Looking and Listening:  
The Construction of Clinical Knowledge in Charcot and Freud

Daphne de Marneffe

Introduction

In the 1870s, the French neuropathologist Jean-Martin Charcot and his staff at the Salpêtrière produced a series titled *Iconographie photographique de la Salpêtrière* (1876–77, 1878, 1879–80). The three volumes presented case histories of women diagnosed as hysterical or hystero-epileptic, amply illustrated by photographs and diagrams. Long verbatim transcriptions of patients’ utterances during hysterical attacks offer highly detailed and often gruesome allusions to past traumas. Yet these allusions, framed by concrete medical measurements (temperatures taken, drugs administered, attacks arrested), receive no direct analysis or attention. Why did the writers of the *Iconographie* introduce these transcriptions, only to ignore them? And why, in contrast, was such great attention paid to photographing these patients, when photography seemed so comparatively ill-equipped to capture the subjective information conveyed by their words?

Less than twenty years later, in 1895, Freud and Breuer published their *Studies on Hysteria*. Like the *Iconographie*, the *Studies* presented carefully crafted representations of cases. Unlike the earlier work, however, Freud’s and Breuer’s investigations relied on verbal information from the (women) patients themselves, rather than on visual representation of their bodies. The *Studies* were motivated by many of the same concerns as the Salpêtrière volumes, but were dependent on radically different modes of inquiry and presentation.

I would like to thank Carol Gilligan, Nancy Chodorow, Peter de Marneffe, and Gabrielle Weinberg Bodow for their helpful comments on an earlier draft of this paper. I am also grateful to Eric Sandweiss for his inspired editing.


© 1991 by The University of Chicago. All rights reserved. 0097-9740/92/1701-0004$01.00

Autumn 1991 SIGNS 71
What is the intrinsic difference between the two approaches? And what difference does this difference make in what they were able to reveal or obscure? A reading of the Iconographie and the Studies demonstrates that both Charcot and Freud had access to similar information—namely, the sexual trauma of their women patients—but that they approached this information in very different ways. It struck me as I studied the two approaches that a comparison between them offered insights into some of the most basic questions of concern to feminist and other contemporary scholars: How can we know others? How does the position and approach of the knower affect the portrayal of the known? When women cannot speak, or speak and are not heard, how is their subjectivity distorted or obscured? What are subjectivity and objectivity, and in what ways do we connect our understanding of these terms with notions of gender and gender difference?

A comparison of Charcot’s and Freud’s approaches to their hysterical women patients touches on a number of specific issues in recent feminist scholarship as well. First, there is an ongoing debate over the feminist or misogynist import of Freud’s work on women. His work is clearly both, at different moments, and psychoanalytic feminists have each found their own ways of working with the ambiguities and challenges presented by Freud’s equivocal corpus. In my discussion here, I attempt to illuminate overlooked aspects of his contribution to the psychology of women by placing that contribution in historical context.

Second, hysteria is of continuing interest to feminists, because of both its historical association with women and its enigmatic status as an actual or socially constructed illness. The term “hysteria” itself derives from the Greek word hystera, meaning uterus, and early Greek and Egyptian medicine attributed the hysterical woman’s emotional instability to the “wandering” of her womb. This idea has had surprising resilience throughout medical history. A number of feminist scholars have explored the interplay of sociological, historical, medical, and psychological factors in the longstanding association of hysteria and women. In this essay, I attempt to show how the methods Charcot and Freud used to study hysteria interacted with the emotions and utterances of the women studied to produce very different accounts of the nature of the disorder and the process of cure.


Finally, beyond these more particular theoretical and historical questions, I am centrally concerned with approaches to knowing—specifically, the methods of looking and listening used by Charcot and Freud. A great deal of recent writing has explored the relations of gender and epistemology, and these writings inform the perspective I take here. In what follows, I describe the methods that Charcot and Freud each used in studying hysteria and hysterical patients, paying special attention to the kind of information each sought to obtain from the patient, and the role and status given that information. An inquiry into the differences between the two approaches illuminates, I believe, the ways in which Freud’s innovations in clinical method offered a radical solution to the problem of how to study subjective information scientifically.

Charcot

Background

In the early 1850s, Jean-Martin Charcot served his medical internship at the Salpêtrière. A virtual warehouse for roughly five thousand demoralized and sick women, the hospital held little interest for most other interns his age. Charcot, however, was attracted by the Salpêtrière’s large and diverse patient population, which provided an ideal opportunity for the comparative study of disorders. He had little respect for theoretical or experimental medicine carried out separately from patient populations, and the Salpêtrière’s great number of patients provided a basis for statistical inferences about the incidence and prevalence of diseases in the general population. Charcot immediately set himself to the task of systematically categorizing the patients at the great hospital, which he would later enthusiastically refer to as “a museum of living pathology.”

Charcot’s appointment in 1862 as chief physician of a large unit at the Salpêtrière ushered in the first major phase of his career in neurology. Between the years of 1862 and 1870, Charcot made important contributions to the medical description of sclerosis, tabes, aphasia, and cerebral and spinal localizations. His prolific output during this period established neurology as a science and solidified his own reputation as the


foremost neurologist of the day. In 1870, the restructuring of the Salpêtrière's wards led to the placement of women with the diagnosis of epilepsy and hysteria within the same ward. (This restructuring, as we shall see, had important implications for the clinical picture of hysteria that Charcot developed.) Charcot took charge of the ward and subsequently became interested in distinguishing epilepsy from hysteria. Charcot thus began working with hysterics in 1870 and pursued their study until his death in 1893. He became professor of pathological anatomy in 1872, and from 1872 to 1882 he delivered a series of influential lectures on his previous and current discoveries.

Between 1882 and 1893, Charcot devoted more than one-third of his lectures to hysteria. His service at the Salpêtrière continued to expand as more research space was commanded, more sophisticated technology was employed, and photography studios were equipped for the documentation and study of hysteria and other disorders. The means by which Charcot examined his patients and carried out his research was the celebrated clinicoanatomic method, developed in France during the late eighteenth and early nineteenth centuries. Through his use of this method, Charcot analyzed and categorized clinical phenomena into "archetypes," fully developed examples of the disease, and analyzed these further to detect their anatomical bases. The differentiation of an archetype from its "variants" emerged from the careful observation of numerous cases. Freud, later describing what Charcot proudly called his "practicing nosography," wrote that the archetypes "could be brought into prominence with the help of a certain sort of schematic planning, and with these archetypes as a point of departure, the eye could travel over the long series of ill-defined cases—the 'formes frustes'—which, branching off from one or other characteristic feature of the type, melt away into indistinctness."

Since the central tenet of the clinicoanatomic method was that disease arose from an anatomical lesion, it was suited to the study of diseases with obvious biological bases but was less well adapted to disorders whose main manifestations were psychological. Before the method's development, clinically observed symptomatology had been a far more important basis for the categorization and treatment of disease, and "neurosis" had been an adequate term for nervous conditions of various kinds. With a shift in emphasis toward anatomical lesions and the importance of their localization, the concept of neurosis became problem-

---

atic, because few actual anatomical lesions could be found to account for them. By the time Charcot turned his attention to hysteria, he had been using the clinicopathologic method on other disorders for many years and with great success. Diseases such as tabes yielded up the most precise information to Charcot's method. Yet hysteria proved more perplexing, because as a grande névrose, it gave no evidence of pathological lesions.

In his inaugural lecture in 1882 for the new university chair of diseases of the nervous system, Charcot discussed how conditions such as hysteria appeared to the physician:

Epilepsy, chorea, hysteria... come to us like so many Sphinxes. ... These symptomatic combinations deprived of anatomical substratum, do not present themselves to the mind of the physician with that appearance of solidity, of objectivity, which belong to affections connected with an appreciable organic lesion.

There are some even who see in several of these affections only an assemblage of odd incoherent phenomena inaccessible to analysis, and which had better, perhaps, be banished to the category of the unknown. It is hysteria which especially comes under this sort of proscription.9

To account for the origins of hysteria, Charcot devised the concept of "dynamic lesions," or psychologically traumatic events. These he assigned, however, the limited role of agents provocateurs, capable of catalyzing a hereditary propensity for nervous disease. His view of exactly what was inherited remained relatively ill-defined and untested by comparison to the precise picture of symptoms yielded by his observational strategy. In his development of elaborate family trees to trace various forms of neurological "degeneracy," he did not consider those familial and sociological experiences that affected people at early ages psychologically rather than through bloodlines—a position to which Freud ultimately strongly objected.10 In his clinical demonstrations with patients, Charcot regularly overruled his patients' pronouncements about actual predisposing experiences in favor of his own hereditary explanations.11 The importance Charcot and his colleagues gave heredity constituted, in their view, a justification for detailed case histories; these histories were taken with the purpose of providing crucial information about family history relevant to the study of hereditary transmission of neurological disease.

10 Gelfand.
11 See, e.g., the case presented in chap. 1 of Goetz, annotator and trans.
Charcot, like his predecessor Briquet, insisted that “hysteria is governed, in the same way as other morbid conditions, by rules and laws, which attentive and sufficiently numerous observations always permit us to establish.”12 By repeated scrutiny he developed a clinical picture of hysteria that conformed to rules and laws in much the same way as the other diseases he studied. In hysteria, the typical convulsive attack was preceded by the “aura”—a group of premonitory symptoms including palpitations, nervous cough, yawning, and the globus hystericus, a sensation of obstruction in the throat. Sharp pains in the ovaries were often present in this stage as well. The epileptoid stage marked the beginning of the attack proper and tended to last for a few minutes, although its duration and tempo varied. In the first epileptoid subphase, the “tonic phase,” the patient’s arms and legs stretched and oscillated violently. In the “stertorous phase,” the patient fell backward and lost consciousness, breathing weakened, the neck swelled, and the mouth foamed. The muscles then relaxed and normal respiration resumed.

