Freud Teaches Psychotherapy

Identity of the Psychotherapist

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By 1913 Freud was considering the question of nonmedical psychotherapists. Although the bulk of his argument in favor of the subject was presented twenty years later in *The Question of Lay Analysis* (Freud 1926E; 20:179ff), his brief introduction to Pfister's book on psychoanalytic method already contains a memorable quote (Freud 1913B;12:331) on the subject:

> The practice of psychoanalysis calls much less for medical training than for psychological instruction and a free human outlook. …The educator and the pastoral worker are bound by the standards of their profession to exercise the same consideration, care, and restraint as are usually practiced by the doctor, and apart from this their association with young people perhaps makes them better fitted to understand these young people's mental life. But in both cases the only guarantee of the harmless application of the analytic procedure must depend on the personality of the analyst.

In *An Autobiographical Study* (1925D;20:8) Freud points out, "Neither at that time, nor indeed in my later life, did I feel any particular predilection for the career of a doctor. I was moved, rather, by a sort of curiosity, which was, however, directed more towards

human concerns than towards natural objects; nor had I grasped the importance of observation as one of the best means of gratifying it." On the other hand, he warns us that anyone who wants to make a living from the treatment of nervous patients must clearly be able to do something to help them. And he reminds us that the "art of interpretation" requires tact and practice. Freud makes much of his insistence that psychoanalysis should be treated like any other science and he objects to philosophy proper, which he claims to have carefully avoided. He wants psychoanalysis to be "serious scientific work carried on at a high level."

Freud complained because *The Question of Lay Analysis* (1926E; 20:179ff) was published in America in the same volume as his autobiography; because of that the autobiography was eclipsed since the entire volume received the title *The Question of Lay Analysis.* Actually the two works do belong very much together, especially since Freud's remarks in the autobiography about not really wanting to be a doctor are expanded in the postscript to *The Question of Lay Analysis.* Here Freud remarks that the triumph of his life lies in having "after a long and roundabout journey" found his way back to the earliest path which was "an overpowering need to understand something of the

riddles of the world in which we live and perhaps even to contribute something to their solution."

Freud states unequivocally that medical training produces a one-sided attitude which must be actually overcome by the person's wishes to become a psychotherapist in order to help the medical psychotherapist "resist the temptation to flirt with endocrinology and the autonomic nervous system, when what is needed is an apprehension of psychological facts with the help of a framework of psychological concepts" (1926E;20:257).

In his book on lay analysis, one of his most eloquent efforts, he argues strongly against the notion that a psychoanalyst must be first a physician, thereby taking a firm position on one of the thorniest and most controversial issues facing the field of psychotherapy at least in the United States. Because of the U.S. courts, this seems now to be resolved and psychiatrists have retreated to doing “prescribing and med checks” that psychologists are also recently clamoring to be allowed to do. The book also contains a remarkable literary conception, consisting of a dialogue between Freud and a so-called Impartial Person, in which, in his lightest style, Freud introduces the

impartial person to the practice of psychoanalysis in a nontechnical way, for the purpose of demonstrating that medical training is really unnecessary.

The aim of psychoanalytic psychotherapy is beautifully expressed:

> By encouraging the patient to disregard his resistances to telling us these things, we are educating his ego to overcome its inclination towards attempts at flight and to tolerate an approach to what is repressed. In the end, if the situation of repression can be successfully reproduced in his memory, his compliance will be brilliantly rewarded. The whole difference between his age then and now works in his favour; and the thing from which his childish ego fled in terror will often seem to his adult and strengthened ego no more than child's play (1926E;20:205).

What are the issues involved in the question of lay analysis? I believe the problem is actually more difficult today because of the advent of psychopharmacology than it was in Freud's time. First of all, Freud agrees that the initial work of evaluation should include a thorough investigation by a physician who should be a psychiatrist, as the dangers of overlooking any organic condition which is being expressed by mental symptoms are obvious. Furthermore, the

psychiatrist must be available for medical consultation whenever any organic symptoms appear in the treatment. It seems impossible to quarrel with this—yet lay analysts practicing today generally do *not* make it a rule to have a psychiatrist involved in their initial work-up of a patient. I have never been able to find any kind of reasonable argument that would excuse exposing patients to such a risk.

