Freud Teaches Psychotherapy

EARLY PSYCHOANALYTIC Hypotheses

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An examination of Freud's early psychoanalytic publications from 1893 to 1899 is of interest in the understanding of hypothesis formation and hypothesis change in the field of intensive psychotherapy. In Freud's early theories, the notion of a traumatic event in the Charcot-Breuer tradition as the precipitating cause of the psychoneurosis is retained, and discussion of the predisposition to neurosis is somewhat vague. The importance of sexuality is a basic revolutionary contribution.

In 1895 Freud made an attempt to distinguish the "actual neuroses," which are thought of as resulting from current factors causing "damming up" of libido due to blocked or inadequate forms of sexual discharge, from the "transference neuroses" which, like hysteria, are based on unacceptable sexual thoughts and memories from the past; thus the famous quotation "hysterics suffer mainly from reminiscences." More specifically (Freud 1896C;3:189ff), no hysteria arises from a single experience but is a matter of a series of experiences and so is "overdetermined"; these experiences take place in early childhood and are sexual in nature; an incredibly complicated

chain of associations leads to the memories of these significant experiences. Ideas associated with these unacceptable reminiscences call forth a "defense" on the part of the ego, writes Freud in this early work, and he continues by borrowing the philosopher-psychologist Herbart's notion of the "thrusting" of an idea outside of the conscious.

Wollheim (1971) points out that Freud attended the seminars of the famous philosopher-psychologist Franz Brentano, probably most well known for his influence on Husserl. Brentano contended that every mental state or condition can be analyzed into two components: (a) an idea, which gives the mental state its object or what it is directed upon; and (b) its charge of affect, which gives its measure of strength or efficacy. Thus ideas with high charges of affect, which are unacceptable to the conscious mind, produce a defensive reaction in which idea and affect are separated and expressed in disguised manners. In hysteria the vital factor is "conversion" (Freud 1894A;3:49), defined as the transformation of affect or excitation into some bodily manifestation, while in the obsessional neuroses both idea and affect are expressed but are totally separated from each other and pursue divergent paths. For example, the affect attaches itself to another idea while the original idea remains weak and unnoticed in

the consciousness. These basic principles are elaborated in various ways in the early publications.

In the early hypotheses Freud firmly insisted that a traumatic sexual experience in childhood was at the basis of all the defense psychoneuroses; this is the so-called "seduction theory" of the psychoneuroses. The shift from the seduction hypothesis to an understanding of the importance of infantile fantasies and how they attain a psychic reality of their own was the great turning point in the development of a viable scientific theory of psychotherapy, and was contingent upon Freud's self-analysis. This shift is dramatically described in Freud's (1950A;1:175ff) letters to Fliess.

The realization that his seduction theory was leading him into an absurd and improbable explanation led Freud to a bewilderment and depression that was only resolved by his self-analysis. Here again Freud's courage and willingness to persevere in his exploration are remarkable. In the summer and fall of 1897, his self-analysis revealed the essential features of the Oedipus complex; by 1898 he was at work on the first draft of *The Interpretation of Dreams*, written in final form in 1899, the year in which, according to Kris (1954), he discovered

that dreams were the royal road to the unconscious mind and in which he united the study of dreams with the clinical questions of the neuroses.

As Jones (1953) explains, "It was the awful truth that most—not all—of the seductions in childhood which his patients had revealed, and about which he had built his whole theory of hysteria, had never occurred. It was a turning point in his scientific career, and it tested his integrity, courage, and psychological insight to the full. Now he had to prove whether his psychological method on which he had founded everything was trustworthy or not. It was at this moment that Freud rose to his full stature" (p. 265).Jones sees 1897 as the acme of Freud's life, in which the first understanding of infantile sexual fantasies and the importance and explanation of dreams were achieved!

Sadow et al. (1968) convincingly contend that the seduction hypothesis was formulated on the basis of a defensive projection of blame for infantile sexuality onto parental figures. When Freud succeeded in becoming aware of his own sexual wishes by means of his self-analysis, he was able to correct his error and arrive at a universal hypothesis of the role of the Oedipus complex. This emphasizes in a spectacular way the most important feature of the honest and dedicated day-to-day practice of intensive psychotherapy. As psychotherapists, on the basis of their own prior and thorough psychotherapeutic treatment, continue with their own perpetual analysis of their countertransference reactions, they gain further understanding of their patients and are able continually to revise their hypotheses about the meaning of patient material. Even Freud, according to Jones (1953) "never ceased to analyse himself, devoting the last half hour of his day to that purpose." An extremely good idea.

