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Lost Objects: From the Laboratories of Hypnosis to the Psychoanalytic Setting

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Argument

The psychoanalytic setting counts today as one of the familiar therapeutic rituals of the Western world. Taking up some of the insights of the anthropology of science will allow us to account for both the social and the material arrangements from which Freud's invention emerged at the end of the nineteenth century out of the clinical laboratories and private consulting rooms of practitioners of hypnosis. The peculiar way of neglecting or forgetting the object world and the institution of the psychoanalyst as a "transference object" will be traced back to multiple reconfigurations in the history of hypnotism in France and in Germany. In this process, different practitioners tried to achieve a synthesis of clinical work and experimental psychology, with the aim of objectifying knowledge about human subjectivity. While Freud retained the claim of psychoanalysis performing an experimental situation, he set apart his own setting from the objectifying practices which were characteristic of this experimental psychology located in the clinic and the private consulting room.

> It is not easy to over-estimate the importance of the part played by hypnotism in the history of the origin of psychoanalysis. From a theoretical as well as from a therapeutic point of view, psycho-analysis has at its command a legacy which it has inherited from hypnotism.
>
> Sigmund Freud, *A Short Account of Psycho-Analysis* ([1923] 1924, 192)

Introduction

A patient who consulted Professor Sigmund Freud during the first decades of the twentieth century was certain to be surprised when entering the consulting room at Berggasse 19. First of all, he had to notice that the room did not resemble in any way a doctor's office.[1] Instead of a sterile environment, the patient found himself surrounded by a multitude of objects: Roman, Greek, and Chinese antiquities, mostly sculptures were displayed in showcases or on the shelves of the library, and portraits of Egyptian

[1] The pronoun "he" is used to refer to the patient or the subject, following the masculine gender of the German *der Patient* or the French *le sujet* both of which denote positions that can be occupied by male or female individuals. All translations of French or German sources are mine if not indicated otherwise.

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mummies and pictures of mythological scenes covered the walls. On their first visit, many patients got the impression that Freud was not a physician, but rather the curator of some odd private archaeological museum.[2] The second surprise for the patient came with the start of the psychoanalytic session: the presence of all these objects was now declared to be completely insignificant to the treatment during which his "unconscious," the unknown objects in his interior dimension, had to be revealed. For the entire object world the patient was visually confronted with was constantly focused back to the only single object that had to remain invisible throughout the entire session: Freud himself, who was sitting in a chair behind the head of his patient.

This article attempts to elucidate this peculiar way of "losing" or forgetting objects or the actual material components that make up the psychoanalytic setting. The famous couch is a case in point. Although this piece of furniture has become the emblem of psychoanalysis itself, its history has remained a blind spot. Whereas we have dozens of books on "Freud the Man," there is not one single monograph devoted to the couch.[3] Remembering Freud seems to entail forgetting the object world that surrounds the patient and also enables psychoanalytic practice. But what would happen if we took the opposite stance? What about a patient who would only look – and keep looking – at the profusion of objects surrounding him, asking questions about carpets, chairs, or paintings on the wall? Such a position is nicely captured by a scene from Hilda Doolittle's fictionalized account of her own analysis with Freud. At their first encounter, the "Professor," as she calls him throughout the text, singles out the peculiarity of this patient: "You are the only person who has ever come into this room and looked at the things in the room before looking at me" (H.D. [1956] 1985, 98).

The patient's shifting gaze shall direct me here towards a historical perspective which takes the psychoanalytic space seriously, down to its very material components. Much of the writing about the history of psychoanalysis, past and present, has neglected the materiality of the setting because it was always centered on humans and their respective relationships: were it in the grand hagiographic attempts of Ernest Jones (1953) and others (such as Eissler 1951) which pictured the emergence of psychoanalysis as an outcome of Freud's heroic self-analysis, or were it in more sociologically oriented accounts which looked at the formation of psychoanalytic organizations in various countries or the complex interactions between analysts and their patients (e.g. Forrester 1994). Even in this sociological vein, only few contributions have been made to the history of the psychoanalytic setting itself: Robert Castel ([1973] 1980) devoted a critical study to what he termed the "social unconscious" of the Freudian (and Lacanian) enterprise, focusing on the hidden power-relations and the socio-economic conditions which govern psychoanalytic practice. Even if this kind of critical analysis provided a number of important insights, to unveil a *social* reality

[2] On Freud as a collector, see Forrester 1997a, and on the history and changing function of the objects in his consulting room and office, see Marinelli 1998.

[3] The history of the couch is the subject of a forthcoming book (Marinelli and Mayer 2006).

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denied by psychoanalysts meant ultimately to bypass many of the concrete features of the actual setting. Another notable contribution had a quite different orientation: in the light of the historical sociology of Norbert Elias, the psychoanalytic setting appeared as an expression of a process of long-term rationalization of the medical profession and as a quasi-experimental situation (de Swaan 1980). Both authors thus agree that the psychoanalytic setting should be compared to a "sort of experimental laboratory which seeks to produce a certain type of effects" (Castel [1973] 1980, 63). However, the notions of a laboratory or of experiment are not specified historically or sociologically, but refer to an *ideal* of controlling a certain type of situation.

My concern for a historical clarification of how the psychoanalytic setting emerged from the laboratories of hypnotism takes up lessons from the ethnographic and historical studies of scientific laboratories (see Knorr Cetina 1999; Latour [1984] 2001; Rheinberger 1997; Shapin and Schaffer 1985). The role of materializing devices is the major focus of the first section which expounds the conflicts between two divergent approaches on how one should deal with the practice of hypnosis in a clinical culture, as developed in Paris at the hospital La Salpêtrière by the neurologist Jean-Martin Charcot and in Nancy by Hippolyte Bernheim. The controversy between the two schools has been treated in different manners (see e.g. Carroy 1991; Gauld 1992, 306–362; Harrington 1988a, 1988b), but without sufficient attention to the intricate interplay of the respective local clinical cultures and their strategic use of laboratory equipment and other materials (such as museum objects). This neglect may be due to the fact that most of the historiography of hypnotism is strongly biased in favour of Bernheim who appears, quite in opposition to Charcot and his school, as the true founder of modern psychotherapy.

The second section is devoted to the emergence of the private consulting room of hypnotherapists during the 1890s, when the Bernheimian treatment by "suggestion" became a flourishing business in most Western countries (see Gauld 1992, 336–353). The focus here is on attempts to create a laboratory-like setting which aims to subordinate all its physical components to the verbal expression of the subject's state of mind. This search for a formalization of the procedure of hypnosis, represented by the work of Oskar Vogt and Korbinian Brodmann, paralleled Freud's and Breuer's work on the *Studies on Hysteria* and the first formulations of what Freud, from 1896 onwards, called "psycho-analysis."

