

Freudian Legacies

Sigmund Freud made significant contributions to our understanding of how the human mind works (Gay, 1988). Recently, however, his ideas have come under intense criticism. Eysenck (1985), MacMillan (1991), Fisher and Greenberg (1995), Webster (1995), Andrews and Brewin (2000) and Gomez (2005) review the issues (with different degrees of politeness and different conclusions). This post comments on some of Freud's contributions.



The photograph shows the Czech sculptor David Černý's *Hanging Man* (1997) in its original location high above Husova Street in Prague. Copies have since been exhibited in various other cities. It is a life-size sculpture of Sigmund Freud, hanging from his right hand which grasps a beam projecting over the street. He seems unconcerned by his precarious position, his left hand remaining insouciantly in his pocket. Like most artists, Černý is noncommittal about the meaning of his art.

According to some, the sculpture may represent the role of the intellectual in modern society. Freud goes often unattended, but when noticed he tends to shock. He considers ideas that are not grounded in the normal world; yet he is comfortable in his own thinking.

(i) The Unconscious

Freud proposed that the unconscious controls much of what we do. He did not invent the unconscious but he certainly demonstrated how great a role it plays in our thinking. Current scientific psychology has recognized how much of our thinking is unconscious. Most of our mental processes occur automatically without ever entering consciousness. Most of our memories are implicit and affect our thought and behavior without our ever noticing. Most of our motivations exercise their effects without our knowing. Westen (1999) reviews the extensive role of the unconscious in modern cognitive psychology.

The unconscious mediates what Freud called the “psychopathology of everyday life.” Unconscious activity often shows up in everyday speech, especially when we are not closely monitoring what we say. We currently use the term “Freudian slip” for those speech mistakes (parapraxes) with a sexual meaning: “we must encourage the breast (instead of best) and the brightest.” However, sex is not the cause of every mistake. There are often other things on our unconscious minds.

Free association, a key procedure in psychoanalytic therapy, may be a productive way for discovering what is active in the unconscious but not readily accessible. Relaxing on a couch and talking about the first thing that comes to mind may be as

good a way as any for a patient and therapist to begin to talk.

The defense mechanisms described by Freud and his daughter Anna are the cognitive processes we use for handling stress. Repression, regression, sublimation, rationalization, and somatization all seem to be ways that the mind uses to cope with unwanted desires, to shield us from traumatic memories, and to reduce anxiety.

Dream recall may be an efficient way to trigger free associations. The experience of the dream may reflect what is active in our unconscious. Furthermore the retelling of a dream probably taps into all sorts of other mental information in addition to the actual dream. However, the interpretation of dreams is not the royal road to the unconscious. Freud proposed that a dream could represent the fulfillment of a repressed wish or it could mean exactly the opposite. In either case it could be disguised as something else. With such guidelines, dreams can be interpreted in an infinite number of ways.

Many of Freud's dream-interpretations seem without any justification. Perhaps, the most famous of the dreams is Sergei Pankejeff's recurrent nightmare of the white wolves in the tree outside his bedroom window (Gardiner, 1971). The patient drew a sketch of the dream for Freud during his 1910-1914 analysis. Many years later in 1964 he made a painting (shown below), which now hangs in the Freud Museum in Hampstead, London. Freud linked the dream to an eighteen-month-old infant's memory of seeing his parents copulating. The interpretation seems far-fetched. Perhaps it betrays more the mental associations of the analyst than the repressed memories of the patient. The Wolfman later stated that the supposed memory was unlikely since his cot was in the nurse's room and not his parent's bedroom (Obholzer & Pankejeff, 1982, p. 36). We cannot consciously remember events before the age of about two or three years – "infantile amnesia." Freud

claimed that this specific memory from infancy was unconscious, but this was speculation without any corroboration.



(ii) Mechanisms of Memory

Freud's views of childhood sexual abuse provide an intriguing case history on the difficulty of determining truth and the problems of memory (Gleaves & Hernandez, 1999). In his initial writings, Freud acknowledged that children had been sexually abused by their fathers, and suggested that this might be the cause of conversion hysteria. This formed the basis of the seduction theory. Later papers proposed that the abuse was fantasized rather than real, and that the fantasies were the effects of repressed desires on the part of the child. Freud has been both praised for recognizing the reality of childhood sexual abuse and criticized for later suppressing these ideas.