This subject brings up the entire issue of moral responsibility. Freud emphasizes that the complete honesty demanded from the patient puts a "grave moral responsibility" on the therapist as well, but he argues that the ethics of other professions such as psychology, ministry, and social work all stress the same moral responsibility to patients or clients as do medical ethics. In this day and age of malpractice suits one would be hard put to argue that the professional ethics of the physician are above or more stringent than those of psychologists or ministers or social workers; and clearly, the issue of moral responsibility rests on the personal treatment of the psychotherapist. That is to say, the best protection of the patient against being exploited by the therapist is the thorough, intensive psychotherapy of the therapist. Personal integrity is not simply developed by professional training, but is rather a function of

emotional maturity. As Saul (1958) puts it, "The child lives on in the analyst as in every one else; only one expects the child to be a little less fractious, unruly and disruptive in those whose profession it is to help others in life's journey."

Thus the crucial issue in determining whether a layman (nonphysician) should practice psychotherapy, in my opinion, rests on the adequacy of the intensive psychotherapy or psychoanalysis of the layman. As Freud points out, "The work is hard, the responsibility great." The second cornerstone of qualification to practice intensive psychotherapy is the training that the therapist has received. Freud writes, "anyone who has passed through such a course of instruction, who has been analysed himself, who has mastered what can be taught today of the psychology of the unconscious, who is at home in the science of sexual life, who has learnt the delicate technique of psychoanalysis, the art of interpretation, of fighting resistances and of handling the transference—anyone who has accomplished all this *is no longer a layman in the field of psychoanalysis*" (1926E,-20:228). Conversely, no one should practice intensive psychotherapy, whether or not they are physicians, who have not received a long, arduous training. I have outlined in detail the kind of training I think necessary

for the practice of intensive psychotherapy in another book (Chessick 1971).

As Freud explains, the power of professional feeling makes it very difficult for physicians to accept lay analysts. This feeling involves the physician's wish to remain alive to the medical profession, with the identity that the physician has carefully developed in his medical training, in addition to what then was the well-earned competitive advantage. The lay therapists who are enemies of the medical profession stress the economics of this situation, but those who are physicians realize there is an extremely important identity problem involved here. This identity problem today pervades the entire field of psychiatry as well as psychotherapy.

The resident in psychiatry suffers acutely from his sense of isolation from other medical colleagues and is the continual butt of jokes and ostracism from residents in all other fields of medicine. This is true, even with the advent of psychopharmacology, because physicians in all other fields simply do not wish to deal with mental disorders. Even within the psychiatric profession itself a sharp dichotomy exists between those few psychiatrists who wish to take a

primarily psychological approach to mental disorders and those psychiatrists who wish to approach mental disorders within an increasingly biological orientation—the very orientation that Freud warned must be corrected after medical training if one is to become an intensive psychotherapist. This leaves the psychotherapist ostracized by the rest of the medical profession and under continual attack from the members of the psychiatric profession who disagree with his approach; those who are certified psychoanalysts have the security of the psychoanalytic associations to help them with their identity problem, but those who are not are forced to go it alone.

The hard truth must be faced that *a different curriculum* is necessary for those who will work primarily with mental phenomena utilizing the method of introspection and empathy, as I have described it in my book on the training of psychiatrists who wish to be psychotherapists (Chessick 1971). As Freud puts it, "The experience of an analyst lies in another world, with other phenomena and other laws" (p. 247). Thus the great mass of what is taught in medical schools is of no use to the psychotherapist for his purposes and is, according to Freud, the hard way of preparing to be a psychoanalyst.