The distinctive features of the psychoanalytic setting and their variations between 1900 and 1914 are addressed in the last two sections. Less than a full-fledged model invented in a sort of "splendid isolation," Freud's specific arrangement for the psychoanalytic treatment was rather the outcome of a number of trials inside and outside of psychoanalysis. Although his technique was heavily indebted to the treatment by suggestion, the new spatial distribution in the consulting room led gradually to what came to be identified as the "classic" psychoanalytic setting. In the light of the therapeutic and experimental "legacy" of hypnotism, it seems therefore necessary

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to explore in depth the extent to which Freud's practice was designed as a form of experimental situation.[4]

1. Effects of visibility in experimental cultures of French hypnotism

Any historical account of the psychoanalytic setting has to tackle the issue that Freud's new technique was to a large extent an outcome of the practice of hypnosis. The late 1870s saw the emergence and proliferation of experimental cultures of hypnotism, especially in French hospitals. It is a well-known fact that Freud, as a young doctor, traveled to Paris and later to Nancy to become familiarized with the techniques of key actors such as Charcot and Bernheim and even translated their major works into German. The term "psychoanalysis," which makes its appearance first in 1896 and is then further specified by Freud, most notably in his *Interpretation of Dreams* (1900), may thus seem more as an attempt to relabel an array of older practices, be they hypnotism, suggestion or, earlier than these two, magnetism, Braidism, or Mesmerism. Historiographies emphasizing continuity usually attempt to find a common denominator for this multiplicity of names, tacitly assuming that there exists an identity of things or a shared experience to which they refer. The work of Ellenberger (1970) which posited a system of "dynamic psychiatry" and introduced notions such as "creative illness" or the "pathogenic secret" would be a typical representative of this trend. In opposition to this stance are approaches favoring the discontinuity of singular practices (such as Foucault's work from the 1970s onwards) and, in a similar vein, nominalist positions which hold that the invention of new diagnostic categories actually creates new types of subjects and forms of experiences (Hacking 1995). The advantage of the latter position is that it gets rid of the spontaneous identification of diagnostic or therapeutic labels with things (states of mind) or people. However, such epistemological acuity often shifts the attention away from the ways in which practices are linked to local cultures and to the dynamics of controversies over epistemic and political stakes.

The debates about the possibility of experimental hypnotism during the 1870s cannot be isolated from the specific medical cultures in which they were located. Although it is true that the seeds of interest in hypnotism was planted by Mesmerists, stage magnetizers, and spiritists, it has to be noted that the early controversies sourrounding Mesmer and other practitioners can hardly be portayed as a conflict

[4] The following historical-sociological exposition does not make any normative stance about the right way of doing science. In this way, it is quite distinct from attempts by philosophers of science to account for the scientificity of psychoanalysis (for a more recent example, see Stengers 1997). Whereas I would agree that the idea of an "epistemological break" between hypnosis and psychoanalysis is not defendable, I conceive of the social scientist's task as a more modest one. The discussion about whether a certain therapeutic practice corresponds to "good" or "bad" science lies beyond any historical-sociological analysis.

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between lay and expert science.[5] Such a situation prevailed only after the 1860s, in the process of the increasing professionalization of scientific disciplines and the creation of laboratories. In this process, various medical sub-disciplines emerged that were shaped by a combination of "hospital medicine" and "laboratory medicine" (see Ackerknecht 1967; Jewson 1976). Hospital medicine which emerged in its exemplary form in the large Parisian hospitals founded after the French Revolution allowed for a high spatial concentration of patients, the development of new research methods and instruments, and a training program for students that was bound to a practice and a specific location. In spite of the fact that laboratory medicine which, along with the disciplines of experimental physiology and bacteriology emerging in France and Germany, increasingly claimed for itself the title of "scientific medicine," the hospital was turned into a field of experimentation in many Parisian clinics. "Experimental hypnotism" was not just a new label, but was also an attempt to create a new type of laboratory in a clinical space and to establish a new form of expertise.

By the end of the 1870s, the famous neurologist Jean-Martin Charcot from the hospital La Salpêtrière had integrated a number of already widespread techniques of hypnotization into a new clinical arrangement that aspired to become a laboratory of hypnosis. The *grand hypnotisme*, which Charcot introduced to his colleagues in a séance at the Parisian Académie des sciences in 1882 as a new experimental approach, cannot be seen as a return to Mesmerism or a predilection for occult phenomena indebted to the zeitgeist (Harrington 1988b). Rather, it is to be located in a specific manifestation of laboratory and hospital medicine. Hypnotism was to become the prototype of a new experimental psychology based in the clinic and as such clearly opposed to academic laboratories (such as Wilhelm Wundt's in Leipzig) where only "normal" subjects were admitted and trained in the practice of introspection. In Paris, the relationship between experimentator and his "subject" (*sujet*) thrived on the asymmetric doctor-patient-relationship that was characteristic of hospital medicine.[6] A crucial role in this new practice was assigned to the use of various objects and instruments.

The subjects of the experiments conducted under Charcot's direction were patients diagnosed as suffering from "hysteria" and the inextricable link between this specific ailment and the material apparatus deployed to exploit it to experimental ends was specific to the introduction of hypnotism at La Salpêtrière. The various stages of the *grand hypnotisme* were intimately bound up with the nosological classification of *Grande Hystérie* (for different historical accounts of this project, see Gauchet and Swain 1997; Goetz, Gelfand, and Bonduelle 1995; Micale 1990). The establishment of this articulation in an experimental program was linked, as Fischer-Homberger (1975) has shown, to the problems arising from the pathologies and accidents produced by new

[5] For a clarification of this point, see Winter 1998.

[6] Danziger (1990, 53–55) argues in his social constructivist account of experimental psychology that the meaning of the term "subject" was introduced in the wake of the clinical experiments undertaken in French hypnotism. For the French context, see Carroy 1991.

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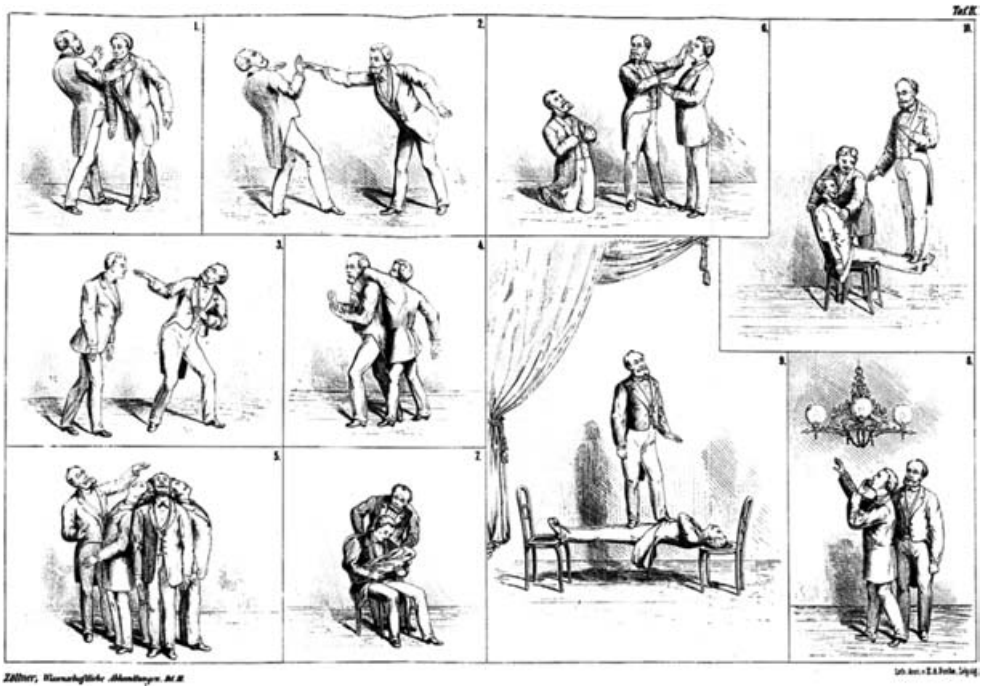


Fig. 1. Synoptic view of performance by the stage hypnotist Carl Hansen (from Zöllner 1879).

technologies of transports, most notably the railway. Thus the laboratory setting at the Salpêtrière was designed to a large extent to reproduce the ensemble of physical agents that were held responsible for the appearance of traumatic neuroses. As a consequence, the phenomena of hypnotism as classified by Charcot in three stages (catalepsy, lethargy and somnambulism) were always triggered by a "shock" affecting the nervous system of the subject.