Why did Freud change his ideas? Was the change based on new evidence? Recent psychological investigations of false memories have shown how what we remember may not be what actually happened. Freud himself recognized that the physician may suggest the memories and that the patient may invent them. The actual events behind his patients' histories are now

impossible to determine. Freud's change of theory may also have been caused by his (consciously or unconsciously) succumbing to social pressures. Viennese society was extremely strait-laced and did not wish to deal with the problem of childhood sexual abuse. One thing that is lost in the controversies is whether the new theory of repressed fantasies rather than repressed memories could explain the available data better than the old. Freud clearly thought that in many cases it did.

The incidence of childhood sexual abuse is likely higher than our sense of morality and decency would suggest. This has led to the idea that many psychological disorders in adulthood may be due to repressed memories of actual (not fantasized) abuse during childhood. Though such cases can occur, memories that are recovered during therapy are often not repressed memories of actual events but imagined memories suggested by the therapist (Crew, 1995).

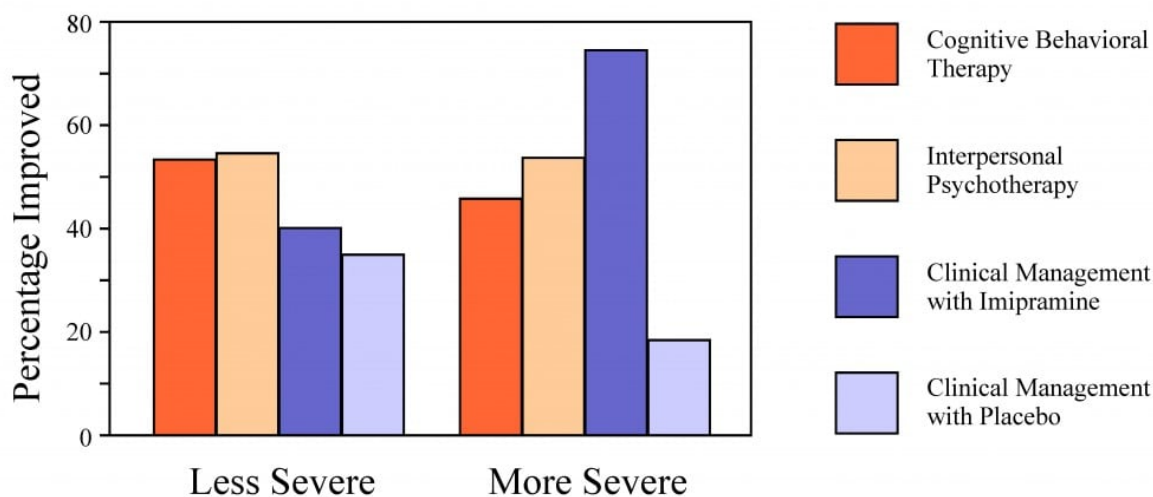
If we accept that memories can be true or false, it is impossible to evaluate patient's histories without some corroboration. Freud thought that the new theory was true because it led to success in treatment. Psychoanalytic success typically involved the cessation of symptoms once the patient and analyst came to a convincing interpretation of the symptoms in terms of repressed desires, and a re-integration of the personality so that such desires can be more effectively handled.

(iii) Psychoanalytic Therapy

Nowadays, the success of psychoanalytic treatment is not really clear. Psychoanalysis is resistant to scientific evaluation. In the last lecture of *A General Introduction to Psychoanalysis* Freud stated that each patient is unique, and "statistics would be valueless if the units collated were not alike." People are too different from each other to allow comparable treatment groups. Family interactions are too

complex to control. Anecdotal evidence of psychoanalytic cures abound. Yet analysts have a biased view of their ability, and patients do not wish to admit that the treatment has been unhelpful despite the huge investment of time and money. Objective outcome measurements are difficult to establish. We can measure improvement in the level of the symptoms and the quality of life. However, does improvement mean that a patient has recovered? Can a patient who has regained some semblance of normality still remain abnormally susceptible to stress?