The second stage was named the “period of clownism” and was characterized by rapid movements of two possible sorts: the arc de cercle (as was seen in tetanus) and rhythmic chorea. The third stage in Charcot’s series was the attitudes passionnelles. Though this stage differed critically from the preceding two stages in that it introduced the “psychical element,” Charcot’s description of it, like his account of the other stages, centered on visible physiognomic signs. The duration of this period varied, and the patient’s outbursts, remonstrances, and conversations with hallucinated interlocutors were often repeated several times before the entire attack subsided. In some patients a fourth stage was recorded, a “posthysterical derangement” that lasted for several hours or days. The patient suffered a delirium during which the thoughts and ideas of the attitude passionnelles were repeatedly expressed.

As is clear from his clinical description of hysteria, Charcot’s characterization of the disorder relied upon visually observable signs, through which its fundamental structure was deemed detectable. Charcot announced in 1882 that “an attack of hysteria major . . . is reduced at the present time to a very simple formula. Four periods succeed each other in the complete attack with mechanical regularity. . . . In the attack, . . . nothing is left to chance, everything follows definite rules—always the same whether the case is met within private or hospital practice, in all countries, all times, all races, in short universally.”13 Yet this “universal” sequence of stages that Charcot constructed was later discredited as being due to the witting or unwitting mimicry by hysterics of the seizures they

13 Ibid.
had observed by epileptic patients with whom they shared the ward.\textsuperscript{14} Thus, although the structural and social conditions of the ward played a role in producing the behaviors associated with hysteria, this role was overlooked by Charcot in his use of close, minute observation to develop his clinical description of the disease.

**Visual method, photography, and art in the clinical enterprise**

For anyone trying to understand Charcot's model of hysteria, it is important to examine the primary method used by the Salpêtrière doctors: visual observation. "To gaze, to look, to keep looking, always: thus only one comes to see. Charcot's penetrating observation [and his] precise look, often resulted in precious discoveries, revelations of illness unknown until then"—this was how Henri Meige described Charcot's method and its results.\textsuperscript{15} Charcot relied on a natural and cultivated gift for seeing. Since early childhood he had decorated the carriages his father built, and he spent much of his reclusive and studious adolescence drawing. When he was eighteen, his father offered to sponsor his education as either a painter or a doctor; Charcot chose medicine.

The attention Charcot paid to visual information derived not only from his natural gifts, but from his concept of the scientist and of scientific objectivity. Two of his students wrote: "Meticulous clinical scrutiny, particularly of a visual type, was at the root of all Charcot's discoveries. The artist in him, who went hand in hand with the physician, played an interesting part in these discoveries."\textsuperscript{16} Seeing provided the appropriate image for discovering: Freud remembered Charcot as saying that "the greatest satisfaction a man could have was to see something new—that is, to recognize it as new; and he remarked again and again on the difficulty and value of this kind of 'seeing.'"\textsuperscript{17} According to Freud, Charcot answered a theoretical objection to his observational findings with the comment, "La théorie, c'est bon, mais ca n'empêche pas d'exister" (Theory is good, but it doesn't keep something from existing).\textsuperscript{18}

\textsuperscript{14} In his lecture "The Mental State of Hystericals" in 1925, P. Janet retrospectively surmised that Charcot's description of the *grande attaque* was not stable but in fact highly variable in terms of both the number of stages represented in the actual attacks and their order of occurrence (see Owen, 66). Charcot, Janet said, "described a type of hysteria which disappeared with him" (The Major Symptoms of Hysteria: Fifteen Lectures Given in the Medical School of Harvard University [New York: Macmillan, 1925], 21).


\textsuperscript{16} Quoted in Guillaume (n. 6 above), 51.

\textsuperscript{17} SE, 3:12.

\textsuperscript{18} Ibid., 1:139; ibid., 3:13. Charcot's emphasis on visual observation was related to his pride in the approach of French clinical medicine, superior in his view to the abstract theorizing and contrived laboratory study of the Germans. Gelfand (n. 5 above).
The visual observation that characterized Charcot’s method of diagnosing his patients often came at the expense of direct interaction. His laudatory biographer Guillain, a pupil of several of Charcot’s own students, describes how Charcot discontinued examining patients at bedside soon after his appointment at the Salpêtrière in 1862. Instead, Guillain writes, Charcot “spent the entire morning in his office, and had the patients brought to him one by one. In 1881, when he was appointed clinical professor of diseases of the nervous system, he rarely visited the wards of the hospital and did not leave his own office except on rare occasions to go to the autopsy room, to his laboratory of pathologic anatomy, or to his ophthalmologic office.”

Guillain quotes further from a description by two of Charcot’s students, A. Souques and H. Meige:

He would seat himself near a table and immediately call for the patient who was to be studied. The patient then was completely undressed. The intern would read a clinical summary of the case, while the master listened attentively. Then there was a long silence, during which Charcot looked, kept looking at the patient while tapping his hand on the table. His assistants, standing close together, waited anxiously for a word of enlightenment. Charcot continued to remain silent. After a while he would request the patient to make a movement; he would induce him to speak; he would ask that his reflexes be examined and that his sensory responses be tested. And then again silence, the mysterious silence of Charcot. Finally he would call for a second patient, examine him like the first one, call for a third patient, and always without a word, silently making comparisons between them.

For the clinicians at the Salpêtrière, photography provided the ideal method for accurately recording symptoms and their sequence. In their application of photographic method to medical study, these doctors belonged to a recently established tradition. Almost as soon as photography was invented, it had been applied to medical subject matter. The first photographer of madness, Hugh W. Diamond, had exclaimed in 1856 that “the Photographer secures with unerring accuracy the external phenomena of each passion, as the really certain indication of internal derangement.”

Albert Londe, the director of the photographic service of

19 Guillain, 51.
20 Ibid., 52. As the pronouns attest, some of Charcot’s patients, including some hysterical patients, were men.
21 H. W. Diamond, “On the Application of Photography to the Physiognomic and Mental Phenomena of Insanity” (paper presented to the Royal Society of Medicine, Lon-
the Salpêtrière in the 1880s and 1890s, wrote that “the photographic plate is the true retina of the scientist.”22 In 1888, countering a view that hysterical phenomena might be produced by his own suggestion, Charcot exclaimed, “But in truth I am nothing but a photographer; I register what I see.”23 Photography was thus established as a more perfect extension of the clinician’s eye, a means of recording objective truth and knowledge.

Charcot found in photography the appropriate tool for representing the distillation of general symptom characteristics from the observation of many cases. By capturing various hysterical poses on film and then superimposing negatives from different cases, a general picture of the syndrome was created that expunged individual difference.24 Hysteria, the Sphinx of disorders, presented a challenge to the creation of a uniform clinical picture. But by carefully cataloging symptoms in sequence, Charcot was able to use documentary photographic evidence to ensure the veracity of his universal sequence of stages.

By far the most carefully rendered and complete series of photographs in the Iconographie is that of “Augustine,” a patient who arrived at the Salpêtrière in October 1875, when she was fifteen and one-half years old.25 We can see in her series how the photographic plates are generally sequenced to conform to Charcot’s theory of the course of a hysterical attack. The series has seventeen plates in all, beginning with a picture of Augustine fully clothed in the “Etat normal” (normal state), staring out at the viewer with an arresting gaze. These are followed by “Debut de l’attaque” (beginning of the attack) and two manifestations of “Tétanisme” (tetanus). The next ten plates represent the “Attitudes passionnelles”: “Menace” (threat) (two), “Appel” (call), “Supplication amoureuse” (amorous supplication), “Erotisme” (erotism), “Extase” (ecstasy) (two) (fig. 1), “Hallucination de l’ouie” (auditory hallucination), “Cruciféction” (crucifixion), and “Moquerie” (teasing). (The eleventh plate, not in sequence, depicts another aspect of the “Debut d’une attaque” [fig. 2], the extension of the tongue.) The final two images show the contractures of limbs (figs. 3 and 4).

The entire arrangement of photographs provides, in effect, a rendering of a “perfect attack,” as seen from an omniscient view. We can witness the careful fencing of this representation of the attack in a variety of

---

22 Quoted in G. Didier-Huberman, Invention de l’hystérie: Charcot et l’iconographie de la Salpêtrière (Paris: Macula, 1982), 35. Translations from the French are mine unless otherwise indicated.
24 For a more extensive description of this process, see Didier-Huberman, 51.
25 IPS (n. 1 above), 2:123–86.
ways. First, in the text of Augustine’s case itself, the display of the full sequence of hysterical symptoms is quite rare. Augustine is plagued by “incomplete” or “abortive” attacks; on March 9, her report documents thirty-five attacks, on March 17, forty-three attacks, and on March 18, sixty attacks. Such a superabundance of hysterical symptoms suggests a more frenzied and chaotic expression than is depicted by the orderly sequence of photographs. In light of the variability in manifestations of symptoms, and the recorded difficulty with which an attack could be accurately observed, the arranged presentation of the stages of attacks in the photographs appears as a contrivance intended to support the medical veracity of their fixed sequence.

The photographs also validate Charcot’s model of hysteria by giving fixed physiognomic, psychological, and medical content to the variable emotional states of the attitudes passionnelles. These states are actually

26 Ibid., 139.
marked by variable duration and involve subjective utterances. Yet these fluctuating moods and expressions are presented as symptoms that share the stability of such neurological symptoms as “tétanisme” and “contractions.” The very naming of the attitudes passionelles (“passional attitudes” or “poses”) renders primarily visual a subjectively meaningful state. The meaning of these variable states was further fixed through the use of captions, which ostensibly identified, but in fact constructed, the specific meaning of each gesture. Finally, the poses present as stereotyped depictions of emotion what were probably witnessed as chaotic gestures. In fact, the style of the photographs has much less in common with other early photographs of mental patients than with the theatrical portraiture of the day.  

To observe their kinship to theatrical portraiture, see E. A. McCauley, A. A. E. Disderi and the Carte de Visite Portrait Photograph (New Haven, Conn.: Yale University Press, 1985).