But the impressive apparatus of optical and acoustic machines at the heart of the experiments had yet another function. Hypnotism had to be detached from the metaphysical and mystical air that surrounded the power of the stage magnetizers or mesmerists touring European cities and eliciting strong public reactions. Neither the "will" nor a mysterious "fluid" would explain the extraordinary acts, but simple physiological facts of sensory impression. To mobilize a vast machinery should leave no doubt to the fact that the doctor was not serving as a *moral* agent, but that only the *physical* agents had an effect on the senses of the subjects. This machinery allowed doctors to be both present and absent during various sequences of the action. During the session the doctors or the parts of the body (eyes, hands) which used to have an effect on the subject, were ostentatiously replaced by optical and acoustic apparatus. Thus, in his first series of experiments (in the late 1870s), Charcot demonstrated in front

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Fig. 2. Catalepsy, produced by the vibrations of a tuning fork (from Bourneville and Régnard 1876–80).

of an audience of foreign visitors how the patient could be brought into the hypnotic condition by staring fixedly into her eyes. She was then transferred to a darkened room, in which the doctor's gaze was replaced by "a spiral of platinum heated by a powerful gas blow-pipe" emitting a light "almost as intense as the magnesium light. If she stared into the flame for an instant, she immediately fell asleep and passed into a cataleptic condition" (Gamgee 1878, 546). Proceeding from such demonstrations the doctors in Paris claimed that only physical agents had an effect on their experimental subjects. Thus the medical expert with all his social authority was visibly cut out of the hypnosis experiment.[7]

Some commentators saw a scientific stroke of genius in Charcot's demonstrations: George Beard praised the physician for having "taken these emotional and wretched

[7] This shift is also reflected on the level of visual representation: While the doctor is still present in the schematic account of the hypnosis procedure taken from the *Iconographie de la Salpêtrière* (Bourneville and Régnard 1876–80) similar to popular representations of stage magnetizers (such as Hansen, see fig. 1), he disappears entirely in the photographs demonstrating the experimental production of diverse hypnotic states (see figs. 2 and 3).

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Fig. 3. Catalepsy, produced by intense light.

women, these waste products thrown off in the evolution of the race" in order to experiment with them "as to produce results as clear, as true, and as pure as the chemist can obtain with the inanimate elements in the laboratory" (Beard 1882, 37). Other observers adopted the opposite position, emphasizing that given their arts of deception, these patients might have succeeded in misleading their physicians.[8] The status of the hysterics as subjects thus remained epistemologically dubious: either they figured among the "rare pieces" in a collection of patients who could be used to gain unusual insights on unconscious processes or the experiments conducted with them were essentially without any value given the moral characteristics ascribed to them.

In this situation, Charcot sought to rule out the possibility of simulation by mobilizing the resources of his clinic. On the one hand, a number of new devices were introduced to make it possible to measure and control phenomena appearing in hypnosis and to identify simulators beyond doubt. On the other, the clinic and Charcot's private practice were furnished with various museum objects that could be deployed

[8] There is an abundant literature on the topos of the hysteric as a liar. For a survey, cf. Micale 1995.

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for different strategic purposes. In the course of the critical debate, the space of the *Musée Charcot* itself became one of the major arenas of experiment (Mayer 2001b; 2002, 89–112). The clinical system of reference was expanded to include areas outside of the clinic such as religious iconography. At first the combination of both strategies may seem contradictory. In one case, the instruments of the graphical methods propagated in France by the physiologist Etienne-Jules Marey were used to measure and control the nervous states generated in subjects in the form of curves, while in another case artistic representations of religious motives were to testify to the existence of *Grande Hystérie*, as described by Charcot. The French neurologist and his students derived their authority from the use of the graphic methods and thus followed the tendency of mechanizing the social patient-doctor relationship in modern hospital medicine. A new system of inscription devices supplemented older techniques of constant surveillance of the patient's behavior by the doctor, the nurses. and other patients. At Charcot's clinic at *La Salpêtrière*, the patient-doctor relationship was reconfigured in a way that the confrontation between the "will to know" of the doctor and the will to deceive assigned to the patient was deferred from the direct interaction between both parties and was handed over to the instruments. In the experimental hypnotism, the yardstick for a good subject was its constancy in displaying certain symptoms that could be translated into a regular curve. What deviated from this pattern was simulation or exaggeration and could be extracted from it.

By contrast, the strategic use of artistic reproductions was entirely based on the positivist program of "retrospective medicine." The collected objects were to prove that the neuropathological images of illness had already presented themselves in exactly the same way in the past as the doctors at the Salpêtrière had demonstrated with patients at the clinic. The museum thus functioned primarily as a place where testimonies for the identification of symptoms or patients were collected (Mayer 1998). Both strategies aimed at clearly visualizing the manifestation of a symptom for doctors and detaching the decision regarding a diagnosis from the patient's statements.[9]

Soon after Charcot had presented his new "experimental hypnotism," competitors appeared on the scene. Hippolyte Bernheim, professor at the newly founded University of Nancy, assumed the most prominent role in the controversies concerning the new facts presented by his famous Parisian colleague. He took issue with the hypnosis experiments conducted by Charcot, declaring all physical agents ineffective. Taking up the lesson from the practice of Ambroise Liébeault, a local doctor who healed his patients by putting them into a sleep-like state through the power of mere words,[10]

[9] The visual culture of the *Salpêtrière* can be emblematically represented on the basis of the Bourneville's and Régnard's *Iconographie de la Salpêtrière* (1876–80), as Didi-Huberman (1982) has done. However, such an endeavor ignores the heterogeneity and specificity of the visualization strategies used in Charcot's clinic. Gauchet and Swain (1997) have argued convincingly for a more differentiated picture of Charcot's practice. For a more detailed account of the respective strategies of visualization, see Mayer 2002, 49–60.

[10] The voice holds a privileged role in this kind of treatment. For details, see the reports by Delbœuf (1889) and Renterghem (1896-97).