Studies evaluating psychotherapy using various outcome measurements have shown that it has a beneficial effect compared to no therapy (Wampold, 2001, 2007). The “talking cure” that began with Josef Breuer and Bertha Pappenheim works. However, the different types of therapy (those involving psychoanalytic theory and those not) are similar in the amount of benefit they provide. In patients with major depression, a large NIMH study (Elkin et al., 1989) compared two different psychotherapies (cognitive behavioral therapy and interpersonal psychotherapy), routine clinical management with imipramine and routine clinical management with placebo. The psychotherapy sessions were conducted weekly and lasted one-hour. The clinical management sessions were also weekly and lasted 20-30 minutes. The diagram shows some of the results, based on one of the several scales used in the study. All “treatments” led to improvement, even the placebo. The two psychotherapies and the active pharmacological treatment tended to be significantly better than placebo (though the tests were borderline and varied with the scales used to rate the severity of the depression). Part of the placebo effect may have been related to the passage of time, and part to the minimal psychotherapy involved in the once weekly brief meetings with the physician. The pharmacological treatment condition was better in patients with more severe depression. The results were variable and the differences between conditions were statistically borderline (and varied with the scales).



The study is typical. Psychotherapy has a beneficial effect. However, this effect is variable and sometimes different to demonstrate. Furthermore, there are often no clearly demonstrable differences between different types of therapy.



Bruce Wampold (2001) described the lack of statistical difference between different therapies as the “Dodo bird verdict,” quoting an earlier paper of Saul Rosenzweig (1936). The reference is to Chapter 3 of Lewis Carroll’s *Alice in Wonderland*. When asked to determine who had won the “caucus-race” (a competition with no rules or measurements), the Dodo bird thought for a long while and finally decided

that “Everybody has won, and all must have prizes”

The general idea of the talking cure is good, but it seems much less used in psychiatry in recent years, particularly in North America. This is unfortunate since for non-psychotic mental disorders the talking cure is probably as good as any

pharmacological treatment. Even for psychosis, where medication is essential, the talking cure still helps. Nowadays, the interactions between psychiatrist and patient often serve only to assess symptoms, adjust medications and monitor side-effects. Psychotherapy (of whatever kind) is often not the primary activity.

The fact that all therapies work regardless of the type suggests that the beneficial effect is due to the interaction between the patient and a therapist. What makes a therapist good and the therapy beneficial remains difficult to determine. Clearly the therapist should be rational, sympathetic and supportive. The precise system of therapy does not seem to matter. Perhaps there may be some interaction with the personality of the patient. Some patients may do better with some system of therapy than with another. The therapist must have some bona fide training. The patient should not be treated by any mad charlatan who claims to be a therapist. And we need further evidence-based studies will determine which therapy is better for which patient (Hunsley & DiGiulio, 2002).

Most of the studies comparing different kinds of psychotherapy consider periods of time much briefer than used in classical psychoanalysis. "Psychodynamic therapy" is informed by psychoanalytic ideas but much briefer and much less intense. Although earlier studies have found otherwise, a recent meta-analysis has suggested that a prolonged course of analysis lasting for a year or more has no more benefit than a brief period of therapy lasting several weeks (Smite al al., 2012). On any cost-benefit evaluation, however, classical psychoanalysis involving multiple meetings per week and lasting over multiple years would fare very poorly.

The French Institute of Health recently evaluated published scientific studies of three different types of psychotherapy: psychodynamic therapy, cognitive behavioral therapy and family counseling. Their report (INSERM, 2004) proposed that

cognitive behavioral therapy was the best approach to many different mental disorders and that psychodynamic therapy was never the preferred treatment. The report triggered a tremendous controversy (Meyer, 2005; Miller, 2006). Psychoanalysts claimed that a treatment that involved reprogramming and conditioning was inhumane; the opposition said that psychoanalysis was pseudoscience. Cognitive behavioral therapy (Beck, 2011) is designed to help patients cope with their symptoms and prevent their exacerbation. Symptoms are alleviated by training the patients to re-interpret the situations under which these symptoms become manifest. This type of therapy is clearly going to do well on studies with outcome measures that assess the severity of symptoms. The goal of psychoanalysis is a long-term re-education or re-integration of the personality. Psychoanalytic therapy might have done better with outcome measures that assess a patient's understanding of self and of others (e.g. Berggraf et al., 2014)