FIG 2  Debut d’une attaque—cri. (Plate 28, Iconographie photographique de la Salpêtrière, vol. 2.)
Charcot explicitly believed that his photographs satisfied both an artistic tradition and a scientific demand. Commenting on the series of photographs by Albert Londe in his lecture “On Six Cases of Hysteria in the Male Subject,” Charcot said: “All this part of the seizure is very fine, if I may so express myself, and every one of these details deserves to be fixed by the process of instantaneous photography. . . You see that from the point of view of art they leave nothing to be desired, and moreover they are very instructive.”

The Iconographie photographique de la Salpêtrière was by no means the only visual documentation of clinical material produced by Charcot and his colleagues. In the late 1880s, with others, Charcot’s collaborator

28 J.-M. Charcot, Clinical Lectures on Certain Diseases of the Nervous System, trans. E. P. Hurd (Detroit: George S. Davis, 1888), 129. A. Rouillé and B. Marbot provide the following quote from Albert Londe: “Medical photography had great importance from the didactic point of view, especially benefitting the doctors, but the sick person who was used as subject of observation did not benefit from it at all” (Le corps et son image: Photographies du dix-neuvième siècle [Paris: Contrejour, 1986], 60).
Richer produced the *Nouvelle iconographie de la Salpêtrière*, "clinical picture books" that were half case histories and half discussions and reproductions from the Great Masters. In *Les démoniaques dans l'art* (1887), Charcot and Richer argue that the portrayal of hysteries by photography offers a contemporary equivalent of the Great Masters' portrayal of "maniacs." They also state their view of the relation of artistic and scientific observation:

Every resource is lacking to the painter, sculptor, actor, outside the exact observation of nature. For it does not suffice simply to deform

things as pleases you and to make things strange as you see fit; beneath this apparent incoherence there is a hidden reason that arises from a morbid process, and, in the nature of the deformations of the parts or in the contortions of the whole, as well as in the order and grouping of all these phenomena, one finds, just as is demonstrated by our studies of the works of ancient and modern masters, the indisputable signs of a pre-established order, all the constancy and inflexibility of a scientific law.30

Since Charcot viewed artists and scientists alike as faithful renderers of a “pre-established order,” the use of painterly techniques to retouch his photographs probably seemed a necessary enhancement rather than a selective distortion. The alignment of Augustine’s photographs with representational traditions in art is effected through both the application of paint and the use of pose. A striking feature of the series taken as a whole is the liberal use of white paint or gouache on the surfaces of the drapery, and in some cases on Augustine’s hair. Paint may have been applied in some cases to compensate for variable depth of field or badly focused shots; however, its application constitutes an aesthetic choice.31 The application of paint to the drapery creates a sculptural effect, particularly in plates 16, 21, 28 (fig. 2), and 30 (fig. 4). These images, ostensibly taken at the precise moment of a hysterical attack, look timeless. They are made weighty and solid, and Augustine, surrounded by her heavy drapery, is imbued with static permanence. The addition of paint creates a contrast in dimensions and surfaces that renders Augustine’s skin comparatively soft and luminous. Her vitality becomes tender and seductive in juxtaposition with the painted fabric. The photographs belie the prevalent notion of hysteria as an illness almost defined by the changeability of its manifestations.

The photographs of Augustine’s attitudes passionnelles evoke traditional religious and erotic depictions of women. Plates 29 and 30 (figs. 3 and 4) offer a particularly interesting convergence of medical and aesthetic concerns. In these two images, Augustine gazes out at us; in plate 29 (fig. 3), her frank stare complements the frontal exposure of her body parts. Her body is posed to be viewed straight on, presumably so that the contracture may be fully inspected in an image offering the best opportunity for clinical observation. The perspective of the body is at odds with that of the chair and floor. The chair seems dwarfed by her, and her appearance of abnormality is heightened since the distortion of

31 Walter Benjamin writes of the ways photographs were made to appear more artistic through the “arts of retouching.” See “Walter Benjamin’s Short History of Photography,” trans. P. Patton, Artforum (February 1977), 46–51. I am grateful to Martha Sandweiss, director of the Mead Art Museum at Amherst College, for information on the history of photography.
the contracture is rendered more extreme by the inconsistency of planes. At the same time, her exposed flesh heightens her apparent vulnerability and seductiveness. Her bareness, the exposure of as many body surfaces as possible, and the angles at which these body parts meet each other, fulfill the demands of medical viewing and, at the same time, combine with Augustine’s gaze to create an erotic allure. In plate 30 (fig. 4), medical and artistic concerns are in tension. The scientific rationale for Augustine’s position is problematic, for the contracture would be better displayed if the disfigurement of the shoulder joint were not incorporated into a familiar posture of feminine seduction. The composition of plate 30 demonstrates for us, however, the subordination of medical to aesthetic concerns through its use of a stock female display pose.

The sexual content of the *attitudes passionnelles*, and the suggestiveness of their portrayal, are particularly interesting in light of Charcot’s repeated statements that hysteria was not a disorder of sexuality at all. In an 1892 article, he and P. Marie wrote: “As to the sexual life, we protest against the opinion universally adopted by the public that all hysterical women have a tendency to lubricity, almost bearing on nymphomania. Far from this, our opinion founded on the observation of numerous hysterical females in the Salpêtrière is that hysterical women are less sexual than sane and normal individuals; we may even add that hysterical patients with total anesthesia show absolute indifference to intercourse.”

In *Studies on Hysteria*, Freud would excuse his own initial inattention to the sexual dimension of hysteria by saying, “I had come fresh from the school of Charcot, and I regarded the linking of hysteria with the topic of sexuality as a sort of insult—just as the women patients themselves do.” The contradiction between the photographic representations and Charcot’s stated observations might have been resolved through attention to the actual effects of sexual trauma; it might have been possible, for instance, to discover in the experience of sexual trauma the reasons why hysterics both sought attention and showed “absolute indifference to intercourse.” Yet the Salpêtrière doctors could only have gained such an understanding through listening to their patients’ words.

*The treatment of verbal information*

In his renowned “Tuesday Lessons,” Charcot demonstrated the extemporaneous application of his clinical technique. Examining a


33 *SE* (n. 8 above), 2:260.

34 Charcot’s case presentations were not, in fact, always extemporaneous. Although the Tuesday Lessons were promoted as Charcot’s exposure to cases he had never seen before, in fact they were often cases he had seen at one point or another. For more information on the structure of Charcot’s clinical presentations, see Goetz’s preface and introduction to *Charcot, the Clinician* (n. 7 above).
woman in order to arrive at a differential diagnosis of epilepsy or hyst-eria, he says:

Let us press again on the hysterogenic point. Here we go again. Occasionally subjects even bite their tongue, but this would be rare. Look at the arched back, which is so well described in the textbooks.

Patient: Mother, I am frightened.

Charcot: Note the emotional outburst. If we let things go unabated, we will soon return to the epileptoid behavior. Now we have a bit of tranquility, of resolution, followed by a type of static contracted posture. I consider this latter deformity as an accessory phenomenon to the basic attack. (The patient cries again: "Oh! Mother.")

Charcot: Again, note these screams. You could say it is a lot of noise over nothing. True epilepsy is much more serious and also much more quiet."

In its implicit linking of epilepsy’s seriousness to an absence of subjective outbursts, this vignette suggests Charcot’s view of the status, significance, and usefulness of patients’ talk.

The case history of Augustine offers a vivid array of subjective information, remarkable for how uneasily it is fitted into the overarching biological-hereditary framework its authors attempt to provide. The case history opens with an exposition of the topic of primary medical interest (menstruation) and a summary specifying the topics to be covered. Bourneville offers this description of Augustine’s appearance upon her arrival at the hospital: “L . . . [her name is given several different ways within the case] is blonde, tall, and strong for her age, and gives every appearance of a pubescent girl. She is active, intelligent, affectionate, impressionable, but capricious, loving to attract attention. She is coquettish, takes a great deal of care with her toilette, and with fixing her hair, which is abundant, arranging it sometimes in one way, sometimes in another, with ribbons, bright ones, making her especially happy."36

The case goes on to record the results of neurological examination and Augustine’s symptoms (her aura, her digestive functions, and breathing). A year and a half of her stay in the Salpêtrière is recorded over thirty-six pages, detailing her periods, attacks, and treatment, and illustrated by the photographs. Fragments of her périodes de délire are given in the context of the course of her attacks. In the périodes de délire, Augustine engages


in what Bourneville calls her "bavardage" (chattering or gossip).37
"More expansive" than the other patients, her "veritable delirium of
words" occupies more than seven pages of fine print. In her hallucina-
tions, she converses with what the doctors at the Salpêtrière call her
"Invisibles," a term that refers to her hallucinated characters while in-
advertently suggesting the workings of her mind, hidden from the obser-
vational techniques of the Salpêtrière doctors.

Augustine's history, entitled "Antécédents," supplies the lurid details
of her young life. While she is a student at a religious school away from
home, the husband of a woman she knows tries to rape her. She returns
to her family in Paris on her vacation, where she meets Mr. C., her
mother's employer. Her mother compels her to kiss this man and call him
her father. She is then placed in his home, under the pretext of teaching
his children to sew and sing. Lodged in a small isolated back room,
Augustine is visited at night by Mr. C., "who was not on good terms with
his wife," and who attempts to rape her twice without success. The third
time, "[Mr.] C. . . . after having made all sorts of promises shine before
her eyes, having offered her pretty dresses, etc., seeing that she did not
want to give in, threatened her with a razor; taking advantage of her
fright, he made her drink a liqueur, undressed her, threw her on the bed,
and had complete relations."38

Afterward, Augustine lost blood, "had pain in her genitals and was
unable to walk." Her doctor thought she had begun her period. At this
time Augustine was thirteen and a half. Soon thereafter she had her first
hysterical attack.

Following these events, Augustine runs into Mr. C. on other occa-
sions; he threatens her and thereby provokes renewed attacks. She is
placed with an old woman as a chambermaid, at which time her brother
introduces her to two of his friends, with whom she has sexual relations.
She also realizes that Mr. C. was her mother's lover and that her mother
procured her for him.