I think this is not so true for the intensive psychotherapist, especially because of the current advent of psychopharmacology and its common use as an adjunct in psychotherapy. In a substantial number of intensive psychotherapy cases, psychopharmacological agents are employed from time to time; if they are not used in the proper fashion the patients are either deprived of something they ought to have or are endangered needlessly. Those lay therapists I know and admire have familiarized themselves with the indications for these medications and have developed a close working relationship with psychiatrists to help them when such indications arise; but here again we have nothing but the personal integrity of the lay therapist to depend on in his frequent search for psychiatric consultation.

The lay therapist remains in one sense a second-class psychotherapist, because he cannot judge the use of psychopharmacological agents and is not aware of the possible manifestations of neurologic and other organic disorders that may present themselves in the mental sphere. On the other hand, many cases can be adequately treated by the lay psychotherapist, the most obvious of which are cases needing brief therapy or crisis intervention.

Furthermore, there is no reason to believe that a well-trained and properly treated lay therapist could not do long-term intensive psychotherapy, provided he or she developed the proper consulting relationship with a psychiatrist and providing the cases are properly chosen. The importance of continuing to train psychiatrists who are also experts in long-term intensive psychotherapy should be evident from this discussion, since not only do they have the basic responsibility to treat patients of a most difficult kind, but also they are necessary to guide and supervise well-qualified lay therapists and to participate in their proper training. The attempt of the fanatical fringe of American psychiatrists to remove all cases requiring long-term intensive psychotherapy from the responsibility of the psychiatrist and to dump all psychotherapy into the lap of lay therapists, can only be described as a potential disaster for the patients and an inexcusable flight from responsibility to society. To redefine mental illness in order to avoid this responsibility is not honest.

Because of the poor training and the even worse personal psychotherapy that goes on in the career of the professional of many disciplines, a problem remains which ought to be resolved with amity

instead of quarrels filled with professional jealousy as well as economic competition. The result of this unfortunate current situation is that psychiatrists—especially psychiatrists who are intensive psychotherapists—are not making the contribution to the training and supervision of lay therapists which would be in the best interest of the patients. The disciplines quarrel and compete rather than cooperate, and the patient is the loser.

Although Freud's teaching on this subject is just as pertinent today as it was when he wrote *The Question of Lay Analysis* in 1926, it still remains largely ignored. The psychiatrists, because of their intradisciplinary identity problems, ignore the fact that lay therapists are here to stay and therefore it would obviously be most sensible to cooperate and offer them opportunities for training, as Freud points out. The lay therapists, on the other hand, due to narcissistic problems refuse in any sense to be considered second class and therefore avoid psychiatric supervision and consultation—thus endangering their patients. In this age of psychopharmacology and highly complex medical diagnostic techniques, the lay therapist can no longer justify the practice of intensive psychotherapy without a close relationship to a consulting psychiatrist. The psychiatrists can neither justify nor

ignore their obligation to the training and supervision of desperately needed lay therapists. The reader will note, therefore, that I am taking a position akin to that of Jones (1957), which is essentially a middle position with a condemnation of fanatics on both sides: "a plague on both your houses." In no way, however, does this affect my unalterable opposition to *all* forms of so-called "touchy-feely" or "primary process" psychotherapy regardless of by whom it is performed and for what excuses; this was certainly also Freud's point of view!

The last item in the first volume of the *Standard Edition* represents Freud's final and unsuccessful effort to remain in the realm of organic neurology and medicine. He calls it "Psychology for Neurologists" or *Project for a Scientific Psychology* (1950A;1:283ff); it represents a brilliant failure of great historical interest and is coming under considerable scholarly study. He dashed it off in two or three weeks, left it unfinished, and criticized it severely at the time of writing. Even more interesting, later in life he seems to have forgotten it, and when in his old age he was presented with it he did his best to have it destroyed.