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Bernheim maintained that a mere "verbal affirmation," an "order," seemed to be entirely sufficient to produce hypnosis (Bernheim 1884). As a consequence, he argued, the production of hypnotic facts was not restricted to the rare kind of the hysterics at La Salpêtrière, but could be applied to anybody. Bernheim summed up his criticism in the radical formula that all the striking phenomena of hypnotism could be produced by the single factor of "suggestion" alone: "Tout est dans la suggestion." This formula of suggestion implied a radical *dematerialization*, if not iconoclasm, with regard to hypnotic experimentation. In his counter-experiments, Bernheim replaced the magnet by various instruments and fake objects – such as dummy magnets (made of wood or paper) – and demonstrated how he could produce the same symptoms as the Parisians. For instance, he used a stethoscope, suggesting to the patient that he could produce a *transfert* with it, the passage of a symptom from one half of the body into the other, a striking phenomenon which was accomplished by the action of the magnet alone, according to Charcot and his collaborators (Bernheim 1889, 93).[11] Bernheim argued that the extraordinary power of the physician had to be explained entirely by the *belief* – the "suggestibilité" or "credivité" – of the subject and not by a special pathological disposition that could be influenced by material agents. The variety of objects and instruments brought on the scene by Bernheim were not supposed to act on the subject, but should show that the physical agents used by the Parisians were not producing anything. The "facts" displayed by Charcot and his students in Paris were thus ridiculed as being the result of mutual self-deception of experimenters and subjects.[12]

With his iconoclastic gesture, Bernheim became one of the founding figures of psychotherapy positing the realm of the psyche as an inner autonomous space.[13] What acts on the hypnotized subject's brain is the suggested idea, and this very action cannot be observed except from his speech and his physiognomy. According to Bernheim, "the one thing certain, is that a *peculiar aptitude for transforming the idea received into an act* exists in hypnotized subjects who are susceptible to suggestion" (ibid., 137). He therefore could not accept the solution to the problem of simulation adopted by Charcot and his school: whether the subject is simulating or not, cannot be decided by mechanical devices, because the instruments cannot render where and how the subject's

[11] Given the ongoing controversies over the new medical technology of auscultation (cf. Lachmund 1999), such a polemical use of the stethoscope was certainly not accidental.

[12] Some critics went even further. After his visits to Paris and Nancy the Belgian mathematician and philosopher Joseph Delbœuf came to the radical conclusion that there was no real difference between the popular culture of stage magnetizers and the medical cultures of hypnotism. They were to be regarded as manifestations of different schools all of which could be explained by the same mechanism: a form of "education," which, however, both the experimenters and the subjects were unaware of (Delbœuf 1886). To prove his point Delbœuf tried to re-stage the experiments he had observed in his home in Liège with his own house staff. The epistemic strategy of these re-stagings aimed at depathologizing the hypnotic experiment as much as possible. According to Delbœuf the clinical setting was the locus of a sort of "drama" in which the doctors and the subjects "deceived each other in good faith" (Delbœuf 1889, 22).

[13] Bernheim is one of the first to use the label "psychotherapy" (see Carroy 2000; Gauchet and Swain 1986).

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"imagination" interferes in the process. The actions performed by the doctors and their subjects in Nancy were described in a moral vocabulary which was avoided by Charcot: during the execution of the suggestion, they offered a spectacle of "resistance," of the conflict between the "will" of the doctor and their own "counter-will" (cf. Bernheim 1889). Thus, Bernheim argued with his demonstrations for a different system of power than the one set up in Charcot's clinic. Instead of the intricate play of absences and presences as it was enacted by the Salpêtrière doctors with the help of their material technology, in the Nancy hospital the hypnotist's power consisted in his constant presence as a moral agent. The acts of suggesting rested on faith and belief (or make-believe): in the formation of the subject as a *moral* agent, materials had no part to play.

In opposition to Charcot and his school who insisted on the universality of the phenomena of hypnotism (as expressed in a certain pathological disposition), Bernheim declared the technique of suggestion to be a highly localized practice. The ideal arena for reaching the desired effect was to be found in a hospital ward where the doctors could exploit the visibility of the concrete interaction between doctor, patient, and the hospital staff at a maximum. Such conditions prevailed in the Nancy hospital where the beds were located in eight large rooms, separated by the doctors' offices and consulting rooms (see the description in Delbœuf 1889, 50). The practice of Bernheimian suggestion was closely linked to this spatial structure of the hospital ward with its distribution of patients in groups and the regular doctor's visit at the patient's bed. In the Nancy clinic, "a suggestive atmosphere" was created in which patients constantly witnessed how others were hypnotized and healed of their symptoms. The treatment thus thrived on a form of psychic contagion that was supposed to weaken fear and resistance against the procedure of hypnosis.

But the importance of its very local character was also causing problems when the technique had to be transferred from one place to another. Bernheim stressed that in private practice many individuals were "unnecessarily frightened by uninformed doctors about the dangers of hypnotism. . . . One then encounters some resistance. If possible the individual to be hypnotized should be in an environment that is completely under the hypnotist's control and reassuring; then the ground has been properly prepared within a short time and the individual surrenders without any reserve to the doctor" (Bernheim 1891, 89).

For those physicians who visited during the 1880s both Charcot's and Bernheim's clinics in order to apply French hypnotism in their own medical practice, the situation remained highly ambiguous. The school of the Salpêtrière had provided reproductions of certain phenomena on a very small number of patients, but without achieving calibration of its main "instrument," the hysteric. Even adherents of Charcot's program had to admit that "this instrument works in an irregular manner which we are unable to control and we lack the proper education to use it for measurement or an exact estimation" (Benedikt 1894, 25). Bernheim and his allies were successful in making "suggestion" a new and powerful therapeutic label for an expanding medical movement

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of doctors throughout Europe and the United States, but the concrete transfer of practices from the hospital into the private practice encountered a number of obstacles that necessitated substantial modifications of the original arrangement.

Freud, who after his sojourns in Paris and Nancy had become known to the public as both Charcot's and Bernheim's translator, directed attention to this problem in his first publications on hypnotism (Freud 1889; idem 1891). In fact, the problematic transfer of skills and practices affected the entire movement of doctors who strove to put psychotherapy on a scientifc foundation. Before we can inspect Freud's solution to this problem, we therefore have to reconstruct a chapter that is still missing from the historiography of psychoanalysis and hypnotism. This chapter concerns to a large extent what Sigfried Giedion ([1948] 1969) has termed "anonymous history": the emergence of the private consulting room of hypnosis doctors in the final decade of the nineteenth century which was characterized by a redistribution of persons and things and the increasing stress on the control of the sonic environment.

2. Voice control. The soundscape of the hypnotic consulting room

After his visit in Nancy, Freud remarked on the successful cures achieved by suggestion, saying that "a good part of this success is due to the 'suggestive atmosphere' which surrounds the clinic of these two physicians [Bernheim and Liébeault], to the *milieu* and to the mood of the patients – things which I cannot always replace for the subjects of my experiments" (Freud 1889, 100). After the demise of Charcot's experimental program and the increasing spread of Bernheim's views, private practitioners of hypnosis had to face the problem that they did not operate in a stable setting that facilitated an isolated observation of patients. In the homes of their patients, they were confronted with a conflict-ridden terrain where resistance and interventions of family members subjected the course of treatment to unforseeable disturbances.[14] In addition to these difficulties, the doctor had to deal with the fact that the social status of private patients was generally higher than that of patients who were summoned to the out-patients' clinic for hypnotic experiments. Whereas this sociological problematic of the balance of power between doctor and patient has been raised (Forrester 1994; de Swaan 1980), the modification of the material arrangement and the emergence of the psychotherapeutic consulting room during the 1890s is an issue that has been completely neglected. This is quite surprising, since the leading journal of the new movement of Bernheimian hypnotism – the *Zeitschrift für Hypnotismus* – and the correspondence between its founder Auguste Forel (available in an abrigded version [Forel 1968]) and the members of the editorial board (among them Freud during the first years) provides detailed

[14] Freud's first published case-study provides a good example (Freud 1892–93). It should also be noted that, following a number of law suits and discussions about the dangers of hypnotic treatment, suggestion therapy was always conducted in presence of a witness, usually a member of the family (see Forel 1891, 116–117).

