked—hated—me; they probably just didn't come back to counseling. I do remember a small number of clients who seemed to powerfully like—maybe love—me. A few of my “little patients” (as Paul would say) loved me, I think. And at least one of my big patients was powerfully attracted to me. After being in treatment for several months, she revealed that she was deeply in love with me; I was absolutely blindsided, having had no inkling of her feelings. We worked on this in counseling until I left for another position. After we terminated, this client wrote to me, e-mailed me, and called me. She went so far as to contact my parents and woo my father; one of the ways she did this was to ask him to send her the books he wrote as a sociology professor, the surest way into any academic's heart. (Happily, she also sent a letter to him later, in which she apologized and also let him know that she had just married and was feeling much more integrated and healthy and optimistic.)

I don't think her reaction was all about me. Freud tells of an occasion early in his career when he was still using hypnosis. He hypnotized a woman, and when she woke up she threw her arms around his neck; he says that “I was modest enough not to attribute the event to my own irresistible personal attraction, and I felt that I had now grasped the nature of the mysterious element that was at work behind hypnosis” (Freud, 1925/1959, p. 27).

The Therapeutic Relationship: What's It Really Like?

Summary

- From a common factors perspective, the client is where the action is. Thus we begin our inquiry with the first client, Bertha Rappenheim.
- Rappenheim's treatment was complex. Simplified, her counselor helped her recall her symptoms through his hypnosis of her and her own autohypnosis, which brought her relief. In reality, what was most curative was the relationship they formed.
- This early method—the reexperiencing and expressing of powerful, suppressed emotions—is the cathartic cure.
- Freud rejected catharsis and hypnosis. He agreed that the client must bring repressed material to light, but said that the client must be in a conscious

Finding the Sweet Spot

The skeptic is right to point out that in most cases, the therapeutic relationship doesn't go to these kinds of extremes, and in fact, Freud (1940/1964) himself asserted that it generally wasn't ultimately therapeutic for the patient to get caught in extreme feelings of love or hate for the therapist. Fortunately, the therapeutic relationship isn't often characterized by passionate feelings. Instead, things like warmth, and trust, and empathy, attentiveness and positive regard need to be present—a nice, warm, moderate, supportive atmosphere that can withstand apathy, challenge, misunderstanding, and so on, a kind of therapeutic “sweet spot” between extremes.

But we know that it always remains incredibly potent, and we need to always be aware that other feelings—other more passionate feelings—can also arise. And if we do not anticipate this, we might be tempted to flee, like Breuer did, or tempted to act on them, like Paul in *In Treatment* (I won't divulge anything more than that; you'll have to watch the series for yourself). And we know that these kinds of responses are antithetical and potentially very harmful: *Primum non nocere*. While we might prefer to focus on the successes of our profession, it is important from a theoretical perspective to also focus on the cautionary tales, of which Rappenheim's is the first. Despite harm generated by well-meaning helpers, Rappenheim heroically cured herself. Rappenheim's story is where Freud began in his five lectures at Clark University in Worcester, Massachusetts, in 1909, and her story continues to offer modern counseling and psychotherapy essential lessons in this the next millennium.

states; not a prophetic one, so that the client can make rational judgments about this material. Simply reexperiencing the emotions is not enough; cognitive decisions must be made.

- Rappenheim, who became addicted to psychotropic drugs and who was given much-less-than-optimal treatment, continues to hold contemporary importance. Her case reminds us that we can't assume that because we think we are doing good, we are actually doing good.
- Rappenheim's case also furnishes the first example of our clients' ability to transcend their circumstances; she exemplified the idea of the heroic client.
- The treatment relationship is the primary vehicle for positive therapeutic outcome. It is not just the container for active therapeutic techniques and interventions—it is the single most potent intervention itself and cannot be separated from other therapeutic interventions.
- In considering the treatment relationship, the counselor would do well to find the sweet spot between extremes of apathy and disinterest on one hand and overintense engagement on the other; Goldilocks reminds us that the porridge must be neither too hot nor too cold but just right.

Basic Psychoanalytic Concepts

2

Now that we have established the original context of psychoanalysis and counseling and psychotherapy—heroic proto-client collaborates with well-meaning but at times bumbling proto-counselor to create the talking cure—we can now fill in this context with Freud's clinical concerns: his understanding of how the mind worked, how people and their personalities develop or fail to develop, and how someone who wished to help people in a clinical setting could do so. Recall that from a common factors perspective, what we are now discussing is the way that this particular theory, psychoanalysis, organizes what the counselor and client do together in the context of a helping relationship. Using the metaphor of language, this chapter introduces the vocabulary used by psychoanalysts as they work with their clients to understand the issues they face and to achieve positive change in their lives.

As we have seen, Freud fundamentally viewed mental processes as ordered and regulated—"that the mind, however dishveled it might appear, is governed by firm rules" (Gay, 1989a, p. xvi). While Freud's account of the rules that the mind must obey varies at times from earlier and later formulations (Freud tended to modify many of his views, to the exasperation of his followers and to the vexation of his later explicators, making it difficult at times to coherently summarize his perspective), we can nonetheless reconstruct a reasonably simple description that stays true to Freud's vision of what makes people tick. Let us begin by examining both his structural and topographic models so that we may then make clear his views on the essential conflicts that beset human beings.