A properly conducted intensive psychotherapy is marked by a continuing revision of our hypotheses about our patients, on the basis of patient material and our self-analysis of the countertransference that such material produces. When properly conducted it is a meticulous scientific process very much in the spirit of scientific investigation as described by Popper (1965), as I have discussed it in detail in *Great Ideas in Psychotherapy* and in other publications (Chessick 1977a, 1992, 1996, 2000).

In his autobiography Popper (Schilpp 1974) writes:

But it seems to me that what is essential to "creative" or

"inventive" thinking is a combination of intense interest in some problem (and thus a readiness to try and try again) with highly critical thinking; with a readiness to attack even those presuppositions which for less critical thought determine the limits of the range from which trials (conjectures) are selected; with an imaginative freedom that allows us to see so far unsuspected sources of error: possible prejudices in need of critical examination (vol. 1, p. 37).

What a fine characterization of the attitude in the psychotherapist that generates successful interpretations!

The correct application of Popper's methods to the use of interpretations in psychotherapy, and the notion of the psychotherapist in intensive uncovering psychotherapy as primarily a *puzzle solver*—in the sense of functioning as an accessory ego to the patient's observing ego—is central to the crucial conception of the analytically oriented psychotherapist, even as delineated by Freud himself. The differences with Popper come primarily at what he calls—correctly—a metascientific level, in which he attempts to apply his theories in a rather dogmatic fashion to the accumulation of *all* knowledge; for the purposes of the practicing psychotherapist this is an issue of secondary relevance. The point is that Popper's basic schemata are uniquely applicable to the understanding of the progress of knowledge in the individual psychotherapy of the patient. In this process the creative intuition of the therapist, based on empathic perception, produces hypotheses about psychodynamic explanations, which are then subjected to testing by tactfully presenting them to the patient at the appropriate time and observing the patient's reaction, which either corroborates or tends to refute or falsify the hypotheses. The process leads to an elimination of error and the formulation of new hypotheses which, although they may incorporate some aspects of the early hypotheses, are closer to the truth and a deeper level of understanding.

Thus the new and correct interpretations permit us to move deeper into an approximation of the basic truths about the patient; even a failure of an earlier hypothesis or interpretation teaches us something new about where the difficulties lie, and helps us to formulate a more active and deeper interpretation of hypothesis.

It is not even necessary to review the well-known patient's responses which serve the practicing psychotherapist as either corroborations or refutations of his interpretations (or conjectures)—

that is, the error elimination process—since these responses are presented in any standard textbook such as that by Langs (1974, vol. 2). The experienced psychotherapist who has a thorough knowledge of his or her countertransference usually has little difficulty in deciding whether a given interpretation has correctly made its mark, or for some reason is incorrect and is being rejected by the patient. Only the most inexperienced neophyte attempts to hammer an interpretation down a patient's throat without accepting the possibility that the interpretation may simply be wrong. This is a matter for the personal treatment and training of the therapist, but again need not concern us here since we are talking about psychotherapy as practiced by the experienced therapist.

It is this approximation process, when clearly understood, that forms the basis of understanding a patient and works consistently with Freud's notion of therapy as peeling off the layers of an onion. Popper's basic schemata give us a chance to formulate this notion in a specific and exact terminology.

On the other hand, such formulations run us into the difficulty that is presented by Bohr's principle of *complementarity*, in which this neat procedure breaks down at a certain level because of the multiple possible ways of interpreting the same data. Thus some data may be lost through the approach the therapist takes. To minimize loss of data the therapist has to be prepared to take at least two approaches—that of scientific understanding and that of humanistic imagination. In this way Popper's delineation of scientific procedure can be fit optimally into an understanding of the therapy process; however, his basic philosophical preconceptions about science and non-science confuse this orientation, and have given rise to great debate among various philosophers as to what science is and what science does—a question essentially unanswered in any satisfactory manner as of the present date.

Let us turn directly now to certain of the papers that are still relevant in volume 3 of the *Standard Edition*. The first major paper in the volume, a lecture "On the Psychical Mechanism of Hysterical Phenomena" (Freud 1893H;3:26ff), reviews some of the early psychoanalytic hypotheses. The traumatic event and its resistance to recall necessitate hypnosis; the connection between the event and the hysterical phenomena may be simple or have a symbolic relation, as seen in dreams. There may be several "partial traumas," that is, any experience which calls up distressing affect, with the symptoms disappearing on being "talked out." This is known as abreaction, *in which language is experienced as a substitute for action*.