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descriptions and discussions of the design of the appropriate consulting room.[15] This intense preoccupation with the spatial and material components of the hypnosis practice corresponded to the systematic attempt to obtain the standards of a site of study that could compete with the new laboratories of experimental psychologists, especially those in Germany (following the model of Wilhelm Wundt's laboratory in Leipzig).

The private practice of German hypnosis doctors differed in a number of respects from the Parisian clinics in which patients were subjected to the hypnosis experiment. The furnishings of the consulting room were to be geared entirely to calming the patient and to "making it easier or at least not more difficult for the patient to fall asleep" (Löwenfeld 1901, 108). According to the account given in Löwenfeld's manual that found widespread use, the treatment took place in a "room in a quiet location . . . , with dimmed lighting" (ibid.). The triggering of sudden sensory impressions through flashing electric light or hitting tuning forks and gongs – as was common practice at the Salpêtrière and other Parisian clinics – could, according to the suggestion therapists, only lead to "hypnoses based on fright" (ibid., 97) which would have the result of reinforcing symptoms. The spontaneous phenomenon that was now equated with the hypnotic state was not (as with Charcot) a shock triggered by a mechanical accident or coincidence but (following Liébeault) sleep that had been gradually brought on by way of impressing the subject's imagination.

Since the main goal of the procedure was to enable the patient dressed in comfortable clothing and resting on a fauteuil or sofa to fall asleep, the practices of suggestion were to be adjusted as much as possible to the patient's individual sleeping habits at home: "Individuals who are used to taking a nap only in an easy chair are allowed to take such a position while others who can only sleep lying down must be allowed to position their head accordingly and so on" (Löwenfeld 1901, 108–109). The consulting room of the hypnosis doctor was furnished with a number of new pieces of furniture that could be adjusted to the special position of the patient's body. The mechanized forms of the chaise longue, the sofa, the couch and the fauteuil, developed and refined during the second half of the nineteenth century (in part in response to the demands of nursing and surgery) made it possible to adjust to as many gradations as possible between sitting and lying. The comfort of this polyfunctional "patent furniture" was created by active adjustment to the body (Giedion [1948] 1969, 389–481). Some doctors (such as Oskar Vogt) used specially constructed beds or fauteuils with adjustable backs to accomodate to the physical flexibility of their patients.

This new "relaxation" furniture pushed the historistic design into the past once and for all. If we turn to Charcot's private practice in Paris or to his museum at the Salpêtrière (see fig. 4), we see an exemplar of this sort of style. Leon Daudet denounced this arrangement in a retrospective account by evoking the "infernal suffering" of

[15] The following section will be restricted to the emergence of the private practice and leave aside the use of hypnotic suggestion in the psychiatric hospital – as practiced by Forel in Zurich or by Krafft-Ebing in Vienna.

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Fig. 4. Musée Charcot, La Salpêtrière. The only surviving photograph of this museum of pathological anatomy dates from the 1890s. It was frequently used for patient demonstrations.

Charcot's private patients in this "heap of rubbish" (Daudet 1931, 19). It is not a coincidence that, for a later critic, the inhumanity of scientific medicine is entirely reflected in the *material* components of a consulting room. Already a decade after Charcot's death, the adjustment of the furniture to the patient's individual body had become a necessary element of the procedures of suggestion.[16]

Since minor details in the patient's body position on the bed or the chair ultimately decide whether suggestion will succeed or fail, the physician is bound to refrain from all physical manipulations. The only instrument left to the practitioner of suggestion is his voice. In this setting, the doctor speaks and the patient listens. The highly visual culture of the French hypnotism yielded the attempt to construct an acoustic space where the hypnotist had to adjust and control his voice according to the gradual process of suggestion. This change becomes evident, when we consider the ways in which German physicians transformed the various demonstrations used by Bernheim. In the Nancy hospital, the suggestive atmosphere was created through a purely visual effect: the resisting patient saw how the procedure worked with other patients, thus believed in its efficacy and this interplay of seeing and believing enhanced his suggestibility, eventually leading to a successful hypnosis (Bernheim 1891).

In this practice, the individual subject was always placed in a group. Once transferred to the private practice and patients from another social class, the procedure had to be modified (see Freud 1891, 108). A number of Bernheim's followers – Auguste Forel,

[16] And it also does not come as a surprise that most of Charcot's furniture was actually thrown to the rubbish, after his wife's death in 1904.

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Oskar Vogt, or Otto Wetterstrand in Stockholm – invented special arrangements allowing a form of group hypnosis which would make it both possible to bring about the effects of "psychical infection" in private practice and to shield off the private spheres of individual patients from each other.

The prototype of such a practice was created by Otto Wetterstrand in an apartment in an aristocratic quarter of Stockholm. One visitor gave detailed account of his practice in the *Zeitschrift für Hypnotismus*:

> A dark red, very thick rug covers the hard wood floor and hushes the noise of steps. The rooms are furnished like a parlor which is cluttered with all sorts of easy chairs, sofas, chaise longues and settees, each covered with a white spread. Here and there a partition serves to shield off some patient. Between two and four in the afternoon the parlor is never empty. It is a constant to and fro of patients. You enter the room, make yourself comfortable, receive your suggestion and then leave at a given time. Everything happens with hushed voices, you hear nothing but a whisper here, a quiet snore there, a chair that is moved, the swishing sound of a robe. The doctor multiplies himself and finds time within these few hours to see thirty to forty patients consulting him and to spend a certain time or an entire afternoon here, to put them to sleep and give them suggestions and then wake them up again. (Renterghem 1896–97, 53)

In this modification of the Nancy setting, the reciprocal visibility and audibility of the patients is limited by the material arrangement and the hypnotist's voice control. Wetterstrand generally began working with patients who had already been hypnotized and whispered suggestions so softly into their ears that only they were able to hear them: "This way W. achieves a powerful suggestive effect on the gaze of many persons who quickly fall asleep and avoids any disrupting mass effect of his suggestions. . . . lf W. wants to direct a suggestion at one or more patients he raises his voice accordingly" (Forel 1891, 120). The main operator in the practice of hypnotic suggestion is no longer the gaze, but the voice: How loud or how soft, how slow or how fast a suggestion is given by the doctor can be decisive for the success of treatment. Subsequently, the consulting rooms of hypnosis doctors were modified so that the suggestive effects were hardly generated by visible demonstrations but largely by means of producing a special "soundscape," which defined the hypnotic group primarily as an acoustic community.[17]

Oskar Vogt's consulting room in the Bavarian spa Alexandersbad – based on Wetterstrand's model – distributed the patients in various sound-proof compartments. While the patients are shielded off from each other spatially for duration of their individual treatment and are unable to see each other, the voice of the doctor who on his rounds gives suggestions, creates a link between them. The individual patients

[17] A soundscape is composed of the acoustic events that mark off a certain space, such as the range of a speaker's voice or, as in the case of a village community, the sounds of a local church tower bell (see Schafer 1977). For a detailed analysis of soundscapes in medical practice, see Lachmund 1999.

