Freud Teaches Psychotherapy

Curative Factors

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A remarkable disquisition on curative factors in psychotherapy is presented in "Some Character Types Met With in Psychoanalytic Work" (1916D;14:310ff). Freud points out that "under the doctor's guidance" the patient is asked to make the advance "from the pleasure principle to the reality principle by which the mature human being is distinguished from the child." This sounds remarkably like the description of psychotherapy as a learning process, presented in the various papers of Strupp (1969, 1972, 1973).

Like Strupp, Freud sees psychotherapy as an "educative process" in which the doctor "makes use of the influence which one human being exercises over another." Freud describes this as employing one of the components of love:

> In this work of after-education, he is probably doing no more than repeat the process which made education of any kind possible in the first instance. Side by side with the exigencies of life, love is the great educator; and it is by the love of those nearest him that the incomplete human being is induced to respect the decrees of necessity and to spare himself the punishment that follows any infringement of them (p. 312).

Running throughout Freud's writing is a certain ambiguity on the relative importance of the effect of interpretation of the transference in psychoanalytic cure and the effect of the physician's influence on the patient. For example, in a dramatic summary of the problem Friedman (1978) claims:

> At no time from his first psychoanalytic writings to his last did Freud ever lose sight of or minimize the importance of the affective relationship between patient and analyst. Throughout his work on the process of treatment a kind of running battle may be detected between the respective claims of understanding and attachment, although when one looks more closely one sees that it is not equal combat, but a struggle for survival on the part of understanding. To be sure, Freud was very much the champion of the voice of reason, but while he was cheering it on, he seemed to be advising his friends not to bet on it (p. 526).

The therapist is loved both in the transference and in the real relationship, on the basis of the therapist's physicianly vocation as it manifests itself to the patient over the months of long-term intensive psychotherapy. Concentration on the importance of this "love" as an influencing factor is what primarily seems to distinguish the so-called copper of suggestion from the "pure gold" of psychoanalysis, but Freud was not at all clear about such a distinction; his was a forceful

personality and he was a natural and intuitive educator and physician. The contention that in long-term intensive psychotherapy the combination of properly timed interpretations as well as the therapeutic alliance and the experience of the caring personality of the therapist all work together as curative factors is derived from the manifestations of this combination in the writing, clinical reports, and experiences as reported by others, of the therapeutic work of Sigmund Freud.

One of the thorniest contemporary issues is whether or not psychoanalytically informed psychotherapy should be considered primarily as a form of education for difficulties in living, or as a form of medical treatment for illness. This conflict is traceable to Freud's writing and reflects a conflict in Freud's personality. At one point, Freud writes, "You can, if you like, regard psychoanalytic treatment as no more than a prolongation of education for the purposes of overcoming the residues of childhood" (1910A;11:48). This "education" in Freud's view was seen as producing a replacement of repression—which he conceived of as a primitive defense—by conscious "*condemning judgment* carried out along the best lines" (ibid, p. 53). In addition he stressed the goal of the resumption of

arrested development to permit sublimation of the energy of infantile wishful impulses and an increase in the direct satisfaction of libidinal impulses with the consequence of a happier life. As T.S. Eliot put it in his poem *Little Gidding*:

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And know the place for the first time.

Yet, throughout innumerable passages in his writing, Freud speaks of psychoanalysis as a science, as a medical treatment analogous to surgery, and of the psychoanalyst as a doctor. He was steeped in the traditions of the science of his time and pursued a scientific ideal of strict truth; on the other hand, as Robert (1966) explains, "He felt a need to express himself esthetically, to give free reign to the imagination which his background, training and probably powerful inner inhibitions had led him to repress very early in his life." The mixture of the scientist and the artist in Freud is reflected by the two strains of pervasive, unresolved tension in his writings involving antithetical images of man—emphasized by Holt (1973) and reviewed in the introduction to the present book.