The term "repression" is first used here but as meaning a deliberate act of exclusion from conscious thoughts. Freud postulates the existence of ideas marked by great intensity of feeling but cut off from the rest of consciousness. The essence of the therapy is to get rid of the idea's affect which "was, so to say, 'strangulated'," a principle which remains one of the pillars of psychotherapeutic effect to the present day. Even in the case of Emmy von N. in *Studies on Hysteria,* Freud already recognized that suggestion and abreaction are not enough, and he already demonstrated the need to analyze down to causes in a deterministic way—only then, he felt, can one use the abreaction technique successfully.

As already mentioned in the previous chapter, the undoing of repression or the removal of resistance was, from the beginning, considered the central task of psychoanalytic psychotherapy. This requirement has a particularly eloquent expression in the *Minutes of the Vienna Psychoanalytic Society* (Nunberg and Federn 1962, vol. 1, pp. 100-102), where Freud is noted by Rank as adding, "There is only one power which can remove the resistances, the transference. The patient is compelled to give up his resistances to *please us*. Our cures are cures of love. ...The vicissitudes of the transference decide the success of the treatment." Freud regarded transference as affording a chance to produce a permanent change in the patient, whereas he calls hypnosis "nothing but a clever trick." Freud regarded the notions of resistance and transference as the conceptual hallmarks of psychoanalysis.

We come next to two papers in which Freud first gave public expression to many of his major hypotheses: "The Neuro-psychoses of Defense" (1894A;3:43ff) and "Further Remarks on the Neuropsychoses of Defense" (1896B;3:159ff). The former paper is more famous, for Freud's originality of thought. He makes a major therapeutic point in his metapsychologically unsatisfactory explanation (at this point in his development) that in any repression the *affect* is repressed, not so much the idea. Thus in a sense, the purpose of repression is to make a "weak idea" out of a strong one, based on the key point that the "sum of excitation" present in the psychic functions can be increased, decreased, displaced, or

discharged. These processes form the nucleus of the psychic mechanism of the neuroses, which at that time Freud thought had to do with repressing memories of highly affectually charged childhood traumata.

In the second paper, an analysis of a case of chronic paranoia is presented, and the term "projection" is first used and illustrated as a defense.

The notion of symptoms as representing compromise formations is presented; the symptom in a neurosis is explained as a partial discharge in a way acceptable to the conscious mind. I would especially recommend the paper on "The Neuro-psychoses of Defense" and part III of "Further Remarks on the Neuro-psychoses of Defense" for discussion in a basic seminar on psychopathology. They remain pertinent examples of clinical case- presentation and attempts at understanding, based on the theory of repression or defense that Freud called "the cornerstone on which the whole structure of psychoanalysis rests." They also outline the more controversial metapsychological concept of *the quota of affect*, a manifestation of the "sum of excitation," as well as the notion of cathexis, which will be

discussed later and which forms an important concept in Freud's effort to keep psychoanalysis parallel to "scientific" Newtonian physics.

To aid the reader in studying the early psychoanalytic hypotheses it is useful to outline Freud's concept of the factors which cause neuroses, and Freud's nosological system (1898) based on the "conversion theory" of anxiety. According to Freud, a neurosis has multiple causation which involves:

(a) hereditary disposition;

- (b) specific cause—factors without which the neurosis cannot occur: these are sexual and the classification depends on them as will be explained in the nosology;
- (c) contributory or ancillary causes—any other factors which may or may not be present and contribute toward overloading the nervous system;
- (d) an exciting or releasing cause: the traumatic events immediately followed by the appearance of the neurosis.
- This formulation represents Freud in transition from a

neurological to a purely psychological understanding of the neuroses. The specific cause determines more than anything the type of neurosis; whether a neurotic illness occurs at all depends on the total load on the nervous system in relation to its capacity to carry this load.

The classification based on this formulation is:

(a) ACTUAL NEUROSES (due to organic causes)

1. Neurasthenia proper—due to inadequate "abnormal" discharge of sexual excitation, e.g. masturbation.

2. Anxiety neurosis—due to blockage of sexual discharge and deflection into morbid anxiety, e.g., abstinence or coitus interruptus.

(b) TRANSFERENCE NEUROSES ("psychoneuroses")

1. Hysteria—due to childhood sexual traumata of a passive nature, imposed on the child quite early.

2. Obsessive-compulsive neuroses (including phobias)—due to the above plus later a superimposed, more pleasant aggressive sexual activity in childhood.