As her story unfolds, Augustine's delirious account is riddled with ref-
erences to her mother who betrayed her, her father who did not protect
her, her employer who raped her, and her brother who procured her for
his friends. She dwells repeatedly, incessantly, on her own blamelessness,
articulating her efforts to fend off unwelcome advances and to protect
herself from pregnancy. In reference to Mr. C. and the rape itself, she says:

Then, I had Mr. C. . . .; after that I would do well to tell Madame
. . . to tell papa . . . but Mr. C. told me that he would kill me. What

37 Ibid., 158, 172.
38 Ibid., 126.
he showed me, I didn’t know what it meant. He spread my legs . . . I didn’t know that it was an animal that was going to bite me . . . I’m going to go out every night because he wants to go to bed with me. He told me that he would kill me. He hurts me. . . . He says that later on it will make me feel good. . . . But it’s a sin . . . I will be forced to tell papa. . . . That’s how people make children. What! a baby! If Mr. C. . . were to make me a baby. . . . And mother claimed that she was putting me in a safe house!39

Battling with her brother Antonio about the sexual goings-on between herself and his friend, she says: “Antonio, you are going to repeat what he told you . . . that he had touched me. . . . But I didn’t want it. . . . Antonio, you lie! . . . It’s true, he had a snake in his trousers, he wanted to put it in my stomach, but he didn’t even find me. . . . Me, I’m a lunatic? . . . Antonio, you’re joking. I’m going to smack you! (Look of contempt and disgust).”40

The centrality of sexual trauma in hysteria is vividly suggested by these utterances; in the medical accounts, however, it finds expression only in the elaborate attention paid to symptoms involving female reproductive biology. The doctors assiduously note, for instance, the onset, heaviness, and length of menstrual periods and observe a relation between periods and hysterical attacks. Although these facts and correlations are carefully recorded and an enormous amount of evidence about sexuality is laid out, the doctors do not cast these as correspondences whose meaning is mediated by subjective experience.

This simultaneous fascination with, and neglect of, the relation between sexual functions and convulsive attacks is shown more clearly still in the case of “Geneviève.” “We insisted above,” the authors write, “on the relation that existed between menstrual periods and the attacks. We must add again, that sexual relations, at least at first, diminished the convulsive crises, of which the two pregnancies had augmented the number, whereas breastfeeding appeared to lead to a certain amelioration.”41

The report reads as if biological signs had self-evident and unequivocal meaning, and it does not address meanings for which Geneviève’s verbal utterances provide a wealth of suggestions. Her biographical information reveals that she is an adopted child whose wet nurse died in her first months of life. Her betrothed dies when she is fifteen; at sixteen she is sexually approached by her employer. Soon after, her attacks begin and she is put in a hôtel-Dieu where the nuns think she looks pregnant and punish her. She is transferred to a mental hospital, where she cuts off her

39 Ibid., 161.
40 Ibid., 149.
41 Ibid., 1:94. The emphasis is in the original.
right nipple. Geneviève goes from asylum to asylum, ending up at the Salpêtrière. She then escapes to Montbard, where Prussian soldiers hold her: “During eight days she had relations with one (?) Prussian officer, relations that resulted in a second pregnancy.”42 When she is returned to the Salpêtrière, Bourneville remarks that Geneviève’s “attacks were very numerous and very strong during pregnancy,” although she “insists that during the six weeks of breastfeeding she did not have one attack.”43 When her child dies at six weeks, the attacks resume.

At the Salpêtrière, “her talk rolls on without cease about the most striking events of her existence, which are the object of her preoccupation in her normal state.”44 In her hallucinations she complains that serpents and vipers are penetrating her stomach and making her suffer; she says that “if she refuses to eat, it’s because she doesn’t want to feed all those beasts.”45 Her imagery resonates with Augustine’s reference to the erect penis of her brother’s friend as “a snake in his trousers” that he wants to put in her stomach. The similarity of Augustine’s and Geneviève’s fears might have suggested to the Salpêtrière clinicians a common pool of misinformation, sexual theories, or fantasies whose meaning could be explored. However, hereditary-biological explanations provided a rationale for not interrogating these connections further.

Most critically, perhaps, the doctors did not take into account the emotions and motives of their women patients, or the interaction of their patients’ emotional agendas and their own investigative procedures. Describing the social structure of the hospital wards, Bourneville writes: “G. is jealous of another sick person A. . . , with whom we are engaged for the purposes of research on magnetism, hypnotism, etc. Mr. Charcot addressed a sharp reprimand to her. She was profoundly mortified by it. Under the influence of this strong emotion the spinal pain completely disappeared and the attacks could no longer be provoked.”46

This passage hints at the fraught emotional milieu in which the research was being conducted. It suggests triangular jealousies between patients and doctors, competition for attention, and direct links between symptomatology and emotional experiences. Yet G.’s response is not discussed in this light; instead, the spheres in which the hysterical patient’s motives and feelings are most readily invoked include simulation, fraudulence, and the “natural” coquetry of the hysteric.

The question of fraudulence was a pressing one at the Salpêtrière, related as it was to the establishment of hysteria’s legitimacy. Charcot

42 Ibid., 2:67. The (?) is in the original.
43 Ibid., 1:56.
44 Ibid., 69.
45 Ibid., 64.
46 Ibid., 2:205.
betrays in his Lectures on Diseases of the Nervous System a mistrust of the patients’ behavior altogether different from his unquestioning faith in visual evidence: “Simulation . . . is met with at every step in the history of hysteria. One finds oneself acknowledging the amazing craft, sagacity, and perseverance which women . . . especially under the influence of this great neurosis . . . will put into play . . . especially when a physician is to be the victim.” This pronouncement reveals an inconsistency in Charcot’s opinion of the relationship of women and hysteria; for although he generally insisted that hysteria was not specific to women—contrary to a view that had prevailed since antiquity—he here implies that hysteria amounts to an exacerbation of female nature.

The hysterical tendencies toward self-display and adornment were not simply recorded but, rather, encouraged when she was placed in front of the camera’s eye for the purposes of medical documentation. In this meeting of the patient’s desires and the doctor’s intent, the question of “objective” knowledge through visual representation in photographs was thrown into confusion. The doctor’s interpretation was that her desire for attention and self-display were typical hysterical signs; yet for the patient who had suffered severe trauma in the spheres of love and loyalty, the treatment of her illness and the “doctoring” of her photographs may both have expressions of the attention and care she had been deprived of in the past.

47 Charcot, Clinical Lectures on Certain Diseases of the Nervous System (n. 28 above), 230.
48 IPS (n. 1 above), 2:190.
49 Ibid., 168.
50 This hidden dynamic by which the needs of both doctor and patient are filled provides, Michel Foucault writes, an instance where “the sign no longer speaks the natural language of disease; it assumes shape and value only within the question posed by medical investigation. There is nothing, therefore, to prevent it being solicited and almost fabricated by medical investigation. It is no longer that which is spontaneously and almost by the disease itself; it is the meeting point of the gestures of research and the sick organ-
Freud

Background

Richard Wollheim has written that “Freud’s life work . . . was a research into the deafness of the mind.”51 Ultimately for Freud, the deafness of the mind revealed itself in a special way in the symptomatology of hysteria: memories of events the conscious mind could not tolerate were expressed in physical symptoms. It was this commemoration of events by symptoms that Freud and Breuer sought to describe in their well-known aphorism, “Hysterics suffer mainly from reminiscences.”52 Freud’s conceptualization of hysteria diverged from Charcot’s, and it depended on a very different method—that of listening—for its construction.

Though Freud was a neuropathologist by training, his interest in medicine was by no means narrow or even particularly focused. His family noted in him a “lack of genuine medical temperament,”53 and he took seven years to finish his medical studies, having plunged himself instead into the study of zoology, biology, and philosophy at university. A critical figure in Freud’s philosophical training was Franz Brentano, with whom Freud studied for five semesters.54 For Brentano the science of psychology stood on ground as firm as the natural sciences; in terms of method, Brentano advocated “a scientific working back and forth between the evidence of the inner ‘subjective’ world and the outer ‘objective’ world”—which, as McGrath points out, marked the mature method of Freud as well.55

Freud’s wide-ranging interests, and his ambition to use medicine as a path to “realizing his intense curiosity in nature and human relations,” were consonant with an interest in establishing the relationship of biological and psychological phenomena. With specific regard to hysteria, Freud’s goal was to establish “a combined psychophysiological basis for both hypnotic and hysterical phenomena.”56 This is why Freud sought to study with Charcot, the reigning expert on the neurological aspects of hysteria.

52 SE (n. 8 above), 2:7.
54 The influence of Brentano’s philosophy of psychology on Freud has been explored in great detail by W. J. McGrath in Freud’s Discovery of Psychoanalysis: The Politics of Hysteria (Ithaca, N.Y.: Cornell University Press, 1986).
55 Ibid., 100.
Throughout his published references to Charcot, Freud lavished praise upon his mentor for his method of diagnosis and classification, as well as for his use of hypnosis, which had begun to suggest the importance of the "psychical element" in hysteria. In terms of method, Freud was deeply influenced by Charcot's combined use of anatomical knowledge and clinical experience.57 In his obituary of Charcot in 1893, he lauded Charcot's special gifts: "He was not a reflective man, not a thinker: he had the nature of an artist—he was, as he himself said, a visuel, a man who sees."58 Freud was also impressed by the fruitful transfer of Charcot's method from the study of organic diseases to the study of neuroses; he credited Charcot with having made clear the lawful nature of these phenomena.59 Through Charcot's use of the archetype as a way of understanding clinical disorders, hysteria was, by Freud's account, "lifted out of the chaos of the neuroses, was differentiated from other conditions with similar appearance, and was provided with a symptomatology, which though sufficiently multifarious, nevertheless makes it impossible any longer to doubt the rule of law and order."60 Further, Freud was influenced by Charcot's use of hypnosis, both for its therapeutic effects and for the legitimacy it conferred upon what was still regarded in some Viennese medical circles as quackery.