Although the ideas expressed in *Project for a Scientific Psychology*

re-emerged strongly in many of his later metapsychological theories, what is significant for us here is how these ideas represent his final attempt to maintain psychodynamics (or as he called it, depth-psychology) as a neurological science and his realization that this was impossible. This brings us, as it did Freud, to the painfully hard and frank realization that the practitioner of intensive psychotherapy cannot consider himself or herself as engaged in the practice of general medicine in the commonly used sense of this term. He or she is not applying the results of basic laboratory research to the amelioration of organic disturbances in the human body, and there is an unbridgeable gap between the work they do and the usual approach in the medical specialties. The basic science of intensive psychotherapy resides in the discoveries from the clinical practice of psychoanalysis (such as that of the phenomena of transference). The application of these discoveries to the treatment of many disorders by intensive psychotherapy is the essence of our task. Therefore, there is no general acceptance of intensive psychotherapy as a specialty of medical practice even among some psychiatrists.

The intensive psychotherapist, like Freud, will have to endure a certain isolation from the mainstream of medical practice no matter

how hard he or she tries to integrate his or her work with other physicians. This isolation means that nonphysicians will feel justified in engaging in the practice of intensive psychotherapy, and indeed many of them have the potential or the capacity to do excellent work. This leads to blurring the boundaries in the public mind between the "doctor" who is a Ph.D. and the "doctor" who is an M.D. when both are engaged in the practice of psychotherapy. And now we have the “PsyD”.

Since the basic science on which intensive psychotherapy rests does not have the customary firm laboratory foundation that one finds in the sciences behind other specialties in medical practice, it is comparatively easy for emotionally disturbed psychotherapists to rationalize their exploitation of patients and their hostile retaliation and other acting out of every sort of unethical behavior. The only protection we can afford to the patient in this situation is careful training and personal psychotherapy of the psychotherapist as well as the establishment of basic guidelines and principles for the technique and practice of psychotherapy (see Chessick 1969, 1971, 1974).

The most serious problem in this area occurs for the

psychotherapist who is a physician. Even in training one soon comes to learn that specialists in other medical fields do not consider one a legitimate "doctor," and hence experiences the derision and isolation this entails. This represents an assault on one's identity as well as a chronic wounding on top of the inevitable narcissistic wounding involved in making mistakes as one learns any discipline (Chessick 1971a). The way in which the intensive psychotherapist resolves these problems has a *profound effect* on the kind of psychotherapist and psychiatrist he becomes.

For example, Dr. A was an eminent and brilliant biological psychiatrist, always at the forefront of the attacks on intensive psychotherapy and psychodynamics. He lectured repeatedly during a long and prominent professional life, urging the formal separation of all intensive psychotherapy from the discipline of psychiatry and the limitation of psychiatric treatment to those disorders which respond in a brief period to pharmacologic and other techniques. Investigation of his past revealed that as a young physician he wished to specialize in psychiatry but because of financial difficulty had to accept a high-paying residency in a large state hospital system. At that time, all residents were poor and were expected to be so, but some large

county and state institutions paid a somewhat better stipend. Dr. A explained that soon after he had begun his residency, he received a few lectures on schizophrenia, was given the keys to a ward of seventy-five to one hundred patients, and was then ordered to assume the total responsibility for their care. As the only physician on the ward, in the days before the antipsychotic drugs, he literally was placed in a situation of bedlam, assisted only by a few untrained male attendants recruited from nearby farms.

The anxieties in the situation were overwhelming and Dr. A suffered an emotional breakdown. He went to a nearby city and consulted a poorly trained psychoanalyst who immediately placed him on the couch and advised him to free-associate—I remind you that this was many years ago. Needless to say Dr. A's anxiety worsened and in a few weeks he became transiently psychotic so that his treatment had to stop. He reintegrated spontaneously, left the residency, and resumed the practice of general medicine in a large hospital where he began to treat emotional problems with "medicines." Although he never became board-certified as a psychiatrist, he immersed himself in biological research work and remained an undying enemy of psychodynamics and psychoanalysis. The return to general practice

brought him considerable support from his medical colleagues in the other specialties and enabled him to form a firm sense of identity which protected him throughout his life.

