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TRANSFERENCE

THE CASE OF DORA

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For three months in the autumn of 1900, Freud treated a hysterical eighteen- year-old girl named Dora. Immediately after she broke off therapy, he wrote the case up; the paper contained several mistakes about dates and times and also some contradictions. This case report (Freud 1905E;7:3-122) is a logical extension of *The Interpretation of Dreams.* It was written to demonstrate the use and importance of dream analysis in psychoanalytic work as well as to present his current views on the psychodynamics of hysteria, and is worthy of very careful study by the psychotherapist. The report presents the first detailed consideration of transference, and also illustrates Freud's meticulous attention to the slightest detail in the study of psychological data.

The therapy essentially breaks up due to the counter-transference flounderings of the therapist. For example, rather than trying to interpret the long second dream in the somewhat forced way that Freud does, it may be argued that this dream is probably a resistance dream characterized by the desire to dominate the therapy hour. Dora, a very vengeful girl, sought revenge on her father, on Herr

K., and then on Freud; an erotic transference developed which Freud should have foreseen, as he later admitted. Freud suggests that the sexual excitement accompanying this transference resulted in her leaving treatment (p. 74).

The eighteen-year-old Dora was the second of two children; her older brother was nineteen-and-a-half. She did not get along at all well with her mother who is described as having a "hausfrau psychosis," meaning that she spent most of her time cooking and cleaning, mainly as an effort to escape sexual or spontaneous libidinal relationships with her family. Dora's father is described as a rather well-to-do businessman in his late forties. His brother was a hypochondriacal bachelor; his sister had died of "marasmus"—apparently some sort of melancholia.

When Dora was six, her father became ill with tuberculosis and at that time began an affair with a Frau K. who was nursing him at the sanitarium or resort area where he stayed. Frau K. was married to a gentleman called Herr K., and had two children. When Dora was eight she developed chronic dyspnea, although it is notable that she had been suffering from bed-wetting previous to the chronic dyspnea

attacks; when the attacks of chronic dyspnea occurred, the bed-wetting stopped. Some attention had been paid to the bed-wetting by her father, who hovered over her bed and made efforts to keep her clean. When the patient was ten, her father developed impairment of vision due to a retinal detachment. The etiology of this became apparent when the patient was twelve and her father had a confusional attack which was seen by Freud and diagnosed as a case of taboparesis. There was no question about the luetic origin of the father's symptoms.

At the time of her father's confusional attack, the patient developed two symptoms; migraine headaches which disappeared by the time she was sixteen, and attacks of nervous coughs which lasted from three to five weeks and which continued until the onset of her treatment with Freud. At age sixteen these nervous coughs had developed into an aphonia; at this point the patient was first seen by Freud. He proposed psychoanalytic treatment which she refused.

When the patient was seventeen, she developed a feverish disorder; by eighteen she had become steadily worse: she developed low spirits and wrote a letter about suicide; she was unable to

concentrate; she suffered from fainting spells, amnesia episodes, and, along with the previous symptoms of aphonia and nervous cough, she developed a rather unsociable personality. At this point she was brought to Freud for treatment for the second time.

Study of the case revolves mainly around the analysis of the major symptoms—the nervous cough and the associated aphonia. In the psychological history we find that the patient became quite friendly with the Frau K. who was carrying on an affair with her father. Quite an intimate relationship existed between the two women, which continued until the patient was sixteen, when she accused Herr K. of making a sexual advance. She slapped his face and ran off but did not tell anyone of the sexual advance for two days. Nine months after this accusation (whether the sexual advance actually occurred is not clear), she was put to bed with the feverish disorder.