Between 1886, when Freud returned from Paris, and 1895, when Studies on Hysteria was published, Freud's views diverged from Charcot's in three important areas: the etiology of hysteria, the use of hypnosis, and clinical method.61

In looking to sexuality as the critical link between the psychological and physical aspects of hysteria, Freud rejected the explanations he had received from Charcot. Charcot had eschewed the importance of sexuality in hysteria and had revealed himself to be relatively uninterested in exploring possible points of contact between the physiological and psychological origins of hysteria. Charcot's lack of interest in the role of sexuality later appeared to Freud in a strange light. Freud recounts an

57 See, e.g., SE, 1:10 and 3:11–23.
58 Freud, "Charcot" (n. 8 above), 3:9–23.
59 Sulloway, 49.
60 SE, 1:12.
anecdote in his 1914 article, “On the History of the Psychoanalytic Movement”:

At one of Charcot’s evening receptions, I happened to be standing near the great teacher at a moment when he appeared to be telling Brouardel some very interesting story from his day’s work. I hardly heard the beginning, but gradually my attention was seized by what he was saying. A young married couple from the far East: the woman a confirmed invalid: the man either impotent or exceedingly awkward. “Tachez donc,” I hear Charcot repeating, “je vous assure, vous y arriverez” [Keep trying, I assure you, you’ll get there]. Brouardel, who spoke less loudly, must have expressed his astonishment that symptoms such as the wife’s could have been produced in such circumstances. For Charcot suddenly broke in with great animation, “Mais, dans des cas pareils c’est toujours la chose génitale, toujours . . . toujours, toujours” [In these kinds of cases, it’s always a genital thing, always . . . always, always]; and he crossed himself with his arms over his stomach, hugging himself and jumping up and down on his toes several times in his own characteristic lively way. I know that for one second I was almost paralyzed with amazement and said to myself, “Well, but if he knows that, why does he never say so?” But the impression was soon forgotten; brain anatomy and the experimental induction of hysterical paralyses absorbed all available interest.62

Within his own developing psychological framework, Freud began to reinterpret some of the symptoms Charcot had observed. Reconceptualizing Charcot’s attitudes passionnelles, Freud wrote: “The core of a hysterical attack, in whatever form it may appear, is a memory, the hallucinatory reliving of a scene which is significant for the onset of the illness. It is this event which manifests itself in a perceptible manner in the phase of ‘attitudes passionnelles’; but it is also present when the attack appears to consist only of motor phenomena.”63 In a letter to Fliess in late 1896, Freud devised a novel account of Charcot’s périodes de clownisme: “The explanation of the phase of ‘clownism’ in Charcot’s schema of [hysterical] attacks, lies in the perversion of the seducers who, by virtue of the compulsion to repeat what they did in their youth, obviously seek their satisfaction by performing the wildest capers, somersaults, and gri-

62 SE (n. 8 above), 14:13–14.
63 Ibid., 1:137.
Behaviors of hysterics were, to Freud, meaningful mimicry of traumatic past events.

Freud's overall dissatisfaction with, and shift away from, Charcot's method is evident in his 1893 view of Charcot's use of hypnotism: "The exclusively nosographical approach adopted at the School of the Salpêtrière was not suitable for a purely psychological subject. The restriction of the study of hypnosis to hysterical patients, the differentiation between major and minor hypnotism, the hypothesis of three stages of 'major hypnotism,' and their characterization by somatic phenomena—all this sank in the estimation of Charcot's contemporaries when Liébeault's pupil, Bernheim, set about constructing the theory of hypnotism on a more comprehensive psychological foundation and making suggestion the central point of hypnosis."65

Thus, Freud saw the approach of visual observation as simply inadequate to a "purely psychological subject" such as hysteria. This shift, combined with a change in his orientation to hypnosis, ushered in Freud's third critical divergence from Charcot, his use of a novel clinical-investigative method.

Listening, speaking, and the use of words in "Studies on Hysteria"

Freud visited Bernheim in Nancy in 1889 in order to perfect his hypnotic technique, but he soon became dissatisfied with the efficacy of suggestion and began experimenting with a method which, along the lines of Breuer's, used hypnotism to uncover memory of past events. Much earlier, in November 1882, Breuer had told Freud of his treatment of Anna O., which had been conducted between 1880 and 1882. Freud was extremely interested both by Breuer's use of hypnotism as a method of catharsis and by the young woman patient's response to it.

With Anna O., Breuer had found that hypnotism operated to reproduce the "hypnoid state" in which the symptoms first appeared. When Breuer returned her to her hypnoid state, she could recite the events that had originally brought on the symptom. In his treatment of Frau Emmy von N., which began in May of 1888 or 1889 and lasted a year, Freud used the cathartic method "to a large extent" for the first time.66 His 1924 footnote to that case affirmed that he also used a great deal of direct therapeutic suggestion. His "first full-length analysis of hysteria,"67 that of Fräulein Elisabeth von R., began in the fall of 1892, and the analysis of Miss Lucy R. began later that year. The fourth case study, that of Katha-

64 Masson, ed., 218.
66 Ibid., 2:105.
67 Ibid., 139.
rina, is undated but occurred within the same time span. An exploration of the two most detailed cases, those of Emmy von N. and Elisabeth von R., offers a picture of the method Freud developed to investigate what he understood to be the psychological disorder of hysteria. Moreover, they emblemize Freud's approach to understanding and representing hysteria in the same way as Charcot's photographs emblematize his.68

Emmy von N. was a woman of about forty whose symptoms and personality interested Freud so greatly that, as he wrote, "I devoted a large part of my time to her and determined to do all I could for her recovery."69 She was an exceptionally intelligent woman of "finely-cut features and noble character," who was able to conduct herself with great competence except during her bouts of hysteria. Freud visited her daily, usually twice, during the first three weeks of treatment at the nursing home where he had recommended she stay. Sometime in the course of Freud's first meeting with her, Emmy's coherent self-presentation and poised bearing gave way to "an expression of horror and disgust," and she exclaimed, "Keep still—Don't say anything—Don't touch me!" Freud conjectured that the words provided a "protective formula," an attempt to control her frightening thoughts.70

On the morning of May 10, as he massages Frau von N. (part of the acceptable practice of the day), Freud alleviates her doubt about an incident with Dr. Breuer, and her agitated tongue-clacking and grimaces stop. He remarks:

So each time, even while I am massaging her, my influence has already begun to affect her; she grows quieter and clearer in the head, and even without questioning under hypnosis can discover the cause of her ill-humor on that day. Nor is her conversation during the massage so aimless as would appear. On the contrary, it contains a fairly complete reproduction of the memories and new impressions which have affected her since our last talk, and it often leads on, in a quite unexpected way, to pathogenic reminiscences of which she unburdens herself without being asked to. It is as though she had adopted my procedure and was making use of our conversation, apparently unconstrained and guided by chance, as a supplement to her hypnosis.71

68 Studies on Hysteria is a joint work of Freud and Breuer, but here I am exploring two of Freud's cases. For a detailed summary of the two doctors' respective roles in producing the work, see J. Strachey, "Editor's Introduction," SE, 2:ix–xxviii.

69 SE, 2:48.

70 Ibid., 49.

71 Ibid., 56. Strachey notes, "This is perhaps the earliest appearance of what later became the method of free association" (ibid.).
In some respects the passage contains in microcosm the development of Freud’s technique. First, his “influence” begins to take hold without the necessity of actual hypnotism. His massage, his presence, and his attentiveness elicit her conversation, which, unlike the “babbling” of Charcot’s patients, is not “so aimless as would appear.” Frau von N. begins to recount her recent memories and impressions since their last talk and works her way back to pathogenic reminiscences. She herself makes use of the conversation for her own purposes, “without being asked to”; she thus participates in constructing the method in a context provided by Freud, a context that is, at least, not inimical to fluid self-expression.

When Freud does not provide Frau von N. with what she needs, she tells him. Asked about the meaning of each piece of her “protective formula,” “she explained that when she had frightening thoughts she was afraid of their being interrupted in their course, because then everything would get confused and things would get even worse.”72 Two days later, Freud asks the hypnotized Emmy to remember by the next day why she had gastric pains; “She then said in a definitely grumbling tone that I was not to keep on asking her where this and that came from, but to let her tell me what she had to say. . . . (I saw now that the cause of her ill-humour was that she had been suffering from the residues of this story which had been kept back).”73

Freud realizes from this exchange that by directing the conversation, he has been creating an impediment to his patient’s “free association.” He takes her statements as evidence that his procedure has not been “carried out exhaustively enough.”74 By noting Frau von N.’s moods following their sessions and relating these to the exhaustiveness with which he carried out the catharsis, Freud draws a theoretical conclusion that symptoms are attached “not solely to the initial traumas but to a long chain of memories associated with them,” which must likewise be dealt with through catharsis.75 When Freud uses visual cues, it is to read in the patient’s face whether she has truthfully divulged her entire story. Even though Freud might at first prefer to cut his patient’s words short, he realizes the importance of thoroughly listening to all the patient needs to say if a cure is to be reached and his theory is to be proven.

Freud, like Charcot, did not see himself as a therapist. In a letter to Fliess dated April 2, 1896, Freud conveyed his own reluctant involvement in psychotherapy: “As a young man I knew no longing other than for philosophical knowledge, and now I am about to fulfill it as I move from

---

72 Ibid.
73 Ibid., 63.
74 Ibid., 74, n. 1.
75 Ibid., 75, n. 2.
medicine to psychology. I became a therapist against my will."\textsuperscript{76} Freud may have had, at least initially, a distaste for therapeutics, but he recognized in therapy a process necessary to the study of the illness.

When Emmy von N. becomes fearful of how she will fare when her treatment ends, Freud reassures her, telling her that she has become healthier and suggesting "that she would get in the habit of telling her thoughts to someone she was on close terms with."\textsuperscript{77} His injunction reveals the importance he attributes to the act of verbal unburdening for the hysteric. Freud also specifies a relational context for the unburdening—"someone she was on close terms with." He thereby suggests a fundamental similarity between the doctor's relationship to the patient and the patient's relationship to a friend or confidante in daily life.