There is no better description of the anxieties encountered in facing the plethora of dramatic phenomena in mental disorders and attempting to apply the principles of psychodynamics, than in the first volume of the *Standard Edition.* The outcome in Freud's case was very successful, but he was a genius. The outcome in the case of lesser mortals can often be disastrous—personally and for the hostility and destructiveness toward our field that may result. This problem is unfortunately accentuated by the tendency of some psychoanalysts to sequester themselves in "institutes," and it is only recently that the introduction of psychoanalysts as teachers as well as courses in psychoanalysis have become a more common practice in some university programs. It remains to be seen whether it is not already too late.

Medical students must be educated so that *early-level training* produces a greater awareness of the vital importance of psychological factors both in the production and treatment of emotional disorders.

The urgency of this matter is not yet sufficiently appreciated; even the American Psychiatric Association is seriously splintered at the present time between those who see a complete return to the practice of general medicine as a solution to the identity crisis in psychiatry and those who have the conviction that intensive psychotherapy is a very important subspecialty in psychiatry.

Kris (1954), in his introduction to the first published edition of Freud's letters to Fliess, explains that "Freud's friendship with Fliess filled the gap left by his estrangement from Breuer and provided a substitute for a friendship and intellectual relationship that had ceased to be viable." Although Fliess was important to Freud in the development of his theories and his self-analysis, the transition from neurologist to psychologist actually occurred somewhat earlier, during what Jones calls the "Breuer period," from 1882 to 1894. Only after his self-analysis had taught him to realize the crucial significance of the past history of the individual, did Freud become aware that Fliess's attempt to explain neurotic conflict by a pseudobiological "periodicity" meant shackling the dynamic thinking of psychoanalysis. These pseudobiological explanations tend to recur over and over again in the recent history of psychiatry.

The final phase of Freud's transition from neurologist to psychologist is marked by his explaining neurotic phenomena on the basis of the individual's past history without reference to neuroanatomy or neurophysiology. The *Project for a Scientific Psychology*, written during his early studies of hysteria, marked Freud's last effort to synthesize psychology and the anatomy of the brain; "Not until after his self-analysis, when he was able completely to fuse the dynamic and genetic points of view, did Freud succeed in establishing the distance between the physiological and psychological approaches" (Kris 1954). It is this distancing upon which our entire conviction about psychodynamic psychiatry and intensive psychotherapy stands or falls.

Every student, especially if one is a physician, must undergo a similar kind of evolution in one’s training and thinking if one is to become an intensive psychotherapist. The resident faces a crucial triad of difficulties: (a) the development of his or her identity as a psychotherapist; (b) the anxiety attendant upon the development of psychological mindedness; and (c) the need to develop conviction about the meaningfulness of psychodynamics and long term psychotherapy. How the resident resolves these difficulties is crucial

to one's entire professional future. Not only is there a need for the beginning resident to move away from the physiological model but he or she *must* mourn systemized and controlling medical styles painstakingly developed over recent years. He or she *must* suffer tension and depression; and *must* struggle to comprehend the unknown inside himself or herself as well as that around one and in one's patients.

This identity problem is confounded by many factors. The training environment requires the resident to have capacities for empathic understanding and behavioral observation which he or she has not developed. Brody (1969) points out that developing the identity of "psychotherapist" threatens loss of the physician's professional mantle of social responsibility and authority. Like Freud, he also mentions the irrelevance for the psychiatrist of so much learned at arduous cost during medical school. Many authors have described the increasing sense of alienation the psychiatric resident feels from his or her fellow residents in other specialties as their development progresses.

The tremendous anxiety problem of the resident has been

mentioned in the literature, but it has not received the attention it deserves. D'Zmura (1964) has discussed the interference with learning that undue levels of anxiety in the student produces. This anxiety is often increased by the usual experience of the resident in the first year where he or she is assigned the most pathologic and the most difficult patients that psychiatry has to offer. Between the resident's lack of experience and the serious pathology of his or her case load, not very many of his patients in long-term intensive therapy are going to respond successfully.