"Analysis Terminable and Interminable" (1937C;23:211ff) was written in 1937 when Freud was 81 and is called by Jones "for the practicing psychoanalyst possibly the most valuable contribution Freud ever wrote." It is also probably his most pessimistic work as far as the hoped-for therapeutic outcome from psychoanalysis or psychodynamic psychotherapy is concerned. This pessimism seems based primarily on a view of the potential for alterations of the ego expressed in this paper, a view somewhat different than that expressed in his other work. We may say that this is Freud's major paper on failures in psychotherapy [a topic to which I have devoted a book (1971)]. The alteration of the ego in intensive psychotherapy is viewed in Freud's paper as not having a prophylactic power over the future occurrence of both fresh and different neuroses, or even the power to prevent a return of the neuroses that already have been treated. In therapy, Freud views the ego as being helped to cope with the conflict that brings the patient to treatment, but this treatment does not assist the capacity of the ego to deal with another conflict that may arise later. In my clinical experience this is simply not true. All other views regard the ego alteration through intensive psychotherapy in a more general sense, as making it more capable of dealing with

various problems as they arise later in life. About a year later, in *An Outline of Psychoanalysis* (1940A;23: see p. 179) Freud himself reverts back to regarding the alteration of the ego as advantageous in a more general sense, as holding good in life.

In "Analysis Terminable and Interminable" Freud also appears rather pessimistic about the personality of psychoanalysts who "have not invariably come up to the standard of psychical normality to which they wish to educate their patients" (p. 247). He explains, "It is therefore reasonable to expect of an analyst, as part of his qualifications, a considerable degree of mental normality and correctness. In addition, he must possess some kind of superiority, so that in certain analytic situations he can act as a model for his patient and in others as a teacher. And finally, we must not forget that the analytic relationship is based on a love of truth—that is, on a recognition of reality—and that it precludes any kind of sham or deceit" (p. 248). He states that a careful analysis of the therapist is required for such a standard, and warns us that the therapist's constant preoccupation with all the repressed material in his or her patients may stir up instinctual demands which he or she would otherwise be able to keep under control. Therefore, he recommends

that "Every analyst should periodically—at intervals of five years or so—submit himself to analysis once more, without feeling ashamed of taking this step" (p. 249). This course of action makes the therapeutic analysis of patients and also the analysis of analysts an interminable task—and as far as I know, this excellent recommendation is not generally followed, most likely because it is unrealistic. I have not been able to find, in the vast literature on Freud, a satisfactory explanation of his unusual pessimism in this particular paper.

For our contemporary purposes, the most important issue of this extremely important publication is its discussion of why psychotherapy fails. First of all, we know that if the strength of the ego diminishes, whether through illness or exhaustion, or if the strength of the drives become altered or reinforced such as in puberty or the menopause, we are not surprised if previously defective repressions fail and symptoms have to form. We hope that psychotherapy enables the ego, which has attained greater maturity and strength, to demolish unnecessary repressions and construct more solid repressions in other areas, as well as encouraging sublimation. We agree, of course, that under conditions of a subsequently weakened ego for example, due traumatic events or physical illness, or increased strength of the

drives during the developmental process this arrangement may not always hold, but we think that its chances of holding are best if the patient's ego has been strengthened through psychoanalytically informed psychotherapy.

It is important to understand, as Freud points out, that the difference between a person who has not had therapy and the behavior of a person after intensive psychotherapy “is not so thorough-going as we aim at making it and as we expect and maintain it to be" (p. 228). Certainly a more modest expectation for the results of psychotherapy would be useful; in my work I am more interested in the difference between the internal suffering that the patient has endured before therapy, and afterwards, as well as in removing the external suffering that the patient brings on himself or herself and loved ones by neurotic behavior. It is in these differences that the crucial value of intensive psychotherapy lies, and upon which the entire procedure must be judged. The objectives of intensive psychotherapy, in contrast to those of formal psychoanalysis, are a bit less extreme. We are not hoping for total rearrangement at all and we can rest content with Freud's statement that when we endeavor to replace repressions that are insecure by reliable ego-syntonic controls,

we achieve only a partial transformation, and portions of both mechanisms remain untouched. Freud's point is that this holds true for psychoanalysis as well.