In his treatment of Emmy von N., Freud further develops his opposition to Charcot's hereditary view of hysteria. He specifically objects to Charcot's insufficient distinction between hereditary predisposition to neurosis and the acquisition of nervous disease either through early childhood events or through the combination of trauma and inherited vulnerability.\textsuperscript{78} Charcot's theory of the \textit{famille néropathique}—"which, incidentally, embraces almost everything we know in the form of nervous diseases, organic and functional, systematic and accidental"\textsuperscript{79}—was far too general and dismissive in Freud's view. Statements in the \textit{Studies} of his opposition to the hereditary hypothesis show that Freud believed the issues Charcot deemed biological belonged instead in the realm of relationships. The issue of degeneracy, important to Charcot, is only relevant in cases where it impairs the ability of the patient to participate in the process of psychotherapy: "The procedure is not applicable at all below a certain level of intelligence, and it is made very much more difficult by any trace of feebleness of mind. . . . It is almost inevitable that their personal relation to him [the doctor] will force itself, for a time at least, unduly into the foreground. It seems, indeed, as though an influence of this kind on the part of the doctor is a \textit{sine qua non} to a solution of the problem."\textsuperscript{80} Here "influence" refers to hypnotic suggestion, and it hints at the concept of transference. Later in the chapter, Freud more fully addresses the centrality of the doctor-patient relationship: "I have already indicated [\textit{SE}, 2: 266] the important part played by the figure of the physician in creating motives to defeat the psychical force of resistance. In not a few cases, especially with women and here it is a question of elucidating erotic trains of thought, the patient's cooperation becomes a

\textsuperscript{76} Masson, ed. (n. 61 above), 180.

\textsuperscript{77} \textit{SE} (n. 8 above), 2:75.

\textsuperscript{78} See, e.g., ibid., 294, and 1:139.

\textsuperscript{79} Ibid., 1:142–43.

\textsuperscript{80} Ibid., 2:265.
personal sacrifice, which must be compensated by some substitute for love. The trouble taken by the physician and his friendliness have to suffice for such a substitute. If, now, this relation of the patient to the physician is disturbed, her cooperativeness fails, too."\(^8^1\)

To counter the hereditary hypothesis, however, Freud did not simply offer a psychological one. He invoked the exemplary qualities of the hysterical patients themselves in order to break the equation of hysteria with degeneracy. In closing the case of Emmy von N., Freud writes: "The woman we came to know was an admirable one. The moral seriousness with which she views her duties, her intelligence and energy, which were no less than a man's, and her high degree of education and love of truth impressed both of us greatly; while her benevolent care for the welfare of all her dependents, humility of mind and the refinement of her manners revealed her qualities as a true lady as well. To describe such a woman as a 'degenerate' would be to distort the meaning of that word out of all recognition."\(^8^2\)

Freud's legitimation of his psychological theory, then, was intertwined with the question of the status or worthiness of the patient. Freud lays great stress on the refinement and high social standing of Frau von N.; though she has a "more lively and uninhibited way of expressing her emotions than [is] usual with women of her education and race,"\(^8^3\) she is a highly educated woman nonetheless. And, interestingly, the measure of her superiority is described in terms of her equality with a man. If man is the measure, then the extent to which she is not "degenerated" is the extent to which she equals a man precisely in those qualities where man is superior. Freud's repeated emphasis on Emmy's character, breeding, and general superiority not only serves to correct some prejudices (in-crimination by association) against the victims of the disorder and against the disease, but also buttresses the utility of his particular method of cure.

Describing the difficulties and disadvantages of his psychotherapy later on in the Studies, Freud writes: "The procedure is laborious and time-consuming for the physician. It presupposes great interest in psychological happenings, but personal concern for the patients as well. I cannot imagine bringing myself to delve into the psychical mechanism of a hysteria in anyone who struck me as low-minded or repellent, and who, on closer examination, would not be capable of arousing human sympathy."\(^8^4\) Freud brings out with admirable candor the link of compassion and interest (both qualities of a personal relationship) to a sense of

\(^{8^1}\) Ibid., 301.
\(^{8^2}\) Ibid., 104.
\(^{8^3}\) Ibid., 91.
\(^{8^4}\) Ibid., 265.
respect for the patient. Aside from the virtue of his forthright tone, however, his suggestion that probing the mind of someone "low-minded" would not be worthwhile is consistent with, and in some sense justifies, Charcot's failure to question his destitute women patients at the Salpêtrière. High-mindedness and, by implication, membership in "an educated and literate social class"85 made Freud perceive his patients as less distant and their subjective worlds as less strange and repellent.

The case of Elisabeth von R. is the most consummately crafted tale of the Studies and provides the best early account of the relation between therapist and patient. Freud introduces the case with his first interview and shares with us the suspense of his initial ignorance about this young woman and her disease. He leads us through his difficulties in settling on a technique and his slow realization of "the connection between the events in her illness and her actual symptom."86 Freud then unfolds a very long and involved family drama, following which he writes: "If we put greater misfortunes on one side and enter into a girl's feeling, we cannot refrain from deep human sympathy with Fraulein Elisabeth. But what shall we say of the purely medical interest of this tale of suffering and of its relations to her painful locomotor weakness, and of the chances of an explanation and cure afforded by our knowledge of these psychical traumas?"87 In answer to his own question, Freud says that "the patient's confession was at first sight a great disappointment."88 Her life seems too mundane to bring on hysterical symptomatology; the reasons for her symptom choice are far from clear. Like most physicians, Freud does not regard her experiences as sufficiently important to precipitate hysteria. Yet, instead of contenting himself with the common medical view that she is a constitutional hysterical, he inquires into the meaning of her symptoms: What kind of excitations led to them? What would her motives have been, and when had an association between "her painful mental impressions and the bodily pains" taken place? These are questions that can only be answered by information elicited from Elisabeth herself—information that is not always available to her, but which must be made so.

In striking contrast to Charcot's technique, Freud uses cues about what holds Elisabeth's interest as indications of what course to pursue. Thus, after investigating the different pains she has in her legs, he admits, "I did not pursue further the delimitation of zones of pain corresponding to different psychical determinants, since I found that the patient's attention was directed away from this subject."89

85 Ibid., xxix.
86 Ibid., 138.
87 Ibid., 144.
88 Ibid.
89 Ibid., 150.
Central both to the actual case and to its representation as a case history is Freud’s explicit participation as one of the characters in the story. He attempts to achieve objectivity not through the eradication of his own presence but, rather, by carefully describing his own role and tracing the steps of his own logic. We are never allowed to forget his participation, since he often refers to his own questions and doubts about his technique, and continually inserts his own perspective on the conundrums raised by the case.

A major feature of Charcot’s view of hysterics was an emphasis on hysterical dissimulation and the hysteric’s goal of making the doctor a fool. Interestingly, Freud raises these same issues, but in the context of the relationship between doctor and patient. Proceeding first with his pressure technique, Freud finds that Elisabeth has made no confessions that have led to a cure. He remarks that “during this first period of her treatment she never failed to repeat that she was still feeling ill and that her pains were as bad as ever; and, when she looked at me as she said this with a sly look of satisfaction at my discomfort, I could not help being reminded of old Herr von R.’s judgement about his favourite daughter—that she was often ‘cheeky’ and ‘ill-behaved.’ But I was obliged to admit that she was in the right.”90 Freud’s self-disclosure makes clear the doctor’s shared fallibility in the therapeutic enterprise. In this case as in others, Freud is ironic about his own ineptitude at pulling off a successful hypnosis. He gives dimension to the hysteric’s obstinacy and wish to deceive by including his own role in the drama.

One of Freud’s most quoted statements appears in the case of Elisabeth von R. and captures the essence of his innovative shift in method. He writes at the beginning of his “Discussion”:

I have not always been a psychotherapist. Like other neuropathologists, I was trained to employ local diagnoses and electro-prognosis, and it still strikes myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. The fact is that local diagnoses and electrical reactions lead nowhere in the study of hysteria, whereas a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affection.91

90 Ibid., 144–45.
91 Ibid., 160–61.
In a familiar Freudian voice, he refers to his own training and orientation as a way to inform (and convince) the reader that he did not proceed from any natural desire to delve into the minds and lives of his women patients. Rather, he was reluctantlly drawn there in response to the objective facts of the case. Similarly, he self-consciously refers to the product that has emerged from these investigations, case histories that "read like short stories" and "lack the serious stamp of science." He has listened to his patients, and their utterances have "dictated" to him an approach.

Although he almost apologizes for the narrative art of his account, its unorthodox form, it is precisely his worry about his role in constructing that account that is to his credit as a scientist. His innovative contribution operates in two related ways. The first is his inclusion of the subjective accounts of his patients in constructing his understanding of the disease. These early cases are marked by a relationship between doctor and patient in which both contribute to the building of the method, and both collaborate in the process of unearthing forgotten or repressed mnemonic origins of the illness. Freud recognizes, even at this formative stage, the mutual interest of the two participants as central, and the relation of patient and doctor as a fundamental precondition of, or obstruction to, therapeutic progress. We can see in the development of Freud’s technique a profoundly altered relationship to the patient.

The second and parallel innovation is Freud’s acknowledgment of his own subjective contribution, his own hand in constructing the account of hysteria he has presented. His surprise at digressing from "serious science" is conveyed in a rhetorical strategy used repeatedly throughout the Studies. By referring to the position adopted by his colleagues, and by then indicating what observations required him to diverge from their view, Freud conveys the necessity and inevitability of his new approach. For example, in a discussion of an eighteen-year-old patient, Freud writes:

To begin with I myself was unwilling to attach much importance to these details, and there can be no doubt that earlier students of hysteria would have been inclined to regard these phenomena as evidence of the stimulation of the cortical centres during a hysterical attack. It is true that we are ignorant of the locality of the centres for paraesthesias of this kind, but it is well known that such paraesthesias usher in partial epilepsy and constitute Charcot’s sensory epilepsy. . . . But the explanation turned out to be a different one. When I had come to know the girl better I put a straight question to her as to what kind of thoughts came to her during these attacks. I told her not to be embarrassed and said that she
must be able to give an explanation of the two phenomena [facial pricking sensations and convulsive foot stretching].