Halleck (1962) mentions that it is rare for a resident to have more than one or two patients who have materially improved in long-term intensive treatment. In fact, many residency programs do not even offer the opportunity for long-term treatment in the training program. Semrad (1969), for example, delineates three phases in the psychotherapy of the psychotic person. These are restitution of ego function, resumption of ordinary life, and finally "analysis of the vulnerable ego." It is obvious that the resident rarely has much experience with the third phase, which involves several years of therapeutic work. Therefore, the resident is in the embarrassing position of having to take the conviction of the supervisor on faith—a

faith which is threatened by the resident's repeated failures and distresses in his work with severely pathologic or chronic patients, efforts which are rarely buttressed by therapeutic success.

From the training point of view, Gaskill and Norton (1968) present an excellent summary of what is desired. Taking psychoanalytic theory as the basic form of reference, the dyadic therapeutic relationship is conceived of as the primary model of the clinical psychiatrist:

> Fundamental to this is an increasing awareness and understanding of the dynamic unconscious and intrapsychic conflict as it relates to the patient and the therapist. ... Knowledge of the intricacies and complexities of this relationship with all of its theoretical and therapeutic implications and unknowns is the unique tool of the psychiatrist of both today and the future (p. 9).

It is obvious that the crucial triad of anxiety-producing problems interferes with the attainment of these goals. Semrad (1969) summarizes these areas of interference as (a) personal emotional burdens, (b) ignorance and inexperience, (c) the need for omnipotence and omniscience, (d) distress with instincts, (e) countertransference, and (f) the relative lack of empathy.

If these areas of interference are not attended to with deliberate intent on the part of the training staff, three serious dangers are present. The most obvious of these will be the development of a psychiatrist who is mediocre or worse. A second is that the beginner will constrict himself or herself in a narcissistic, self-limiting fashion. Such an individual tends to go his own way and becomes at that point unteachable. In an unfortunately all too common defense, this person makes a closure in his or her points of view too early—a closure based not on training and experience but manifesting instead the rigid characteristics of a flight from anxiety.

Perhaps the most dangerous resolution, because it is so subtle and easy to rationalize, is what Ornstein (1968) described as "uncritical eclecticism." This can take many forms (for example, a premature immersion in community psychiatry, administrative work, or somatic therapies) and results in a psychiatrist who is a jack-of-all-trades, master of none, with a fuzzy identity, and who tends to resemble an "as-if" personality (Deutsch 1965). Everyone who has supervised residents has met these individuals, who represent, as Ornstein points out, a serious pedagogic failure. Thus, the shift toward eclecticism and the disappointment in psychodynamics and psy-

chotherapy are symptoms that the training program is defective.

Freud's greatest and most magnificent exposition of psychoanalysis is contained in his *Introductory Lectures on Psychoanalysis* (1916X;15-16). The first two parts of this work remain the best introduction to the concept of psychodynamics and the unconscious mind ever written, but in the Introduction Freud points out that there is only one practical method for learning psychoanalysis: "One learns psychoanalysis on oneself, by studying one's own personality... One advances much further if one is analyzed oneself by a practised analyst and experiences the effect of analysis on one's own self, making use of the opportunity of picking up the subtler technique of the process from one's analyst. This excellent method is, of course, applicable only to a single person and never to a whole lecture-room of students together" (1916X;15:19).

Of the several volumes of Freud's correspondence (Meng and E. Freud 1963; E. Freud 1960; Kris 1954; McGuire 1974), *The Freud-Jung Letters* (McGuire 1974) are the most painful and poignant to read. One is impressed with Freud's repeated efforts to be reasonable and to try to empathize with Jung's position. Jung's deep ambivalence runs

throughout the letters, combining a worship of Freud with an intense rivalry and admitted ambition. Freud's dedication to the psychoanalytic movement stands starkly against Jung's wish for public acclaim and money (both of which he later obtained). Freud's towering greatness and determination borders on the neurotic in his demand for rapid responses to his letters and his identification with Moses: "If I am Moses, then you are Joshua and will take possession of the promised land of psychiatry, which I shall only be able to glimpse from afar."