Delving deeper into the psychological history, one finds that when Dora was fourteen Herr K. had passionately kissed her on the lips. She reacted to this with a sensation of disgust and a feeling of pressure on the thorax which was followed by formation of a phobia. She avoided walking past any man whom she thought to be in any

state of sexual excitement or affectionate conversation. Freud writes:

> It is worth remarking that we have here three symptoms—the disgust, the sensation of pressure on the upper part of the body, and the avoidance of men engaged in affectionate conversation—all of them derived from a single experience. ...The disgust is the symptom of repression in the erotogenic oral zone, which, as we shall hear, had been overindulged in Dora's infancy by the habit of sensual sucking. The pressure of the erect member probably led to an analogous change in the corresponding female organ, the clitoris; and the excitation of this second erotogenic zone was referred by a process of displacement to the simultaneous pressure against the thorax and became fixed there. Her avoidance of men who might possibly be in the state of sexual excitement follows the mechanism of a phobia, its purpose being to safeguard her against any revival of the repressed perception (Freud 1905E;7:30-31).

So Freud claimed all three of the symptoms served as defenses against sexual wishes.

Another aspect of the case is the so-called "homosexual" relationship between Dora and Frau K. Dora often spoke of Frau K.'s "adorable white body" and they spent much time talking intimately about sexual matters. Although Freud was not aware of it at the time, we might understand this intimacy as a defense against Dora's deeper

infantile wishes to be soothed and to suck at the white breast of Frau K. Both the phobia and the "homosexual" relationship illustrate the important oral (pre-Oedipal) aspects of the polymorphous perverse sexual wishes of the patient who develops hysteria.

The actual analysis of the case hinges around the interpretation of the dream presented in the second part of Freud's paper. The psychodynamics were these: Dora was confronted with frank sexuality by Herr K. and she definitely responded with feelings of sexual excitement toward him. At the same time, Dora was very vengeful and angry at all men, considering them evil and undependable. Because of this, she could not give in to her sexual impulses toward Herr K. She had an incapacity for meeting real erotic demands which Freud explains as one of the most essential features of a neurosis, especially of hysteria. The confrontation with real erotic feelings therefore caused a conflict which led to a regression. The specific type of regression made sense in terms of the conflict, and it appeared in the dream, which represented an infantile appeal to father—to help her repress her erotic impulses—just as he had helped her as an infant to keep her from bed-wetting. Thus she appeals to father in her fantasies to save her from Herr K., who had aroused her sexual feelings directly.

We see therefore how a present conflict causes the patient (a) to regress to an earlier level of satisfaction where she had realized some pleasure from her relationship with her father; and (b) to call upon father to help her repress her sexual impulses toward Herr K. and thus solve the conflict. However, the price of this regression is the revival of oedipal love for the father, and incestuous guilt. So now the patient is forced to erect defenses against the oedipal love for her father.

Dora had many such defenses: for example, there is the compromise formation of identification with Frau K. The patient identifies with Frau K.'s intercourse with her father and gains a vicarious gratification of her love impulses toward her father—a gratification which lessens the energy cathexis on these impulses. One also sees projection in Dora's constant rumination that her father and all men are bad and that she hates them because of their sexual interest in her. The defensive meaning of this projection is, "It is not I who have sexual impulses toward father but it is father who is bad and all men are bad because they have sexual interest in women."

However, the major defense that Dora used against her infantile sexual longings toward her father is that of conversion. In order to

understand this, we have to understand Dora's infantile sexual fantasy concerning the nature of intercourse, a fantasy often characteristic of patients who develop hysteria. Some of these patients imagine intercourse as fellatio; the fantasy is that babies are born as a result of the mother sucking the father's penis. Here again we see the all-pervading oral aspect of the sexual polymorphous perverse fantasies of the patient who develops hysteria.