(iv) Addiction to therapy

One of the difficulties with any psychotherapy is that it fosters an emotional dependence on the therapist that can become unhealthy. The patient may become unable to live without a weekly session with the therapist. This problem was recognized early in the history of psychoanalysis. The Viennese satirist Karl Kraus (1913) proposed that psychoanalysis is the mental illness whose cure it purports to be ("Psychoanalyse ist jene Geisteskrankheit, für deren Therapie sie sich hält"). Even with client-centered therapy, the therapist generally remains the dominant person in the interaction. Psychotherapy has some relations to religion, with confession followed by interpretation rather than absolution.

Some therapies become cults. The patient becomes enslaved to a particular system of thought. Scientology started as a treatment procedure, and therapy continues as a main activity

in the movement. Scientology proposes that a person's achievements may be held back by memories or "engrams" (from early childhood or from another life). The goal of the therapy is to discover (or "audit") these impediments by using an "e-meter" (a simple psychogalvanometer). Once identified these impediments can be removed (or "cleared") by therapy, allowing the patient to become a more complete human being (or "thetan"). Therapies are paid for – a patient who is not willing to pay is not going to be cured. As far as I can understand, scientology is nonsense. It exists not to cure the sick but to allow an elite to make money and to exert power.

Although clearly different, scientology and psychoanalysis have some similarities. Both have a background theory that has not been experimentally tested. Both focus on the handling of anxiety. Both are based on a charismatic leader. Psychoanalysis can be beneficial and Scientology is malignant, but the similarities are very worrisome.

(v) Overview

What then is psychoanalysis? It is a system of thought and a way of treatment based on an imaginative interpretation of human development and culture. Psychoanalytic treatment interprets what has happened to a patient to lead to the present situation, and attempts to re-integrate the patient's personality to reduce the conflict between unconscious desires and ideal goals. Even though Freud considered his work as science, it makes no hypotheses that can be refuted. In a sense anything can be explained. A dream may sometimes represent a wish fulfillment; at other times defense mechanisms may have sufficiently distorted its content to represent the complete opposite of wish-fulfillment.

Psychoanalysis has made significant contributions to our culture. First is the freeing of our minds so that we can recognize our desires, especially those that are sexual in nature. Second is the recognition that most of what we think

and do is the result of unconscious processing. Third is the idea that talking to a sympathetic therapist can help us to understand ourselves and to attenuate the stress that results when desires and ideals come into conflict. Fourth is the description of a life narrative wherein we can realistically cope with our unconscious desires.

Psychoanalysis is imaginative rather than scientific According to John Irving, "Sigmund Freud was a novelist with a scientific background" (Plimpton, 1988). Freud's interpretation of human development according to the story of Oedipus is a powerful metaphor. The meaning is in the way it helps us to see our life, not in how it represents what actually happens. The story of Oedipus encapsulates many aspects of the human condition. (The illustration shows Oedipus being questioned by the Sphinx on a drinking cup from around 470 BCE, Vatican museums, photographed by Carole Raddato).



Jacques Lacan said many outrageous things about psychoanalysis. Within his hyperbole there are germs of truth. The post concludes with two quotations from his seminars:

La psychanalyse est à prendre au sérieux, bien que ce ne

soit pas une science ... parce que c'est irréfutable ... c'est une pratique du bavardage. (Lacan 1979) [Psychoanalysis is to be taken seriously even though it is not a science ... because its propositions cannot be falsified ... it is an exercise in conversation. (I have attenuated the translation of "bavardage," which means "chattering" or "gossip" to better portray the idea of the "talking cure")]

Le psychanalyste ne doit jamais hésiter à délirer. (Lacan, 1977) [The psychoanalyst must never hesitate to imagine freely. (I have attenuated the hyperbolic "délirer" which means "become delirious").

Psychoanalysis is an imaginative way of looking at human life that can help patients in distress and suggest ways to understand the workings of the mind.

Andrews, B., & Brewin, C. R. (2000). Freud in a modern light. (Special issue). *The Psychologist*, 13:605-623.