The factors determining the outcome of the treatment enumerated by Freud have decisive value: the relative strength of the drives which have to be controlled, and the already present pathological alteration of the ego. The latter factor requires the most discussion since there are a great variety of kinds and degrees, either congenital or acquired, of alteration of the ego. When acquired, it is in the first few years of life during which the ego may be pathologically altered, for example, by being forced into the inappropriate use of the mechanisms of defense. Thus the mechanisms of defense may become dangerous themselves since the ego may have to pay too high a price for the services they render, in terms of restrictions of energy as well as when these mechanisms become regular modes of reaction, repeated throughout life, of the patient’s character and as such now become maladaptive.

Freud tells us, “This turns them into infantilisms, and they share the fate of so many institutions which attempt to keep themselves in

existence after the time of their usefulness has passed" (pp.237-8). Thus the adult's ego continues to defend itself against dangerous but no-longer-existing reality—and indeed the ego finds itself compelled to seek out those situations in reality which can serve as an approximate substitute for the original danger, thus justifying habitual modes of reaction. The patient makes a selection from the possible mechanism of defense, choosing a few of them and usually the same ones, and seeks situations in adult life to justify their continued use. This is an alteration of the ego. The strength and depth of the root of these alterations is an important limiting factor in psychotherapeutic success or failure.

Describing patients who suffer from a special adhesiveness of the libido or psychic inertia, or from what Freud also calls a depletion of plasticity sometimes attributed to old age (where we struggle with force of habit and/or exhaustion of receptivity), Freud is introducing a limiting factor in the therapeutic procedure. But this is a dangerous concept because it leads to an obvious circularity and the whole notion of "adhesiveness of the libido" is probably best replaced by the conception on a different channel of understanding (Chessick 1992, 2000, 2007) of the difficulties involved in the giving up or at least

attenuation of malevolent internalized objects. In my clinical experience, the earlier these malevolent internalized objects are formed, the more the patient desperately clings to them, a kind of paradoxical situation. The reason for it is that a bad object is still felt by the patient to be better than no object at all. In those patients with no object at all there is often a schizophrenic collapse or at least what Kohut (1971) would call a fragmentation of self, which is really a psychic catastrophe. This, not penis envy or castration anxiety, is more like what Freud called the "bedrock" (p. 252) beyond which we cannot proceed. It usually presents clinically as an all-pervasive fear of annihilation, world destruction, and/or deathly disease. One watches for manifestations of it often at first in the patient's dreams.

The patient also clings to the old object for its familiarity and out of force of habit rather than to consider substituting a new object for safety and control. Such a substitution involves an alteration of the ego and a change in defense mechanisms. It raises the fear of the inefficiency of the new solution and the danger of being overwhelmed and fragmented. Furthermore, as Cooper and Levit (1998) point out, the patient is aware that the "goodness" of the analyst as a new object is related to the analyst's functioning [including the analyst's fee], and

cannot be entirely believed. I would suggest that rather than attempt a substitution, which these authors correctly call "an outrageously ambitious goal" (p. 622), we consider the possibility that the therapist we hope as an introject functions to neutralize the malevolent object as much as possible. So, for example, when confronted with the temptation to utilize various neurotic symptoms or patterns, the patient hears the internalized voice of the therapist; or remembers sessions in which insight into the ego weakness has offered the chance to find alternative solutions; or, if there is much anxiety, the patient imagines being "held" by the therapist in one way or another and gains a soothing effect. Also, there is an identification within the patient's ego with the function of the therapist, at which point the analytic process may continue even after termination. In this situation, the pathology does not go away; it is not "cured" but it is much attenuated and enables the patient to function much better. Yet, as Freud pointed out, under severe stress it can return.