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lying on various pieces of furniture in the room become a group through the shared soundscape – a group that is formed and controlled by the hypnotist moving through the sound-deadening interior. By modulating his voice in various suggestions he produces variable acoustic zones that create a basic suggestive atmosphere and specific effects. According to Vogt's collaborator Korbinian Brodmann's report the doctor in these hypnosis rooms goes "from patient to patient, giving each of these with a loud or muffled voice the sleeping suggestions adjusted to each individual case. As soon as an effect has been achieved the corresponding therapeutic suggestions are given in a muttering, incomprehensible voice or whispered" (Brodmann 1898, 268). Thus the rising and sinking voice of the doctor acts in a double sense, separating and connecting the hypnotized group.

In the long run, the control of this acoustic space aimed at creating a psycho-therapeutic setting which could reach the standards of contemporary laboratories of experimental psychology such as Wilhelm Wundt's laboratory in Leipzig and those of the Würzburg school. From the mid-1890s Oskar Vogt followed such a strategy. In 1898 he adopted the furnishings used in Alexandersbad for group hypnoses in modified form in his central neurological station in Berlin for methodical individual hypnoses. This private research department consisted of a brain anatomical collection, a "medical psychological institute" as well as an out-patients' clinic (Satzinger 1998). Vogt's private institute thus offered a spatial connection of brain research, hypnosis experiments and therapeutic work similar to Charcot's neurological department at the Salpêtrière. But in marked contrast to the Parisian experimental program, the various research areas were strictly separated here. Vogt and his students worked on an exclusively *verbal* indexicalization of the depth of a hypnotic state and the psychic objects observed therein.

The appropriate subject for a hypnotic experiment was defined within this configuration primarily by its "ability to critically and objectively engage in self-observation" which included the "adequate linguistic expression" of the objects observed (Vogt 1899, 71). The doctor with training in psychology was seen as an exemplary experimental subject who knew how to train those who subjected themselves to his procedure to become "good" subjects – in both a moral and epistemic sense. The numerous self-observations published by Vogt not only served other doctors as an example but also, first and foremost, the patients who were to be both healed from their symptoms and educated to be good subjects.

This strategy of promoting "introspective hypnotism" (Mayer 2001a) was initially not yet bound to a stable setting. Like most of the adherents of Bernheimian suggestion, Vogt was caught up in the contradicting position of working theoretically from the premise that "somnambulism can be achieved in any mentally healthy person" (Vogt, quoted in Brodmann 1898, 281), while at the same time having to rely on patients from the psychiatric and the neurological clinic. Proceeding from this situation he arrived at the conclusion that "it was a doctor's duty in all cases of illness to lend themselves to treatment by hypnosis to train the patients in *somnambulhypnosis through consistent*

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disciplining" (ibid.). This discipline was also to be achieved in "educated patients" who belonged to the upper social classes and were less responsive to the technique of giving simple orders as was generally the case in the suggestion therapy practiced by the School of Nancy.

The technical solution to this problem was the so-called "fractionation method" *(fractionierte Methode)* which structured hypnotization as a slow process divided into a number of stages. At first, the doctors carried out only very short hypnoses again and again interrupted by waking up the patient, in and during which each subject was questioned about his feelings. The division of the procedure into short stages while constantly questioning the subject provided an index for the given state, thereby laying down the measures to be taken in the following stages. By this, Vogt and Brodmann offered a solution for the epistemic uncertainty that appeared in the private practice of suggestion therapists in the 1890s. By dispensing with the older methods of verification used on the patient's body (by attaching graphic recording instruments to it or by triggering automatic movements), the practitioner of suggestion had no visible indicator about the patient's psychic state. The graduation of the procedure, which could encompass hundreds of sessions, served, in addition to this epistemic goal, to discipline recalcitrant patients. Vogt stated that he "had achieved a normal somnambulism in his best hysterical test subjects only after 700 and in his second-best ones only after 200 sessions" (Vogt 1899, 76). The resistance of many patients to adopt a posture of "concentration" in the initial phase of treatment manifested itself in convulsive fits of laughter or crying or pronounced motoric phenomena (such as trembling or hysterical attacks). As the many records published by Brodmann (1898) show, in such cases the patients were gradually brought into a quiet position through suggestion and physically adjusted to the setting.

Once the subject had become increasingly attuned to the procedure he would demand himself that disturbing factors from the inside and outside – such as street noise, the ticking of a clock or piano playing from neighboring apartments – be eliminated. This exemplary behavior of a test person is demonstrated by the extensive records that were published by doctors who also subjected themselves to Vogt's procedure to increase its efficiency (see Marcinowski 1900).[18] Shielding off the room from disturbing noises is a crucial factor in creating a "partial waking state" in which the subject becomes an observer of his own unconscious ideas in the guise of isolated objects. The optimum conditions for looking into one's own psychic interior space correspond to complete silence in the acoustic space, analogous to the self-disciplined silence imposed on the audience in a metropolitan theater or concert hall (Sennett 1977, 205–218). Accordingly, one of Vogt's collaborators describes himself as a "spectator" who can

[18] It is important to note that Vogt and Brodmann attempted not only to cure their patients by making them into skilled self-observers; they also asked future hypnotherapists to subject themselves to the whole procedure. By promoting such a special training for the specialist, Vogt's hypnosis laboratory aimed to create a new school of experimental psychology situated in the clinic.

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observe all the details "without effort or attention like in a theater" (Marcinowski 1900, 23) or as a "person looking into a stereoscopic box and before whose eyes one image after the other flips over" (ibid., 14–15). The subject can now follow his childhood memories, controlled by the suggestions given by the hypnotist as a series of "silent images."

3. Tracking the complex: early attempts at stabilizing the psychoanalytic setting

In spite of the manifold difficulties Freud encountered during the 1890s as a practitioner of hypnosis and Breuer's "carthartic" approach, he did not abandon the idea that psychotherapeutic practice could be developed into an experimental situation. However, the consequences he drew differed considerably from the position adopted by Vogt and other early psychotherapists. In opposition to the attempts of making the consulting room resemble a laboratory of experimental psychology, Freud refused to make his approach dependent on the situative attainment of a psychological state that could be systematically varied according to various conditions. In the exposition of what he termed – first in a merely technical sense – his "self-analysis," as demonstrated in the *Psychopathology of Everyday Life* and *The Interpretation of Dreams*, he sought rather to detach his technique from any specific locale. Self-analysis with its method of free association was initially an activity bound to the desk. In an interplay of reading and writing techniques Freud elaborated a text form by means of which the reader was to reach ideally the same results as the author (Forrester 1997b; Marinelli and Mayer [2002] 2003). The new methods could be acquired only in an informal way, in private correspondence between the analysand and the "other," with Freud's own epistolary analysis with his friend Wilhelm Fliess (Freud 1985) serving as the main exemplar. In the early psychoanalytic practice the tracking of dreams and slips of the tongue which functioned as normal psychological equivalents of hysterical symptoms was the primary strategy for converting medical professionals trained in self-observation and hypnotism to the Freudian analysis of dreams (Mayer 2001a, 187–192).