An analysis of the conversion shows the meaning of the symptoms. Dora's attacks of aphonia are traced to the absence of Herr K. These attacks turn out to be just the reverse of Frau K.'s behavior. Whenever Herr K. was home, Frau K. would be "sick" as a way of avoiding sexual relations with him. On the surface level, Dora's sickness or aphonia means, "If I were his wife I should love him in quite a different way; I should be ill from longing when he is away and well from joy when he was home again." The deeper meaning of the aphonia is connected to the attacks of nervous coughs, which began around the time the patient's father had his attack of lues: this meaning lies in the fantasy of fellatio with her father. Freud honestly explains (p. 48), "But the conclusion was inevitable that with her spasmodic cough, which, as is usual, was referred for its exciting

stimulus to a tickling in her throat, she pictured to herself a scene of sexual gratification *per os* between the two people whose love affair occupied her mind so incessantly. A very short time after she had tacitly accepted this explanation her cough vanished—which fitted in very well with my view; but I do not wish to lay too much stress upon this development, since her cough had so often before disappeared spontaneously." Freud also notes the identification here with mother and Frau K. and that Dora is in the passive situation (sucking); whether this refers to deeper homosexual strivings or oral strivings or not is a matter of controversy.

To recapitulate, when Dora was confronted with actual sexuality by Herr K, she was unable to respond with erotic feelings because of her vengeful pride, her tendency to run from reality into fantasy, and other aspects of her personality. In order to avoid an erotic response, she summoned up help for the repression of her sexual impulses by fleeing from the conflict through a regression to infantile gratifications. Hence, she regressed to the infantile oedipal conflict, summoning up her love for her father to help her repress her love for a mature man. She gained secondary gratification by developing an illness which required care and by touching her father's heart with her

sickness and forcing him to separate from Frau K. (who really stood for Dora's mother).

At the same time Dora had to pay the price of her regression to earlier oedipal satisfaction by having to erect defenses against unacceptable oedipal longings. Her main defense was conversion. The conversion symptom, that of nervous cough and aphonia, represented first of all a substitute gratification through the tickling of the throat and through the gain of being taken care of due to an illness. It also represented a punishment—the unpleasant nature of cough and hoarseness is obvious. The conversion symptom was accompanied by the fantasy gratifications of having sexual intercourse through the mouth with father, identifying with mother on the oedipal level, and at a deeper level, homosexual gratification through identification with the mother (and perhaps at the deepest level through the fantasy of sucking on Frau K.'s breast). Through the conversion symptom the psychological conflict was converted into a physical conflict, thus lessening Dora's anxiety about the unacceptable oedipal wishes and giving, in a distorted, symbolized form, some gratification to these wishes. The physical conflict alleviated the guilt about the oedipal wishes by the punishment of the symptoms themselves.

A follow-up of Dora's case was published by Deutsch (1957), who describes her as one of the most repulsive hysterics he ever met:

> In the first interview where the patient was seen about twenty years after she had broken off treatment with Freud, she continued to complain of ear noises, dizziness, and attacks of migraine. She then started a tirade about her husband's indifference, about her sufferings, and how unfortunate her marital life had been. She felt her only son had begun to neglect her. He often stayed out late at night and she suspected he had become interested in girls. She always waited listening until he came home. She expressed a great amount of hostile feelings towards her husband especially her disgust with marital sex life. Dora's fate took the course that Freud had predicted twenty-four years earlier after the three months analysis with her. She clung to her son with the same reproachful demands she made on her husband and who had died tortured by her vengeful behavior (pp. 159-167).

A number of Freud's comments on this case deserve careful attention by psychotherapists for their clinical value. For example, in his prefatory remarks he mentions the difficulties that are encountered when the physician has to conduct six or eight therapeutic treatments a day. He advises against making notes during a session "for fear of shaking the patient's confidence and of disturbing

his own view of material under observation" (p. 9). Freud frankly admits that he had not at that point succeeded in solving the problem of how to report for publication the history of a treatment of long duration. In Dora's case he recorded the wording of the dreams immediately after the session and used these notes when he rewrote the case from his outstanding memory at the end of the three-month period. However, he mentions that it would be wrong to suppose from this case that dreams and their interpretation occupy such a prominent position in all psychoanalysis.