In this passage Freud moves from his initial emphasis (one shared by Charcot and others) on lesions and cortical stimulation to an explanation based on the causal role of the emotions and the therapeutic approach that must accompany this knowledge. He moves from a highly technical account of physiological symptoms to a question in plain language about the girl’s own experience; thus he contrasts a specific biological diagnosis with a disarmingly simple remedy: “When I had come to know the girl better I put a straight question to her.”

Just as Freud’s treatment depended critically on talking and listening, the role of words was central both to the description of the disorder and to the disorder itself. In terms of his description of the disorder, Freud uses a number of similes in order to “throw light from different directions on a highly complicated topic which has never yet been represented.” In terms of his theory of the causes of the disorder, Freud sees words as critical to the process of symbolization, which he views as midway between conversion and autosuggestion. Examples of symbolization are drawn from the cases of Rosalia H., who hysterically lost her voice at having to suppress anger, and from Cäcilie M., whose facial neuralgia appeared as an embodiment of a slight she had received (“a slap in the face”). Freud shows that as the centrally charged themes in the patient’s affective life are tapped, the implicated organ, in his words, “joins in the conversation,” adding credence to the view that the organ is in fact involved in a psychologically meaningful way. The fluid interchange between words and bodily symptoms defies previously constructed barriers in much the same way as Freud’s use of relationship in therapy.

The centrality Freud accorded verbal communication in uncovering hysteria’s origins, on the one hand, and his rhetorical craft in presenting the cases, on the other, are intertwined but are not identical; after the Studies, each underwent further development. By the time of Freud’s analysis of Dora in the autumn of 1900, he had developed his theory of

\[92\] Ibid., 93–94n.
\[93\] Ibid., 291.
\[94\] Ibid., 178. See also ibid., 275–76, 280.
\[95\] Ibid., 296.
\[96\] Freud comments wryly: “If anyone feels astonished at this associative connection between physical pain and psychic affect, on the ground of its being of such a multiple and artificial character, I should reply that this feeling is as little justified as astonishment at the fact that it is the rich people who own the most money” (ibid., 175).
dreams, had carried out an in-depth self-analysis, and was eager to prove the general importance of the Oedipal conflict he had discovered in himself. Freud’s directive and in many ways clumsy application of these ideas to the situation of Dora, indeed his inability to listen and understand what she was telling him, has received extensive commentary from both psychoanalysts and literary critics.97 Some writers have gone further to insist that Freud not only stopped listening but deliberately falsified what his women patients told him, by reinterpreting their accounts of sexual trauma as fantasies.98 Proponents of this view ignore repeated statements by Freud throughout his career as to the central importance of sexual trauma in some (though not all) cases of psychopathology.99 It is inarguable, however, that beginning with his conduct of the Dora case, Freud retrenched from his earlier reliance on his women patients for credible accounts and a share in the building of his method.

On the level of case presentation, Freud’s impressive rhetorical mastery has also received a great deal of recent critical scrutiny, especially with reference to the Dora case.100 Spence has written about the “Sherlock Holmes” tradition in psychoanalytic writing, which he dates from the case of Dora. The most problematic feature of this detective genre is the assumption that every case (detective or psychotherapeutic) has one possible solution or interpretation. Spence views this tradition as Freud’s unfortunate legacy to psychoanalysts, whose clinical reports tend to present case material geared to confirming or disconfirming existing theory, rather than revealing the actual interchanges and inferences that take place in therapeutic sessions.101

It is in light of these later developments that the Studies emerge as an important, and hitherto relatively neglected, early document. The Studies

97 The case of Dora is presented in Freud’s “Fragment of an Analysis of a Case of Hysteria” (1905 [1901]), ibid., 7:3–122. For commentary on the case by psychoanalysts, see M. Kanzer and J. Glenn, eds., Freud and His Patients (New York: Jason Aronson, 1980), esp. the articles by M. A. Scharfman, R. J. Langs, and I. Bernstein. Literary critical perspectives (and two psychoanalytic articles) are provided in Bernheimer and Kahane, eds. (n. 3 above).
100 See S. Marcus, “Freud and Dora: Story, History, Case History”; and N. Hertz, “Dora’s Secrets, Freud’s Techniques,” both in Bernheimer and Kahane, eds.
capture a moment when Freud’s therapeutic techniques were explicitly provisional and his rhetorical emphasis explicitly oriented to the process of the clinical encounter. Freud’s illuminating discoveries concerning the curative process are made in the context of his consideration of alternative approaches, his attention to details, and his careful recounting of these details. He attempts both to discern clinical realities and to lay bare the processes by which he arrives at them. Freud was, like Charcot, an ambitious man of science; but in the Studies, his desire to discover scientific truths compelled him to humble himself before what he heard and to identify his patients’ utterances as a primary source of clinical knowledge.

Conclusion

I have charted the different methods used by Charcot and Freud to investigate hysteria, and I have characterized these as depending primarily on processes of looking or listening. The questions that prompted my investigation concerned the Salpêtrière’s interest in photography and neglect of subjective patient accounts. These concerns can be captured in a more general question: Why was the subjective information of patients substantially ignored by Charcot, while for Freud it was central in building his theory of hysteria?

In providing an answer, I have tried to demonstrate that underlying Charcot’s use of visual observation was a conception of empirical neurological science and a tradition of the clinicoanatomic method. Gifted as a visual artist, Charcot brought his natural abilities to the task of observing and understanding neurological disease. When photography became available, it was regarded by Charcot and others as providing, quite literally, a truly objective record of reality. It was the retina of the scientist, with the supreme advantage of being able not only to see but also to record visual information.

One might infer from the enthusiasm with which Charcot greeted photography that its value resided, at least in part, in the improvement it represented over drawing and painting. However, it is clear that Charcot did not distinguish between painting and photography insofar as their ability to create truthful records of the disorder was concerned. Rather, he treated painters, photographers, and scientists as similarly accurate observers of nature. It was perhaps not much of a leap, then, for Charcot to incorporate his own documentation of hysteria into artistic tradition through pose, paint, and picture books that linked depictions of hysteria across the ages. Because art, photography, and clinical viewing all were seen by Charcot and his colleagues as objective, the craft—and distortion—necessary to align his representations of hysterics with artistic tradition went unnoticed.

The underside of Charcot’s fascination with the visual was his inattention to the subjective information conveyed by patients’ words. What amazes me about the Iconographie is the wealth of verbal information it presents and
the poverty of interpretation. This poverty can be understood on many levels. On the level of etiological explanation, the Salpêtrière doctors were limited by the global and relatively ill-defined model of heredity by which they understood hysteria and on which Charcot insisted throughout his career. Charcot's view of heredity operated through a deterministic logic by which anything that happened in the family, or that involved the reproductive functions, by virtue of its association with the course of hereditary transmission, was seen to be caused by it. In this light we can understand better how it was that any and all experiences involving menstruation, breastfeeding, pregnancy, childbirth, or sexual intercourse were collapsed together as the product of heredity and were regarded as unmediated by the meaning they might have for those who experienced them. Ironically, in their zeal to create a truly objective picture of hysteria, the Salpêtrière doctors were unable to see the ways in which the women patients' own subjective desires affected the picture they were constructing.

On the sociological level, one obstacle to Charcot's listening to his patients was that they seemed so different: they were women, they were poor, and they were sick. In a period when class, gender, and mental illness were considered more rigid categories than they are today, the disparities between the scientist and his subject gaped very large. To listen to (poor, sick) women's accounts, to see them as something other than "babbling," and to use these as scientific evidence was to throw into confusion accepted notions of knowledge and power. Had Charcot consciously and explicitly admitted these women's words as evidence (instead of recording and then ignoring them), he would also have had to admit that they could be tellers of truth and possessors of knowledge. He would have had to shift his notion of himself as a scientist from someone who talks only about, to someone who talks to, his subjects. With this shift Charcot's claim to the position of neutral observer would have been put into question. The fact that Freud did listen to his patients' accounts may rest in part on the fact that he saw a different group of patients, patients who were not warehoused en masse in an asylum but were able to visit his consulting room and to pay his fees.

On a psychological level, just as the psychoanalyst looks to areas of confusion or contradiction to locate intrapsychic conflict in his patient, one might detect in Charcot's own confused encounter with hysteria the evidence of some kind of internal conflict as well. The core question is why Charcot, who at least to some extent acknowledged the psychological component of hysteria, did not investigate it in his patients despite glaring evidence, carefully collected by the Salpêtrière chroniclers themselves. Successful as it was with strictly neurological diseases, his method rendered consideration of subjective evidence impossible and the subjective patient accounts themselves unintelligible. Parallel to Charcot's inability to take account of the subjectivity of the Salpêtrière patients was his inability to take account of the role his own subjectivity played. Charcot's and his
colleagues’ firm belief in their own objectivity itself constituted a threat to that very objectivity: first, by making them unable to question their own role in constructing the picture of the disease; and second, through their inability to see their own participation in recreating the pathogenic conditions of their patients’ lives—neglect, lack of empathy, and exploitation. They were likewise unable to see how the attention that they gave to the patients who served as photographic subjects contributed to the patients’ display of florid symptoms. What Charcot’s practice does not address explicitly is the ever-present mutual effect of the doctors on the patients and the patients on the doctors.

By drawing attention to Charcot’s problematic use of visual observation, I am not making a claim for the epistemological superiority of listening, nor do I claim with some feminist writers that looking is more closely aligned with masculine understanding, and listening with feminine, however these might be defined. 102 In my view, Charcot’s inability to account for his own subjective contribution did not arise from his visual method per se but, rather, resulted from his opinion that visual observation yielded an unproblematic apprehension of truth. In tracing the uses of the metaphor of vision in our conceptions of knowledge, E. F. Keller and C. R. Grontkowski have pointed out that visual observation can be used both to communicate and to objectify. 103 In Western philosophical tradition, they argue, the objectifying function of vision gained ascendancy at the expense of its communicative function. The Salpêtrière photographers privileged vision’s objectifying function, with the effects noted by Keller and Grontkowski: the radical division of subject and object and the submersion of the communicative, connective functions of vision in the service of objectification. The Salpêtrière’s use of photography can be seen as part of its overall tendency to disavow the observer’s perspective in the process of fashioning reality.

