Freud, Sigmund

Sigmund Freud (1856-1939), the founder of the ‘talking cure’ of psychoanalysis, which has led to most of the forms of psychodynamic psychotherapy extant today, was born in Freiburg, Moravia. He was the first and favour child of the third wife of a wool merchant. In 1861, after Austria abolished restrictions on Jews, the family moved to Vienna, and took pride in Freud’s exceptional performance in school. At the Vienna Medical School, he was mentored in the school of Helmholtz by the physicalistic Darwinian physiologist Ernst Bruke. He undertook research in Bruke’s laboratory, eventually publishing some 200 neurological works, including expert monographs on childhood movement disorders and aphasia.

Realizing he could not support a family in research, Freud prepared for psychiatric practice at the Vienna General Hospital, studying disorders of the nervous system under Theodor Meynert. In 1885, on Bruke’s recommendation, he was awarded a bursary to study in Paris under Jean-Martin Charcot, who used hypnosis to induce and remove symptoms of hysteria. Freud’s subsequent essay on differential diagnosis supported Charcot’s psychogenic approach with the observation that the regions of the body liable to hysterical paralysis or anaesthesia do not correspond with neurological demarcations. Hysteria, Freud observed, knew nothing of anatomy.

In 1886, Freud married Martha Bernays and entered private practice. During the next decade he fathered six children and made his most important intellectual discoveries. His senior colleague Joseph Breuer had enquired into the life and symptoms of one hysterical patient in great detail, discovering with her that her symptoms linked meaningfully with unexpressed emotions from unremembered but significant events and were eased by expressing them. Thus, she was liable to a paralysis of her arm, which she and Breuer traced to a frightening occasion when her arm had gone to sleep and had become immobile while she was nursing her dying father. A whole series of symptoms, including hallucinations and disturbances of speech, were also rooted in experiences from this episode and eased as she and Breuer reconstructed it.

This was one of the first systematic observations of the therapeutic effect of recovered memory, and Freud’s practice corroborated Breuer’s sufficiently for the publication of a book of case studies. Freud then sought to improve his therapy by systematically pressing his patients for deeper traumatic memories. In response, female patients increasingly reported *scenes of seduction* (sexual abuse), often at the hands of their fathers. Freud initially thought he had discovered that mental disorder originated in early abuse. After further investigation, however, he concluded that such “memories” were unreliable. Memory was fundamentally reconstructive and liable to distortion by fantasy, including sexual fantasy about parents.

Despite Freud’s cautions, another memory-based “seduction theory” disrupted psychiatry a century later. In the fall of 1993, thousands of adults across the United States began recovering apparent memories of sexual abuse in childhood whose truth seemed impossible to assess. This crisis was finally resolved, like that in Freud’s early practice, by acknowledging that memory was reconstructive and readily permeated by fantasy; and the episode itself testifies to the power of sexual fantasy about parents, and hence to the difficulty of resolving claims about abuse in childhood, which can, of course, also be remembered accurately.

In light of his growing realization of the unreliability of early memory and the power of fantasy to shape believed experience Freud ceased pressing his patients for memories. Instead he asked patients simply to communicate each idea or thought that occurred to them as fully as possible and without censorship, whether or not it seemed sensible or significant. This unconstrained form of self-disclosure, called *free association*, provided a unique source of relevant information, and in 1895 Freud discovered that it enabled him to understand both his own and his patient’s dreams as expressions of conflicting emotions and desires.

This implied that patients’ difficulties and disorders stemmed not, as Freud had previously thought, from memory, but rather from recourse to phantasy. that is, to the kind of fictive experience or belief manifest in dreaming; and that such recourse was a response to emotional conflict. Apparently, the mind or brain uses fictive experience or belief to regulate desires stemming from deep emotional conflict, and this, in our uniquely conflicted species, creates the alienation from reality constitutive of mental disorder.

We can approach this by generalizing over the contents of desires and beliefs, by speaking of a desire or belief that *P*, where *P* can be replaced by any suitable phrase or sentence that specifies the situation believed or desired (e.g., “I get a drink of water” in the case of my desire to drink). Then in general if a person acts on a desire that *P* (that he gets a drink of water) then if he succeeds, he will bring about the situation *P* (that he gets a drink of water) that *satisfies the desire*; and this in turn will give rise to the believed *experience of satisfaction* of the desire (that of drinking water). This pacifies the desire, terminating thirst prior to water reaching the bloodstream.