In contrast to the doctors of the hypnosis movement who gave very detailed accounts of their procedures and measures, Freud refrained from publishing extensive methodological essays. Even the concrete spatial setting of psychoanalytic treatment was not set down in his early, scattered published remarks. Around 1900 the psychoanalytic setting did not consist of the arrangement in which the freely associating analysand lies stretched out on a divan or a sofa with a silent or interpreting analyst sitting in a chair behind him. While Freud did write, when making some remarks about his technique in *The Interpretation of Dreams*, that it was "an advantage for him [the patient] to lie in a restful attitude and shut his eyes" (Freud 1900, 101), this positioning of the body in a quiet position – as opposed to the practices employed by the suggestion therapists – was not the central factor in his new approach. Rather, the latter consisted in "a

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completely impartial attitude" which committed the patient to following the rule to tell the analyst "whatever comes into his head" and to pursue the many "trains of thought" that opened up (ibid.). Through such uninhibited release of an associative movement within the patient's psyche, the psychoanalyst could make his way through the unconscious. In keeping with this definition, Freud also carried out several analyses while walking with his patients (see the letter from Freud to Fliess, 16. 5. 1897, in Freud 1985, 244).

In 1904, Freud specified for the first time how the doctor and patient were to be positioned in the consulting room:

> Without exerting any other kind of influence, he [Freud] invites them [the patients] to lie down in a comfortable attitude on a sofa, while he himself sits on a chair behind them outside their field of vision. He does not even ask them to close their eyes, and avoids touching them in any way, as well as any other procedure which might be reminiscent of hypnosis. The session thus proceeds like a conversation between two people equally awake, but one of whom is spared every muscular extertion and every distracting sensory impression which might divert his attention from his own mental activity. (Freud [1903] 1904, 250)

According to this description, Freud adopted the spatial arrangement used by the German-speaking suggestion doctors, but without the related practices that were intended to put the patient into what was supposed to be a sleeping state. The positioning of the doctor outside the reclining patient's field of vision, which is mentioned here for the first time and is usually seen as one of the central components of the Freudian setting, was also recommended by several doctors who used hypnosis. Accordingly, a suggestion therapist trained by Vogt urged his colleagues "to sit so that it is difficult for the patient to look his doctor in the eyes" (Marcinowski 1900, 182). In this case, the justification for this asymmetric division of visibility was to be found in the specific nature of the procedure. Since the suggestion therapy aimed at getting the patient to shut his eyes as quickly as possible, it required very precise observation of his eyes. "The clouding of the gaze through accumulation of lacrimal fluid given the lack of eyelid movement, a certain rigid expression in the eye, these are the things . . . that the hypnotist has to lie in wait to be able to use immediately for suggestion" (ibid., 182). The certainty regarding a given state of consciousness, which Vogt tried to achieve with his fractionation method by constantly questioning his subjects, was to be further heightened by this new sitting arrangement. The privileged observation position enabled the doctor during the session to constantly draw conclusions from the signs visible on the patient's body to his psychological states and to take advantage of this lead.

Freud's positioning of doctor and patient, which only dispensed with closing the eyes and the already very limited manipulations on the patient's body, was also aimed at increasing the psychoanalyst's possibilities for observation. In his "Fragment of an Analysis of a Case of Hysteria," known as the "Dora case," Freud cited several

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examples of "symptomatic acts" observed in a patient which visibly confirmed his own interpretations.

Such automatic acts carried out by the patient, accidentally or in passing, during the psychoanalytic treatment were seen as unconsciously motivated expressions. Accordingly, when Dora refused to remember childhood masturbation at his insistence, Freud interpreted her playing with a small purse as "a further step towards the confession": "For on that day she wore at her waist – a thing she never did on any other occasion before or after – 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" (Freud [1901] 1905, 76). In this case study Freud showed how by collecting such symptomatic acts the psychoanalyst complements the narrated dreams and the following associations, thus succeeding in establishing "circumstantial evidence": "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore" (ibid., 77–78).

Endorsing such a criminalistic attitude, in which the patient's repressed wishes were revealed by a concatenation of visible proofs, the first psychoanalysts in Vienna and Zurich worked on further modifications of the setting. The most influential variant in the early period was the combination of the technique of dream analysis with the psychometric association experiment as practiced at the Burghölzli clinic in Zurich. Encouraged by Eugen Bleuler, the clinic's director, who was already in private correspondence with Freud, his assistant Carl Gustav Jung developed a procedure of treatment and diagnosis that combined both techniques.[19]

The diagnostic association experiment was closely modeled on other social rituals such as interrogation in court or religious confession. It drew a close analogy between the unknown complexes split off from the patient's ego and criminal acts (Jung 1905). The complexes were conceived of as being formed by the elements of an offense divided into individual markedly emotional stimulus words (such as murder weapon, site of crime, etc.). These "emotionally invested" words were combined in a list with "indifferent" words. While the words were read to the subject, he had to react as quickly as possible with another word. On the basis of the measurement of reaction times and other disturbances during the test the doctor was able to determine first the connection of words, from which he inferred the hidden complex. The following "psychoanalytic" part consisted of presenting to the subject the written notes of associations and his reactions times. This visible revelation of the complexes led inexorably to the subject's confession. The time measurements and the painstaking tracking of the associations provided data about the subject's supposed resistance and transference of erotic or hostile affects to the experimenter. The combination of association test, with its statistical

[19] Bleuler's role in the history of early psychoanalysis has been strangely underrated. By 1905, the psychiatrist had adopted the position of an analysand in an epistolary dream analysis with the "master" Freud (see Mayer 2001a, 187–192; Marinelli and Mayer [2002] 2003, 25–33).

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style of reasoning, and psychoanalytic technique, with its attention to indvidual cases and details, promised again to achieve objective knowledge about human subjectivity (Jung [1906] 1910).

Some of Freud's first Viennese adherents modified the setting on the basis of such a criminalistic layout of the psychoanalytic procedure. Thus, for instance, the neurologist and sexologist Wilhelm Stekel, one of the most important early popularizers of psychoanalysis, combined in his private practice the writing practices of the Zurich psychiatrists with the clinical observation situation of neuropathology. In this variant, the most important piece of furniture was not the couch on which the patient is expected to lie down, but the desk behind which the doctor sat noting on a sheet of paper the patient's symptomatic acts (Stekel 1908, 288). Since the patient was sitting, he had a wider scope of action. The doctor assumed again the role of an observer, similar to the neuropathological practice of Charcot, but with the difference that all manifestations had to be translated according to a symbolic key. Already the way in which a patient entered his consulting room revealed to Stekel the former's "secret intentions." "A patient suffering from an obsessive-compulsive neurosis showed a strange symptomatic act. . . . This man kept storming into my room, asking me for a key. This also symbolized his train of thought" (ibid., 296).

The psychoanalytic setting emerged in the early phase in various forms, each modifying in its own way Freud's positioning of the doctor and patient. Both at the psychiatric clinic in Zurich and in Stekel's Viennese private practice the doctor refrained from making his patients lie down. Instead, other material measures were taken to regulate the patient's associative and motoric flexibility. In the association experiment the sitting subject was asked to suppress completely his body motorics and to focus his attention on the compulsion of rapid association. The writing up of the deviations from this norm situation led the doctors to those features from which they could infer the unconscious complexes. Stekel's practice, by contrast, offered his patients a space for acting out their "symptomatic acts" to enhance the psychoanalyst's position as an observer. Here the patient's flexibility was not suppressed but rather stimulated.

From both variants it becomes clear that Freud's first publication of his asymmetric positioning of doctor and patient had not become the rule within the two most important branches of the early psychoanalytic movement. In both instances, the interaction between patient and doctor took place in a *face-to-face* situation allowing for reciprocal observation. The positioning of the actors entailed a symmetric division of visibility which also gave the patient feedback on the doctor's thoughts. The asymmetry of the relation which gave the doctor a lead in knowledge was achieved through the use of written documentation methods.[20]

[20] As the publications and case notes of most of the early practitioners show, it was common practice for the psychoanalyst to take shorthand notes of the patient's associations during the session.