The bedrock question is why the patient clings to such self destructive and self defeating internal objects, labeled by Fairbairn as "the internal saboteur." Newman (1992) explains that we must learn by trial and error what helps to create a new object for the patient;

much creativity is required to provide mutative new object experiences. In my opinion, here is where the personal analysis as well as the sheer psychological talent of the therapist is put to the crucial test. On the other hand, Newman also points out that certain patients need us *not* to be a significant object -- it is too threatening to their precarious psychic balance. Elsewhere I (2000, Ch.13) offer a clinical example of this situation.

Bernstein (1987) maintains that although we have acquired a deeper knowledge of the alterations of the ego 50 years after the publication of Freud's paper, "This approach does not seem to offer any prospects of shortening the duration of psychoanalytical therapy. A long and arduous process is inevitable before the ego will tolerate contact with the mental contents and primitive emotions of the id. Time has its measure and penetration to the deep layers of primitive mental functioning involves a different kind of time" (p. 26). Blum (1987) adds that, "the realistic appraisal of the limits of analysis would be swept aside in the later idealization of analysis and its popular appeal in the 1950's" (p. 37), but just because psychoanalysis was oversold in the 1950s does not mean that psychoanalysis and psychodynamic psychotherapy is not an effective procedure in the

21st century; one must be careful not to throw out the baby with the bath water. Lowenberg (1988) asks,

> What does Freud's essay on the impossibility of the psychoanalytic profession, the limits of therapeutic aspiration, and the interminability of psychoanalysis have to say to us after fifty years? A great deal, in fact almost everything Freud wrote in 1937 repays careful attention and offers us intellectual and emotional nourishment today. The conservative de-idealization of the clinical efficacy of psychoanalysis, which we usually date from the nineteen sixties and seventies as a reaction to the over-enthusiasm of the forties and fifties, in fact began with Freud's cautious and skeptical paper of 1937. (p. 280)

Clearly, in states of acute crisis, analysis or uncovering psychotherapy (as Freud points out) is to all intents and purposes unusable since the ego's entire interest is taken up by the painful reality. But Freud also introduces a concept that I regard as dangerous, which he calls "adhesiveness of the libido"—a concept originally brought forward in the *Introductory Lectures on Psychoanalysis* (Freud 1916X;16:348) and which is not always differentiated from a general concept of "psychical inertia" discussed in "Analysis Terminable and Interminable." At any rate, the term refers to the need for detachment of libidinal cathexes from one object and the displacement to another.

As Freud puts it, certain people are very slow in making up their mind to make this detachment, "although we can discover no special reason for this cathectic loyalty" (1937C;23:241). There is also the opposite type in whom the libido seems particularly mobile—in these latter cases the results of treatment are very impermanent since the new cathexes achieved by the treatment are soon given up once more.

In describing patients who suffer from a special adhesiveness of the libido or psychic inertia or from what Freud also calls a depletion of plasticity—sometimes attributed to old age where we deal with force of habit or exhaustion of receptivity—he is clearly introducing a limiting factor in therapeutic procedure. The reason I regard this concept as dangerous is that it is so difficult to demonstrate that a failure of the psychotherapy is due to such factors; thus an appeal to these factors can be used to excuse a poorly conducted psychotherapy or a therapist suffering from countertransference, which may result in no progress in the treatment.

On the other hand, there is no question that a certain percentage of patients literally do seem to suffer from what Freud has defined as adhesiveness of the libido, or, in other cases, a lack of receptivity and a

certain rigidity. As soon as possible in beginning the treatment, it is important to try to identify such patients on the basis of their past history, age, and behavior in the treatment situation. With such patients, a well-conducted psychotherapy is a very long procedure, but when properly conducted small signs of progress should continually appear. Where progress is slow, the therapist's duty is to deal with the narcissistic countertransference problem that must inevitably arise in such treatments.