Beck, J. S. (2011). *Cognitive behavior therapy: basics and beyond*. New York: Guilford Press.

Berggraf, L., Ulvenes, P. G., Hoffart, A., McCullough, L., & Wampold, B.E. (2014): Growth in sense of self and sense of others predicts reduction in interpersonal problems in short-term dynamic but not in cognitive therapy. *Psychotherapy Research*, in press.

Crews, F. C. (1995). *The memory wars: Freud's legacy in dispute*. New York: New York Review of Books.

Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.M., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Docherty, J.P., Fiester, S.J., & Parloff, M.B. (1989). National Institute of Mental Health treatment of depression collaborative research program: general effectiveness of

treatments. *Archives of General Psychiatry*, 46, 971–982.

Eysenck, H. J. (1985). *Decline and Fall of the Freudian Empire*. New York: Penguin.

Fisher, S., & Greenberg, R.P. (1996). *Freud scientifically reappraised: Testing the theories and the therapy*. New York: Wiley

Freud, S. (1922, translated by Riviere, J., 1935). *A general introduction to psychoanalysis*. New York: Liveright.

Gardiner, M. (Ed.). (1971). *The Wolf-Man by the Wolf-Man*. New York: Basic Books (Contains Freud's original case history from 1918 and an interview with the patient)

Gay, P. (1988). *Freud: A life for our time*. New York: Norton.

Gleaves, D. H, Hernandez E. (1999). Recent reformulations of Freud's development and abandonment of his seduction theory: historical/scientific clarification or a continued assault on truth? *History of Psychology*, 2, 304-54.

Gomez, L. (2005). *The Freud wars: An introduction to the philosophy of psychoanalysis*. London: Routledge.

Hunsley, J., & Di Giulio, G. (2002). Dodo bird, phoenix, or urban legend? The question of psychotherapy equivalence. *Scientific Review of Mental Health Practice*, 1, 11-22.

INSERM Collective Expert Reports (2004). *Psychotherapy: Three approaches evaluated*. Paris: Institut national de la santé et de la recherche médicale.

Kraus, K. (1913) *Die Fackel* Nr 376/377, p. 21.

Lacan, J. (1977). *Ornicar ?* No 9, p. 17

Lacan, J. (1979). *Ornicar ?* No 19, p. 5

Macmillan, M. (1991). *Freud Evaluated: The Completed Arc*.

Amsterdam: North Holland.

Meyer, C. (Ed.) (2005). *Le livre noir de la psychanalyse*, Paris: Les Arènes.

Miller, J.-A. (Ed.) (2006). *L'anti-livre noir de la psychanalyse*. Paris: Le Seuil.

Obholzer, K., & Pankejeff, S. (1982). *The Wolf-Man: Conversations with Freud's patient – sixty years later*. New York: Continuum.

Plimpton, G. (1988) Interview with John Irving. In: *Writers at Work: The Paris Review Interviews, Eighth Series*. New York: Penguin.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, 6, 412–415.

Smit, Y., Huibers, M. J., Ioannidis, J. P., van Dyck, R., van Tilburg, W., & Arntz, A. (2012) The effectiveness of long-term psychoanalytic psychotherapy – a meta-analysis of randomized controlled trials. *Clinical Psychology Review*, 32, 81-92

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Lawrence Erlbaum Associates.

Wampold, B. E. (2007). Psychotherapy: the humanistic (and effective) treatment. *American Psychologist*, 62, 855-873.

Webster, R. (1995). *Why Freud was wrong: Sin, science, and psychoanalysis*. New York, NY: BasicBooks.

Westen, D. (1999). The scientific status of unconscious processes: is Freud really dead? *Journal of the American Psychoanalytic Association*, 47, 1061-1106.

Story of Anna O

The case of Anna O., reported by Josef Breuer and Sigmund Freud in their 1895 book *Studies on Hysteria*, provides the initial evidence for the effectiveness of psychoanalytic treatment. The patient's actual name was Bertha Pappenheim (Gay, 1988; Jones, 1953). For the case study, her initials were shifted one letter earlier in the alphabet, and she was given the pseudonym Anna. Since the publication of her story, so many people have given their opinion of what was wrong with her that truth is difficult to determine in the welter of interpretation (recent review by Skues, 2006).