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Fig. 5. Freud's consulting room, Berggasse 19 (photo courtesy Freud Museum, Vienna).

4. The fade-out of the object world: Freud's scene of treatment

In view of these modifications of the setting and the technical measures taken by his first disciples, Freud for the first time lay down in detail his criteria for a concrete realization of a psychoanalytic treatment. In a number of shorter essays published between 1911 and 1915 he set out to formulate a number of practical recommendations and "suggestions" for his medical followers. These texts responded to the fact that – apart from *The Interpretation of Dreams* – there was no introduction to the technique of psychoanalysis.[21] They thus referred directly or indirectly to concrete practical problems that had appeared in the first treatments. In the long run, they provided the historical, technical, and theoretical underpinnings of the concrete form of the psychoanalytic setting which subsequently became canonized as the so-called "classical model." In closing I will outline the basic features of this configuration.

The spatially asymmetric positioning of doctor and patient that Freud adopted from the suggestion of therapists became a central part of the psychoanalytic setting. Adhering to "a certain ceremonial," "getting the patient to lie on a sofa" and moving

[21] Freud had originally planned to write a treatise on the psychoanalytic method (he worked on it between 1908 and 1910), but he soon abandoned the project and left this task to others (such as Pfister 1915).

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the doctor out of his sight (Freud 1913, 133) now obtained not only a historical legitimation. The technical legitimation of this measure resided in the fact that Freud tried "to prevent the transference from mingling with the patient's associations imperceptibly, to isolate the transference and to allow it to come forward in due course sharply defined as a resistance" (ibid., 134). If the doctor remained visible he would inevitably become an object of the patient's associations and would be limited in his position as an observer. His visibility would also distract the patient from the memory work with the unconscious objects that were supposed to be discovered in the course of analysis. In order to reveal these inner psychic objects of a patient's past, at the beginning of the treatment the entire object world visible to him in the consulting room (the objects, the paintings on the wall, the couch) were to be related to an entirely invisible "object of transference," as which the doctor sitting behind him functions: "everything connected with the present situation represents a transference to the doctor, which proves suitable to serve as a first transference" (ibid., 138). The psychoanalytic therapy thus had to begin with a fade-out of the object world that surrounded the patient in the consulting room. The statuettes, receptacles, and fragmentary objects did not assume a positive role in Freud's treatment (see fig. 5). They referred neither to the patient's concrete history nor were they used as materializations of unconscious objects as in the Parisian hypnosis experiment (see Mayer 2001b; 2002, 89–112).[22]

For the doctor to function as an object of transference, he must not only remain invisible to the patient, he must also reject any desires and questions expressed by the patient during the treatment. Positioning the patient on the couch, which most patients protest against, is already seen as being the first refusal of a wish, namely the wish for a "cozy" social interaction between therapist and patient. Freud assumed that the specific arrangement of the cure automatically resulted in the patient developing a "transference love" for the doctor treating him. The patient comes with an emotional readiness which Freud saw as corresponding to the "suggestibility" of the hypnotic subject. The primary goal of therapy was therefore

> to attach him [the patient] to it and to the person of the doctor. To ensure this, nothing need be done but to give him time. If one exhibits a serious interest in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment and link the doctor up with one of the imagos of the people by whom he was accustomed to be treated with affection. (Freud 1913, 139–140)

This way Freud translated the experiences he had gained from hypnotism into a rule of treatment which required an attititude of "abstinence" from both actors. This demand not only referred to the satisfaction of sexual wishes on the part of the patient but

[22] They were certainly suggestive in yet another sense, evoking Freud's erudition and his fascination for Antiquity (see Forrester 1997a).

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to the consistent deprival of all activities that were used by the suggestion therapists to make the treatment as "pleasant" and "reassuring" for the patient. According to Freud the psychoanalytic therapist was to take the surgeon as a model "who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible" (Freud 1912, 115). In Freud's manipulation of the setting, both the material components of the setting and the social relation of doctor and patient are constantly kept separate from the realization of the analysis which – similar to the "self-analyses" conducted in written form – are presented as a *virtual* exchange of messages. Accordingly Freud no longer describes his treatment as an interaction between two persons but as the bodiless communication between conscious and unconscious parts in the psychoanalyst and in his patient, analogous to the transmission of sound waves (ibid., 115–116).

This conception of psychoanalytic practice was not only to be realized by the asymmetric distribution of visibility and the fading out of the object world but also through a practical measure that put the doctor into the role of the listener during the psychoanalytic session. This measure consisted in the therapist refraining from using any instrument to record or note something during the hour of treatment. At the beginning of his clinical account of a "Case of obsessive-compulsive neurosis" (of the so-called Rat man) Freud warned against "the practice of noting down what the patient says during the actual time of treatment. The consequent withdrawal of the physician's attention does the patient more harm than can be made up for by any increase in accuracy that may be achieved in the reproduction of his case history" (Freud 1909, 159). Accordingly he criticized the practice of combining the association test with the psychoanalytic technique of free association and noting in shorthand all reactions of their patients. Instead, Freud recommended writing down from memory the ideas and stories related by the patient in the evening of the same day of treatment. In order to be able to perform such a feat of memory, the analyst was to put himself in the same uncritical state of "evenly suspended attention" which was demanded from the patient in his self-observation.

Removing recording and writing instruments from the scene of treatment and putting them in the background shifted the balance of power between doctor and patient. The reaction words noted down in the association experiment enabled Swiss psychoanalysts to make them visible and break the patient's resistance by means of this evidence to get him to confess. A disadvantage of these writing techniques was, however, to be found in the fact that the complete documentation of all the analysand's utterances and reactions also gave him the possibility of leading the analyst astray. In connection with this idea of refraining from writing during treatment Freud also advised against adopting the practice of Stekel and other psychoanalysts who asked their own patients to write down their dreams. Fixing a dream in writing did not make a path for analysis, but proved to be either an expression of resistance against the treatment or a form of transference (Marinelli and Mayer [2002] 2003, 63–64). Although Freudian dream analysis was born out of writing, material

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recording devices were now banned both from the consulting room and the patient's night-desk.

Ultimately, the conception of the setting as laid down by 1914 required an operation of translating every single component into the technical terms chosen by Freud. Thus, the psychoanalyst would not treat an "ordinary," but a "transference-neurosis . . . , an artificial illness which is at every point accessible to our intervention" (Freud 1915, 154–155). Even if Freud still followed the ideal of a laboratory-like setting that had once led Charcot and his school to mobilize an impressive array of machinery and apparatus, the actual practice proceeded in a very different direction, moving psychoanalysis to the performance of an art of memory *in situ* and the retrospective writing of case notes. One of the crucial specificities of the psychoanalytic setting was the exclusion of a third-party witness as a possible control instance and as a tribute to the public character of science. However, this closure of the setting did not settle the numerous trials and debates surrounding psychoanalysis, but rather fostered new ones. With the institutionalization of psychoanalysis by Freud's followers, the closed setting of the consulting room became a central place for the production of psychoanalytic knowledge. The early practice of "self-analysis" which called for the analysand to reconstruct in writing the experiences made by Freud had given way after 1914 to a new configuration in which the path to the unconscious had to be found by lying on the couch.

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