During his summer holiday in 1906, Freud composed a little book of a hundred pages, apparently to please his friend Jung. It represents Freud's literary abilities at their best and deals with a novel by Wilhelm Jensen entitled *Gradiva.* The bas-relief with which the hero of the story falls in love may be seen in the Vatican Museum. Jones (1955) reports that after Freud published this book "it became fashionable among analysts to have a copy of the relief on their walls. Freud had one himself in his consulting room." (A photograph of the relief is found in the frontispiece to volume 9 of the *Standard Edition*.)

Freud's monograph *Delusions and Dreams in Jensen's "Gradiva"* (1907A;9:3ff) is a charming introduction to Freud's explanation of

dreams, neuroses, and of the therapeutic actions of psychoanalysis; it is useful from college seminars all the way to psychiatry residency and other training programs. It represents Freud's first complete published analysis of a work of literature, thus beginning a new genre in literary criticism, one that has become quite popular—and much abused.

The book begins with a discussion of the question of dreaming as purely a physiological process in which dreams are comparable to twitching of the mind under the excitations which remain active in it as offshoots of waking life. This comparison immediately introduces the issue of modern physiological research on sleep and dreaming and the question of how such research fits Freud's theories of the dream (see also chapter 13). There seems to be considerable confusion on this matter; the best beginning review is Freedman et al. (1976). In the 1950s Aserinsky, Dement, Kleitman, and other researchers studied the rapid eye movement (REM) readily measurable beneath the closed lids of the sleeper in certain stages of sleep, a movement different than non-rapid eye movement (NREM) of other stages of sleep. In a young adult a typical night of sleep begins with NREM; about 70 to 100 minutes after sleep onset the period of REM sleep begins. A cycling

occurs from the onset of REM sleep, constituting about twenty percent of the total sleep time, with each cycle lasting about 90 minutes, although during the last part of the night the REM periods lengthen.

Vivid dreams are recalled 74 percent of the time when subjects are awakened from REM sleep, but only 7 percent of the time from NREM awakenings, so that REM dreams closely resemble what persons ordinarily regard as a dream characterized by detail—vivid and visual dream recall. The inability to recall dreams may have a physiological as well as a psychological basis. The state in which dreams can occur, REM sleep, is a universal and regularly occurring process, and the cyclical patterns of REM sleep represent a basic biological process on which the psychological process of dreaming is superimposed.

Freedman et al. (1976) explain that in REM sleep, motor expression of the dream content is definitely inhibited but not completely absent, thus supporting Freud's conclusion that during dreaming a motor paralysis permits the safe expression of generally unacceptable, unconscious impulses. In addition, the visual system is activated during REM sleep. This activation lends neurophysiological

support to Freud's theory that during dreaming a regression from motor discharge to hallucinatory perception takes place. So the data from sleep and dream research seem to support Freud's theories. The mind makes use of these biological cycles to allow sleep to continue by the production of dreams during REM sleep. A complete discussion of the psychoanalytic implications of recent research in sleep and dreaming may be found in Fisher (1965).

Another important question raised by Freud's monograph on Jensen's *Gradiva* is whether a fantasy of this nature can be made the object of a psychodynamic study. We know that Freud did this in a number of different ways, as in his work on the diary of Schreber (see chapter 8). Even though Freud recognized how easy it is to draw analogies and to read meanings into things, he insisted that the author of *Gradiva* "has presented us with a perfectly correct psychiatric study, on which we may measure our understanding of the workings of the mind—a case history and the history of a cure which might have been designed to emphasize certain fundamental theories of medical psychology" (p. 43). He argues that this feat is possible even though the author had no knowledge of psychoanalysis and the theories on which it is based.