The stance adopted by the Salpêtrière doctors was founded on—and foundered upon—an inability to see their position as interpretive. In a psychoanalytic sense, the ultimate effect of disavowing personal perspectives and aims inherent in one’s enterprise is to create the conditions for their

102 The notion that seeing and sight are linked to masculinity, while listening and voice are particularly female-identified activities, has been articulated by French feminists such as Hélène Cixous and Luce Irigaray (see E. Marks and I. de Courtivron, eds., New French Feminisms [New York: Schocken, 1980]), and developed in other forms by American psychologists and critics (e.g., M. Belenky, B. Clinchy, N. Goldberger, and J. Tarule, Women’s Ways of Knowing [New York: Basic, 1986]). For an interesting slant on the issue, see C. Gilligan, L. M. Brown, and A. Rogers, “Psyche Embedded,” in Studying Persons and Lives, ed. A. L. Rabin et al. (New York: Springer, 1990). Camille Paglia reverses the valorization of “feminine” words over “masculine” vision in her provocative Sexual Personae: Art and Decadence from Nefertiti to Emily Dickinson (New Haven, Conn.: Yale University Press, 1990).

reappearance in unconscious forms. At the Salpêtrière, sexuality was said to be unrelated to hysteria, yet it was used in hysteria’s pictorial representation. Photographs were said to provide a completely objective picture of reality, yet their subject was contrived and surfaces “touched up.” Charcot’s scientific inquiry into hysteria was intended to incorporate the highest forms of art, yet the result was a hybrid representation that conveyed fully neither an artist’s vision nor a scientist’s precision.

Freud’s approach to hysteria, characterized primarily by verbal communication, had both an interpretive and a relational dimension. His awareness of his own role was inescapable from his acknowledgment of his patients’ perspective. The science that Freud constructed involved the study of an individual’s subjective world, with the relationship of analyst and patient as the central activity of exploration. As an objective study of the subjective self, it did not insist that knowledge is acquired only at the price of impersonality, distance, or rigid division of self and object; it held instead that reliable and authentic knowledge could be gained from the involvement of two people in a relationship.

Charcot’s and Freud’s models of inquiry can be fruitfully conceptualized as differing along the lines of the concepts of “static” and “dynamic” objectivity developed in recent years by Evelyn Fox Keller in her work on the philosophy of science. Keller defines the “static objectivity” that characterizes traditional scientific method as “the pursuit of knowledge that begins with the severance of subject from object.” “Dynamic objectivity,” by contrast, is “a pursuit of knowledge that makes use of subjective experience,” in which “the struggle to disentangle self from other is itself a source of insight.”¹⁰⁴ That subjectivity and science are connected is undeniable, according to Keller, but we operate within an ideology that obscures that connection. Ideological pressures can be revealed, Keller suggests, by examining the irrational or inconsistent elements that pervade any given scientific enterprise.

Keller has illustrated, through historical example and psychological analysis, how extrascientific forces influence the development of scientific method and knowledge. She points out that “our ‘laws of nature’ are more than simple expressions of the results of objective inquiry or of political and social pressures: they must also be read for their personal—and by tradition, masculine—content. [Recent sociology of science] uncovers . . . the personal investment scientists make in impersonality; the anonymity of the picture they produce is revealed as itself a kind of signature.”¹⁰⁵ Psychoanalysis is, in Keller’s terms, “a form of knowledge

¹⁰⁴ Keller (n. 4 above), 117.
¹⁰⁵ Ibid., 10. The investment in impersonality derives, in Keller’s view, from the culturally and historically pervasive link between objectivity and masculinity, and the origin of this link in problems of psychological gender development.
of other persons that draws explicitly on the commonality of feelings and experience in order to enrich one's understanding of another in his or her own right.”

Ultimately, the concept of transference, present only in rudimentary form in the Studies, takes the doctor-patient relationship itself as the central process to be investigated. The centrality of transference in psychoanalysis is an instance of the dynamically objective “disentangling” of which Keller speaks.

In the early case studies, Freud's understanding of his women patients, his understanding of hysteria, and his dynamically objective approach powerfully converge. If feminism, as Keller writes, "seeks to enlarge our understanding of the history, philosophy, and sociology of science through the inclusion not only of women and their actual experiences but also of those domains of human experience that have been relegated to women: namely the personal, the emotional, and the sexual,” then Freud's early work develops something of a "feminist" science. Freud's first gropings toward the theory of psychoanalysis incorporated both women's actual experiences and traditionally feminine domains. Further, Freud studied "women and their actual experiences" and integrated the domains relegated to them—"namely the personal, the emotional, and the sexual"—into his psychological theory.

I want to emphasize how short-lived this early phase of Freud's work was. By 1905 he had rejected his own theory of hysteria's necessary origins in sexual trauma and accorded fantasy a central role in its psychogenesis. He had also developed his conception of the Oedipus complex through his own self-analysis, under whose long shadow the analysis of Dora was carried out. Much recent feminist criticism has drawn attention to the ways Freud imposed his theory upon the subjective reality of Dora and other patients and has drawn a picture of Freud more akin to Charcot than the one I have drawn here. Yet while feminist critiques of Freud have offered a necessary corrective, an exclusive focus on the dominating aspects of Freud's treatment results in too rigid a reading of his early cases. Moreover, it misses the opportunity to see in them a way of approaching the study of subjectivity. These critiques are more fruitfully applied, I think, to Freud's "Fragment of an Analysis of a Case of Hysteria" (1905) and to his later writings on femininity.

My purpose has been to examine an earlier period in Freud's work and to describe its contrast to Charcot's work before him. It would be useful now to begin to explore the developmental history of Freud's ideas about the psychology of women. A number of questions suggest

106 Ibid., 117.
107 Ibid., 9.
108 For example, Bernheimer and Kahane, eds. (n. 3 above).
themselves. Specifically, how did changes in Freud’s theoretical agenda make his relationship to Dora so different from his relationship to Elisabeth von R.? More generally, what circumstances fostered his ability to listen to women and what inhibited it? How did the language Freud used to describe women change over time? A number of psychoanalysts and writers have attempted to chart the unfolding of Freud’s understanding of female psychology; such efforts bode well both for the study of psychoanalytic history and for feminist rereadings of Freud’s work. 109

The same contrasts I have described between Freud’s and Charcot’s work, and between Freud’s early and later work, on a larger scale characterize the fields of both psychoanalysis and academic psychology. Within psychoanalysis, the question of whether the discipline is an objective science or a system of interpretation—and the question of what these terms themselves mean—reemerges from time to time with great intensity. These issues have proven central to debates on object relations versus drive theory, metapsychology versus clinical theory, and hermeneutic versus empiricist perspectives and approaches. 110 Until recently, practitioners of psychoanalysis have tended to insist upon the discipline’s scientific stature, while remaining relatively ambiguous in their terminology and imprecise in describing their own role in the clinical process; they have tended, in other words, to insist


on the discipline’s “statically objective” legitimacy at the expense of its “dynamically objective” promise.\footnote{Spence (n. 101 above) offers a fuller description of this problem in The Freudian Metaphor, esp. 71–159.}

In academic psychology there has been a historical tendency to minimize or refrain from investigating the effects of researchers on the researched. Research psychologists traditionally have viewed themselves as investigators of brute facts and have conceptualized methodological rigor as inhering in the removal of their own effects, as if such a thing were possible. More recently, it has become clearer that all research on fellow humans involves both interpretation and relationship, however implicit. Thus, a more accurate view would accept the researcher’s influence as inevitable and demand honesty about its effects. Such honesty involves more than simply giving a short paragraph about the limitations of a study; it demands a richer inquiry into and description of one’s effects. A persuasive demonstration of how one came to a given view must not obscure one’s own emotional impetus; rather it should explore both the insights and distortions that that impetus has fueled. The possibility of grappling with questions of interpretation has been constricted by the empiricist values of the field, and psychology has lagged behind other social sciences in developing self-consciousness about its own enterprise.\footnote{For a refreshing counterexample, \textasciitilde{} J. Haaken, “Field Dependence Research: A Historical Analysis of a Psychological Construct,” Signs: Journal of Women in Culture and Society 13, no. 2 (Winter 1988): 311–30.} Psychologists have seldom reflected critically on the philosophical and historical origins of their own practices. Too often, their conventional methods of inquiry have actually militated against historical reflection, because it seems to threaten the timelessness and universality of their findings.

Fortunately, these issues are slowly moving to the forefront of debate within psychology and psychoanalysis,\footnote{Examples in the psychological literature incl \textasciitilde{} M. J. Packer, “Hermeneutic Inquiry in the Study of Human Conduct,” American Psychologist 40, no. 10 (October 1985): 1081–93, esp. 10 \textasciitilde{} E. E. Jones and A. Thorne, “The Rediscovery of the Subject: Intercultural Approaches to Clinical Assessment,” Journal of Consulting and Clinical Psychology 55, no. 4 (August 1987): 488–95; L. Brown, M. Tappan, C. Gilligan, B. Miller, and D. Argyris, “Reading for Self and Moral Voice: A Method of Interpreting Narratives of Real-Life Moral Conflict and Choice,” in Entering the Circle: Hermeneutic Investigations in Psychology, ed. M. J. Packer and R. Addison (Albany: SUNY Press, 1989). The articles cited in n. 110 above provide examples of a similar trend in psychoanalytic writings.} and both fields have begun to explore more fully what it means to be a science and what it means to be objective. Objectivity, as Keller defines it, is “the pursuit of a maximally authentic, and hence, maximally reliable, understanding of the world around oneself.”\footnote{Keller (n. 4 above), 116.} Charcot and Freud grappled with the problem of
understanding hysteria objectively, and came up with different solutions. To the extent that we can be flexible in our development of methods appropriate to what we study, and aware of the unwitting extrascientific considerations that color our theories and approaches, we will have done what we can to learn from their examples.

Department of Psychology
University of California, Berkeley