Freud's comments raise some important clinical issues. In my opinion Freud is correct in that taking detailed notes, and far worse, tape recordings during the actual psychotherapy sessions will shake the patient's confidence and disturb the material in a hopeless fashion, and is frankly a disservice to the patient—unless it is explained to the patient in advance that notes or tape recordings are for supervision or are part of a research project. Even then, it must be realized that the therapy will be quite seriously distorted. Of course, during the few initial history-taking sessions, the therapist must put down for his case records important names, dates, etc., and most patients accept this in the first few interviews without protest, since it is expected from any

responsible doctor.

Obviously the time to take notes to insure maximum value is immediately after a session—and this brings up the issue of "the decline and fall of the fifty-minute hour" (Greenson 1974). Greenson has presented an eloquent plea for retaining the fifty-minute hour, which nevertheless has become a rarity. Ideally, to follow Freud, who began in 1913 to divide his working day with patients into fifty-five-minute hours, such a schedule allows a ten- minute period at the end of each session for refreshment and note-taking. For economic reasons, most therapists shun the fifty-minute hour; one can squeeze more patients into the working day if there are no time gaps between patients. So one shortens the hour not for the altruistic purpose of treating more suffering humanity or accumulating more analytic experience; the matter almost always comes down to financial gain. Greenson impressively points out, "It is obvious that taking patient after patient on an assembly-line schedule is an act of hostility, subtle and unconscious though it may be."

If a psychotherapist cannot bring himself or herself to retain the fifty-minute hour, at least schedule a fifteen-minute break between

every two patients. It is not acceptable to demand of the patient—in addition to such other requirements as payment, punctuality (especially about leaving the session on time), and a certain amount of restraint of physical behavior in the office—that the patient also fit into an assembly-line schedule. All such demands are for the convenience of the therapist and the therapist alone, and at some level or other they take something away from the patient. Patients are willing to accept certain realistic arrangements made to meet the needs of the doctor, but they react poorly to manifestations of therapist greed and mechanical disinterest, or to lack of consideration in matters of privacy, as, for example, in the use of a tape recorder without recognizing the effect of this on the treatment process.

In a short footnote (pp. 16-17) Freud raises the clinical issue of an organic disorder masking or presenting itself as a psychiatric disorder. In this "footnote" case a patient who allegedly had hysteria turned out to have an early stage of tabes. When he suspected that the case was perhaps not primarily psychogenic, Freud immediately instituted a careful physical examination. Although there is a *great deal* to be said against doing physical examinations on our patients ourselves, it is strongly recommended that all patients at the

beginning of psychotherapy be sent for a careful physical and neurological examination. Freud's continual vigilance in looking for organic causation in the so-called psychogenic disorders enabled him to maintain his primary identity as a physician.

Indeed, Freud at this point certainly practiced authoritatively. For example, when Dora met an explanation of his with an emphatic "no," he took it to signify "yes"—later, when she had an association which seemed consistent with his explanation, he used this as "a fact which I did not fail to use against her" (p. 59). In spite of that, Dora continued to deny his contention for some time, apparently up to the last therapy session at which point "Dora had listened to me without any of her usual contradictions" (pp. 106-9). Freud seems to overlook the point that once a patient has, out of negative transference, decided to leave therapy the emotional investment in the process is gone and the patient simply waits out the last session.

The case of Dora illustrates the importance of paying close attention to symptomatic acts during the therapy session. For example Freud notes and interprets Dora's playing with "a small reticule of a shape which had just come into fashion; and, as she lay on the sofa and

talked, she kept playing with it—opening it, putting a finger into it, shutting it again, and so on. I looked on for some time, and then explained to her the nature of a 'symptomatic act'" (p. 76). Such acts are discussed in Freud's *The Psychopathology of Everyday Life* (1901B;6:1ff). A typical example today is the constant removal and replacing of a wedding ring on the finger while the patient is talking. Notice that Freud "looked on for a while" rather than jumping on the patient immediately—a mark of mature technique.