A literary author proceeds differently from the psychoanalyst in that he or she directs attention to the unconscious in his or her own mind and listens to possible developments and lends them artistic expression. "Thus he experiences from himself what we learn from others—the laws which the activities of this unconscious must obey" (p. 92). This is true even though Freud admits in this work how easily our intellect is prepared to accept something absurd provided it satisfies intense emotional impulses.

Freud is such a powerful writer that it is difficult to resist his analysis of Jensen's *Gradiva* despite the fact that the analysis contains an obsolete theory of anxiety (p. 61). The monograph on *Gradiva* is especially useful because of Freud's emphasis on his sometimes overlooked conviction that the process of cure in analytic psychotherapy rests primarily on "the reawakened passion, whether it is love or hate" which "invariably chooses as its object the figure of the doctor" (p. 90). At the same time Freud cautions us that the case of *Gradiva* is ideal because Gradiva (Zoe) was able to return Harold's love but the doctor cannot: "The doctor has been a stranger and must endeavor to become a stranger once more after the cure; he is often at a loss what advice to give the patients he has cured as to how in real

life they can use their recovered capacity to love" (p. 40). This reminds us again of an obvious error which continues to be made in descriptions of intensive psychotherapy. The doctor is essentially a stranger, not a dear friend or a lover. The patient must be induced to look elsewhere for the gratification of his or her needs for friendship or love. Otherwise psychotherapy becomes prostitution in which the patient is simply paying for temporary love or friendship that he or she is unable to obtain elsewhere.

In his controversial essay on Leonardo da Vinci (1910C;11:59-138) Freud discusses the art-science conflict in terms which some authors have felt to be autobiographical. The first section of this essay is worth special study. Freud is clearly fascinated by Leonardo's double nature as an artist and as a scientific investigator; the resemblance between the two men is obvious. The essay contains a remark about Faust, emphasizing his fundamental attempt to transform his drive to investigate back into an enjoyment of life; the process seems to have been the reverse in the case of Leonardo. Freud suggests that Leonardo's development "approaches Spinoza's mode of thinking" (p. 75). In Leonardo's case the need to investigate, which began as a servant of Leonardo's drive for accurate artistic expression,

became the stronger need and overwhelmed his esthetic productivity. Thus his drive to investigate swept him away until the connection with the demands of his art was severed—leading into his innumerable investigations into almost every branch of natural and applied science.

The genius of Leonardo lies in the fact that he was a master in both art and science—despite the inhibition or impairment of his artistic productivity produced by his inexhaustible investigation of nature. Freud saw Leonardo's compulsive drive to investigate as a substitute for sexual activity, that is, as a successful sublimation allowing the sexual drive to operate freely in the service of intellectual interest. The power of this sexual drive produced an overwhelming sublimination in the case of Leonardo, who:

> ...had merely converted his passion into a thirst for knowledge; he then applied himself to investigation with a persistence, constancy and penetration which is derived from passion, and at the climax of intellectual labor, when knowledge had been won, he allowed the long restrained affect to break loose and to flow away freely, as a stream of water drawn from a river is allowed to flow away when its work is done. When, at the climax of a discovery, he could survey a large portion of the whole nexus, he was overcome by emotion, and in ecstatic language praised the splendor of the part of creation that he had studied, or—in religious

phraseology—the greatness of his Creator (pp. 74-75).

At no point did Freud in his explanation—which sounds suspiciously autobiographical—allow for a legitimate autonomous sense of transcendence; for Freud all mental phenomena must be explained on the basis of the vicissitudes of the primitive instinctual drives. In this way Freud avoided his own speculative urges. Unfortunately, the tendency toward increasing mysticism that appeared in some of his followers has reached a bizarre peak in the so-called third-force psychologies of today, which have the net effect, at least in normal psychology, of denying the power of the unconscious. Whether there is room in Freud's theories for supraordinate concepts, with their own principles of development and source of motivation, such as the bipolar self (in Kohut's "broad" sense) and the autonomous striving toward transcendence—constitute unresolved debates to which we turn in the next three chapters.

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