In 1880, at the age of 21, Bertha Pappenheim became the patient of Josef Breuer. Breuer was 38-years old, a respected Viennese physician, famous for his earlier work in physiology. In 1868 he had shown that inflation of the lungs trigger pulmonary stretch receptors which through the vagus nerve then inhibit the inspiratory centers of the lower brainstem (Hering-Breuer reflex). In 1874 he had shown how the vestibular system was related to the sense of balance and not

hearing (Mach-Breuer hypothesis). After his researches, Breuer had become a conscientious and caring physician. He described his new patient:

She was markedly intelligent, with an astonishingly quick grasp of things and penetrating intuition ... She had great poetic and imaginative gifts which were under the control of a sharp and critical common sense ... Her will-power was energetic, tenacious and persistent (Freud Standard Edition Volume II, p. 21)

Anna's history was complex. She had been nursing her father who was ill with tuberculosis when her symptoms began, and who went on to die while she was being treated. Before she presented to Breuer, she had suffered from brief periods where she was apparently unaware – Breuer termed them “absences.” At the time of her treatment, she alternated daily between normal periods and prolonged spells of self-induced “hypnosis,” wherein she experienced strange aphasic symptoms, hallucinations and left-sided weakness. Breuer interacted with her during these periods and together they traced the history of each symptom:

She aptly described this procedure, speaking seriously, as a ‘talking cure’, while she referred to it jokingly as ‘chimney-sweeping’. (p.30)

These descriptive terms were originally in English, in which Anna was fluent. As Anna remembered the situation wherein the symptom had begun, the hysterical phenomenon disappeared:

Each individual symptom in this complicated case was taken separately in hand; all the occasions on which it had appeared were described in reverse order, starting before the time when the patient became bedridden and going back to the event which had led to its first appearance. When this had been described the symptom was permanently removed. In

this way her paralytic contractures and anaesthesias, disorders of vision and hearing of every sort, neuralgias, coughing, tremors, etc., were “talked away.” (p. 35)

At the end of the case history, Breuer and Freud speculated about the mechanisms of hysterical symptoms and their treatment. The patient showed evidence of a secondary state of mind with “its wealth of imaginative products and hallucinations, its large gaps of memory and the lack of inhibitions and control in its associations” (p. 45) This “unconscious” state intruded into her normal state of mind to cause her hysterical symptoms.

Breuer and his patient interacted intensely over many, many hours. It is difficult not to speculate that the relationship between Anna and Josef went deeper than that between physician and patient. Breuer’s involvement with Anna plays an essential role in Yalom’s novel *When Nietzsche Wept*.

Breuer’s wife became jealous of his fascination with the young woman, and Breuer stopped the treatment. The end of their relationship was terrifying. Anna appears to have undergone an hysterical pregnancy and miscarriage. Later psychoanalytic thought would consider such phenomena in terms of transference and counter-transference.

The case of Anna O marks the beginning of psychotherapy. Reliving the emotions of a past trauma released them. After this catharsis, the repressed emotions no longer needed to manifest themselves in somatic symptoms.

However, Bertha continued to experience various symptoms and her treatment was continued in a Swiss sanatorium (to which she had been referred by Breuer after he ceased to be her physician). Later psychoanalytic thought would suggest that the psychotherapy had not worked because it had not discovered the real repressed emotions – inhibited sexual desires for her father rather than grief at his illness. Furthermore, the goal

of psychotherapy evolved not just to release the anxieties that well up from the unconscious but to make the conscious mind understand and control these forces. The unconscious must become integrated into consciousness rather than simply liberated.

The case of Anna O. continues to be extensively interpreted. Some have suggested that she may have actually had a neurological rather than psychiatric disorder: tuberculous meningitis (extremely unlikely), epilepsy with complex partial seizures, or postinfectious encephalomyelitis (the various diagnoses are reviewed by Webster, 1996). Conversion hysteria may occur in conjunction with neurological disorders (Kanaan, 2009), but this is perhaps not as frequent as once was thought (Stone et al., 2005). Others have suggested that Anna's conversion symptoms were part of a depressive illness (Merskey, 1992).