Freud discovered that *fictive* experience or belief—such as that produced in dreams—could serve the same purpose. His simplest example was a dream prompted by eating anchovies or other salty food: *that he was drinking cool delicious water*. After dreaming this, perhaps several times, he would awake, find himself thirsty, and get a drink. Many people have had such a dream, or its counterpart regarding micturition. In these examples the dream clearly represents *the experience of satisfaction* of a desire; and therefore seems best understood as caused by that desire, and as serving to pacify it, thus temporarily resolving conflict about continuing sleep and dreaming.

This is Freudian *wishfulfilment*, in which a fictive experience or belief that *P* pacifies a conflicted desire that *P***,** so masking conflict, but with illusory as opposed to real satisfaction. The same idea applies to neurotic and psychotic symptoms. Thus, Freud understood the main symptom of his patient the Rat Man—a compulsion involuntarily to imagine, as in a waking nightmare, that his father was suffering a terrible torture—as a fictive believed experience that pacified unconscious hostility to his father. His hostility could be traced to early childhood, and conflicted with the genuine love he felt toward his father, in favor of which the hostility was subjected to *repression*.

These examples illustrate how emotions that are subject to conflict can be pacified and masked by fictive beliefs and experiences, and also how this produces a denial both of the person’s real mental state and of the real nature of the person’s engagement with others. Freud’s interpretations of dreams and symptoms deal with more complex examples and his concept of wishfulfilment was subsequently extended into the more general and inclusive psychoanalytic concept of *phantasy*. These extensions preserve the original underlying insight, namely that the mind or brain uses fictive experiences and beliefs to regulate conflicting emotions and desires, and that this is liable to produce the denial of both internal and external reality constitutive of mental disorder. Freud provided a similar account of paranoid, depressive, and manic phantasies and delusions, as well as those characteristic of other disorders.

From his 1896 *Psychology for Neurologists* onward, Freud argued that the production of such desire-regulating fictive experience and belief was a *primary process* in the mind or brain. This operated with the assistance of the ego (nascent self) from birth, to establish the *secondary processes* of veridical belief and action in accord with the *reality principle*. In this perspective, human development involves a continual and oppositional dialectic between phantasy and reality, and psychoanalytic therapies aim to analyse formations of phantasy masking conflict so as to resolve the conflicting emotions and strengthen the patient’s hold on the dual reality of his or her own mental processes and engagement with others and the world.

Between 1899 and 1905, Freud published his major conclusions on memory, dreams, symptoms, and sexuality, and over the next decade these became the centre of an international intellectual and therapeutic movement. Although he lectured briefly in the United States and occasionally travelled to conferences, Freud continued to work full-time in Vienna, using his clinical experience in treating patients to elaborate and extend his theories.

Thus, he expanded his 1895 discussion of the ego to describe how its executive functions regulated the basic drives of the idvia phantasy representations of the parents embodied in the superego or ego-ideal. The functional role of such phantasy figures was later extended to a range of internal objects mediating object-relations*.* These included the object-relations characteristic of group psychology, in which members of a group enhance self-esteem through identification, by taking a common figure such as a charismatic leader (or, in the case of leaderless groups, a common figure, cause, or creed) as constituting the superego or ego-ideal. This effects the projection of what is contrary to this ideal into another group, which becomes a target for the morally mandatory hatred and guilt-free aggression characteristic of in-group co-operation for violent out-group conflict.

In this use of his concept of projection, Freud well described the group-binding Nazi idealization of Hitler and the concomitant denigration and persecution of the Jews, from which he secured his family by fleeing to London in 1938. The next year, having finished essays including his final outline of psychoanalysis, and suffering increasing pain from the cancer that had caused the removal of much of his jaw, he asked his doctor for the morphine injections that eased his death.

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***See also*** Classical Psychoanalysis: Overview, Freudian Psychoanalysis, Neo-Freudian Psychoanalysis, Contemporary Psychodynamic-Based Therapies: Overview

Further Readings

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