The prescience of Mrs. Jung about the coming break, and Freud's rejection of her warnings on this issue, contrasts with his warmth to her in her personal difficulties. It is interesting to follow the tedious cross-analysis of these pioneers, sitting on a ship headed for the United States, and analyzing each other's dreams and mistakes, and the irritations and narcissistic wounds this must have stored up in them. The Freud-Jung correspondence set precedence for the current acrimony and *ad hominem* arguments which still plague the whole field of psychiatry.

One cannot evade the issue however; Jung's change in libido

theory *had* to be rejected by Freud, because Jung watered down psychoanalysis to abstract meaninglessness and threw out the very essence of Freud's clinical discoveries. Jung still deserves today a psychoanalytically oriented expositor to cull out from his innumerable volumes what is clinically useful and what tends to degenerate into amateur metaphysics and abstract speculations. He really gave Freud no choice. Another issue that lurks in the background is Jung's anti-Semitism and wish for social "respectability"; his cooperation with the Nazis in later years is well known. Freud's determination to hold his beleaguered psychoanalytic movement together against all odds in spite of repeated defections is truly remarkable and a tribute to his energy and strength of character.

Three essays appearing together in volume 14 of the *Standard Edition* deal with the famous issue of Freud's alleged pessimism and are fascinating for the psychotherapist. The first two were written around March and April of 1915, some six months after the outbreak of World War I; the third, "On Transience" (1916A), was written in November of the same year. In the first two, published as "Thoughts for the Times on War and Death" (1915B), Freud outlined the terrible disillusionment of war. This disillusionment is based on the obvious

retrogression from the level of ethics and civilization we had hoped to have reached permanently.

Freud philosophically reminds us that such disillusionment is not altogether justified, since we have never risen as high as we believed in the first place. He points out, "If we are to be judged by our unconscious wishful impulses, we ourselves are, like primeval man, a gang of murderers" (p. 297). He concludes rather sadly, in keeping with the times, "If you want to endure life, prepare yourself for death" (p. 300). A few months later after great inner perturbation, Freud shows, in the essay "On Transience," his understanding of the mourning process engendered by the destruction of civilization in the war, and he concludes optimistically, "When once the mourning is over, it will be found that our high opinion of the riches of civilization has lost nothing from our discovery of their fragility. We shall build up again all that war has destroyed, and perhaps on firmer ground and more lastingly than before" (p. 307). The basically optimistic and resilient strength of Freud's personality, a strength to be tested in his long and tortuous bout with cancer, already shows itself in this interesting series of essays. The short essay "On Transience" has an almost lyric beauty, and reminds one of Rachmaninoff's composing of

his famous second piano concerto, written on his recovery from melancholia.

One wonders if at the end of his life in *Moses and Monotheism* (1939A; 13:3ff), Freud was talking about himself when he discussed, in section II B (pp. 107-111), how a great man influences his fellow men. He stresses two ways in which this influence takes place: "By his personality and by the idea which he puts forward." He sees the decisiveness of thought, strength of will, and energy of action in a great man as part of the picture of a father. Above all stands the autonomy and the independence of the great man. Thus he is impressed with Pharaoh Akhenaten and reminds us that Breasted calls this Pharaoh "the first individual in human history." In chapter 19 of the present book, titled "Transcendence," I discuss in more detail Freud's feeling of identification with Moses, especially at the end of his life, as he was about to leave Vienna. This final identification, of course, has more to do with Freud's personal life and background than with any problems involved in the identity of the psychotherapist.

We turn now to a careful examination of Freud's thought, organized on the suggestion by Graves (1971): "an understanding of

the way in which a theory was actually conceived and developed is essential for an understanding of its content, rationale, function, and modus operandi, as well as the hopes which its users have of possible future accomplishments" (p. 40). Graves also reminds us "that the truly interesting scientific theories are not those whose principles are fixed, static, and codified, but those which are constantly being modified and added to in an effort to achieve a more perfect correspondence with reality" (p. 35).

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