Probably the most important reason for psychotherapists to study the case of Dora is that it represents a failure in psychotherapy. The primary reason for the failure, as Freud correctly notes, was missing the first warning sign of a transference reaction. Freud missed it, probably thinking he had ample time since no apparent further stages of transference had developed in the verbal material. Hence, the transference took Freud unawares, and Dora acted out an essential part of her recollections and fantasies instead of reproducing them in the treatment, by leaving therapy. Thus Freud makes it clear that meticulous attention to transference manifestations—especially negative transference manifestations—are the cornerstone of a successful treatment, and that neglect of such manifestations

inevitably leads to often unexpected and surprising failure.

I (1971, 1974, 1996, 2000) have discussed this problem at length elsewhere. As a patient's defenses are undermined in uncovering psychotherapy, the pressure of unconscious drives focuses increasingly on the therapist. To deal with this properly, a suitable therapeutic alliance must first be established, along with an understanding of the transference and insight into the countertransference. In 1900, when Freud treated Dora, all this was barely recognized; in fact, as Jones (1955) remarks, the case is amazing in that anyone would "take the data of psychology so seriously." Freud himself recognized how the revenge aspects of the transference led to the breakup of the treatment: "Her breaking off so unexpectedly, just when my hopes of a successful termination of the treatment were at their highest, and her thus bringing these hopes to nothing—this was an unmistakable act of vengeance on her part" (p. 109). Indeed, it has been my clinical experience that whenever the therapist feels a certain jubilance about the progress of a case or a session, the patient often follows this reaction (no matter how the therapist tries to hide such feelings) with an upsurge of resistance which often manifests itself by plans to disrupt the treatment for one

reason or another. As Freud noted, such resistance is a manifestation of negative transference and a reaction of narcissistic rage to the therapist's narcissistic gain in the success of the treatment, no matter how positive the transference and therapeutic alliance may appear to have been on the surface.

In more severe cases, such as borderline patients, this resistance is often accompanied by the patient's overt or covert suggestion that the therapist step out of the role of therapist and show concrete manifestations of love and interest in the patient. In the mildest form, the patient demands that the therapist do a lot of talking about his or her own personal life and activities and so become a real object (Tarachow 1963) of gratification; in the extreme form, the patient demands physical manifestations of affection.

If this is not forthcoming, a certain number of patients will indeed carry out the threat and leave treatment in spite of the therapist's best efforts. The answer to this "crucial dilemma," as I (1968) have described it previously, is nowhere better stated than by Freud in the case of Dora, in one of the most beautiful and poignant passages ever written by Freud (p. 109). It is reproduced on the title page of Part III

of the present book.

The moving countertransference emotions produced by the erotic demands of attractive and apparently helpless young patients represent a great threat to the psychotherapy of the patient, and may challenge the personal psychotherapy of the therapist at every turn. At this early date in his career—and perhaps because of his narcissistic investment in using this case to illustrate the interpretation of dreams in psychotherapy—Freud's countertransference produced a blindness to the rage and demanding behavior of this patient, a selective scotomata to the negative aspects of her personality—which suddenly jumped into the foreground just at the moment he was feeling the most jubilant about the success of his therapeutic efforts.

When the same thing happens repeatedly to the insufficiently analyzed therapist, the unfortunate reaction is not to go back for further personal help but rather to react to the narcissistic blow with counter-rage. Not only does this facilitate a breakup of the individual treatment, but the anticipation of further such disappointments spills over into all the therapist's work and produces a vicious cycle of further failures. The typical reaction is a combination of depression

and loss of confidence in the process of intensive psychotherapy itself, a displacement to avoid the blow to personal self-esteem. We are left with the phenomenon of therapist discouragement and the common switch to short-cut techniques that are more gratifying, from the primal scream to psychopharmacology. It is the story of Breuer all over again (see chapter 4).

Proponents of Kohut's psychology of the self have pointed out another aspect of Freud's countertransference in the crucial quotation given on pp. 138-9 of this chapter. They suggest that Freud's interpretation of this fourteen-year-old girl's disgust in the situation described as "hysterical" is unempathic, and they ascribe his failure of empathy to an intense countertransference commitment to his sexual theories. What do you think about it?

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