Many other factors were not fully evaluated in the original case history. Anna had been taking chloral hydrate to help her to sleep in the afternoons so that she could stay up at night to watch over her father. In addition, her facial pains had been treated with morphine. Drug dependence may have played a role in her symptoms and in her hypnotic states. Perhaps Anna's absences were caused by psychomotor seizures (temporal lobe epilepsy) precipitated (and exacerbated) by drug withdrawal and sleep deprivation (Orr-Andrewes, 1987).

Anna O. ultimately led a very productive life (Kimball, 2000; Loentz, 2007). In 1888, Bertha Pappenheim and her mother moved from Vienna to Frankfurt, where Bertha became active in social work, running an orphanage and presiding over the Jüdische Frauenbund (League of Jewish Women). She was skeptical about psychoanalysis and opposed its use in the children under her care. Pappenheim wrote extensively on social issues and women's rights. Her most important book dealt with the need to protect women from prostitution and white slavery (*Sisyphus-Work*).

Under the pseudonym Paul Berthold, Bertha Pappenheim wrote stories and a play *Frauenrecht* (Women's Rights, 1899). The play has intriguing parallels to Bertha's real or fantasized relations with Breuer. The protagonist, who has recently joined the Women's Relief Society, asks her husband for some of the money that she brought to their marriage to support a sick young female worker and her illegitimate child. The husband refuses on principle. However, he does not realize that he is the father of the child.

Bertha Pappenheim suffered in her youth from a conversion disorder. Her symptoms were triggered by her grief at her father's illness and her mourning for his death. The suggestion that her disorder was neurological rather than psychological is unlikely given its outcome. She became well. However, she was not cured by her physicians. Whatever psychotherapy occurred during her interaction with Josef Breuer, she had herself invented. Most impressive, however, was what came afterwards (Kimball, 2000). The photograph at the beginning of this article, taken in 1882 after her treatment with Breuer was over, shows an elegant and confident young woman in riding outfit. However, she still had a long way to go. Somehow, over the next five years, she was able to pull herself together, to stop taking the drugs she had been prescribed, and to find an outlet for her intelligence and will in social work.

Breuer, J., & Freud, S. (1895). *Studien über Hysterie*. (Studies on Hysteria). Translated and edited by Strachey, J., & Freud, A. (1955). *The Standard edition of the complete psychological works of Sigmund Freud. Volume II*. London: Hogarth Press. (Available at arkive.org)

Gay, P. (1988). *Freud: A life for our time*. New York: Norton.

Jones, E. (1953). *Sigmund Freud: life and work*. London:

Hogarth Press.

Kanaan, R., Armstrong, D., Barnes, P., & Wessely, S. (2009). In the psychiatrist's chair: how neurologists understand conversion disorder. *Brain*, 132, 2889-96.

Kimball, M. M. (2000). From "Anna O." to Bertha Pappenheim: transforming private pain into public action. *History of Psychology*, 3, 20-43.

Loentz, E. (2007). *Let me continue to speak the truth: Bertha Pappenheim as author and activist*. Cincinnati: Hebrew Union College Press. Available through Google Books.

Merskey, H. (1992). Anna O. had a severe depressive illness. *British Journal of Psychiatry*, 161, 185-194.

Orr-Andrewes, A. (1987). The case of Anna O.: a neuropsychiatric perspective. *Journal of the American Psychoanalytic Association*, 35, 387-419.

Skues, R. A. (2006). *Sigmund Freud and the history of Anna O: Reopening a closed case*. Basingstoke, Hampshire: Palgrave Macmillan.

Stone J, Smyth R, Carson A, Lewis S, Prescott R, Warlow C, & Sharpe, M. . (2005) Systematic review of misdiagnosis of conversion symptoms and "'hysteria.'" *British Medical Journal*, 331, 989 (epub)

Webster, R. (1996). *Why Freud was wrong: Sin, science and psychoanalysis*. London: HarperCollins. (Chapter 4: Anna O. and the birth of psychoanalysis, pp 103-135).

Yalom, I. D. (1993). *When Nietzsche wept*. New York: HarperPerennial.