(c) NARCISSISTIC NEUROSES

1. Depression

2. Paraphrenia (a term Freud preferred, loosely representing schizophrenia—see discussion below)

Section I of the paper "On the Grounds for Detaching a Particular Syndrome from Neurasthenia Under the Description Anxiety Neurosis'"(Freud 1895B;3:91-99) contains an outstanding clinical description of the anxiety neurosis as it is retained in present day nosology. The curious concept of neurasthenia was given prominence by the American neurologist G. M. Beard (1839-1883); it disappeared from the first edition (DSM-I) of the Diagnostic and Statistical Manual of Mental Disorders, issued by the American Psychiatric Association, and then reappeared in the second edition of this manual. In DSM-II neurasthenic neurosis is differentiated from anxiety neurosis. It is characterized by "complaints of chronic weakness, easy fatigability, and sometimes exhaustion." Beard's description of the typical symptoms of neurasthenia included "spinal irritation" and dyspepsia with flatulence and constipation. Freud clearly differentiates the when anxietv neuroses. and DSM-II separates out the psychophysiological disorders and depressive neuroses, it is unclear what is left for neurasthenic neurosis! DSM-III deliberately moves entirely away from all this.

Although most of the papers in volume 3 of the *Standard Edition* are based on the generally discarded conversion theory of anxiety, in

which Freud believed that libido, here defined as sexual excitement, was converted directly into anxiety if the normal discharge was blocked—one major clinical paper in this volume is still relevant and mandatory reading for anyone engaged in the practice of intensive psychotherapy. This is the paper "Screen Memories" (1899A;3:301ff). A screen memory is a recollection whose value lies in the fact that it represents, in the reported memory of impressions and thoughts of a later date, events—which are associated either by symbolic or other links-from an earlier date in the person's life. (This subject has already been discussed in the latter part of chapter 3.) Curiously, the autobiographical screen memory described by Freud in this paper works in an opposite direction—one in which an early memory is used as a screen for later events; this kind of screen memory has not often been mentioned in the psychiatric literature.

Freud's screen-memory paper implies the importance of asking patients for their earliest memories, the content of which is usually referred back to the period between the ages of two and four. The most frequent content of the earliest memories is some occasions of fear, shame, physical pain, and important events such as illnesses, deaths, fires, the births of brothers or sisters, and so on. Such memories must be regarded as disguised representations of more fundamental psychological interactions with significant people in the past, or even better, as representations of the atmosphere of early childhood. As such they are important clues to what will be forthcoming in the transference and in the uncovering of significant childhood interactions and events.

Freud points out that we are so accustomed to not remembering the impressions of childhood that we are inclined to explain this hiatus as a self-evident consequence of the rudimentary character of the mental activities of children. He continues, "Actually, however, a normally developed child of three or four already exhibits an enormous amount of highly organized mental functioning in the comparisons and inferences which he makes and in the expression of his feelings; and there is no obvious reason why amnesia should overtake these psychical acts, which carry no less weight than those of a later age" (p. 304). The notion of displaced affect is used to explain the fact that many people produce earliest recollections of childhood that are apparently concerned with everyday and indifferent "events" which could not produce any emotional affect even in children. In fact, some of these so-called childhood memories may be of "events" that

never happened at all!

Thus Freud at the age of forty-three gives us a hint of what is now to follow in 1900-his major work, The Interpretation of Dreams, based primarily on his own self-analysis. A screen memory holds its value as a memory not due to its own content but to the relation of its existence between that content and some other content that has been repressed. A hint that we are dealing with a screen memory occurs whenever in a memory the subject himself appears in this way as an object among other objects, since "this contrast between the acting and the recollecting ego may be taken as evidence that the original impression has been worked over." It may even be questioned whether we have any memories at all *from* our childhood; memories relating to our childhood may be all that we possess. Thus the socalled childhood memories were actually formed later, and a number of motives, having no concern with historical accuracy, had a part in forming them, as well as in the selection of memories themselves, explains Freud.

It is a working rule of thumb among experienced clinicians that the earliest memories, along with the first dreams related in

psychotherapy, contain the nucleus of the psychodynamic conflict that has generated the emotional disorder. Of course it may take years of intensive psychotherapy to perceive correctly and interpret the hidden content and nuclear conflicts in this material. It is, however, wise to make notes of the earliest memories and first dreams as they are reported, and to refer back repeatedly to them during the course of the treatment as an overall guide while one is immersed in the specific material at any given period of the treatment.

Two early papers in volume 7 of the *Standard Edition* still represent an excellent starting point in the seemingly endless debate on the legitimacy of the art and craft of psychotherapy. They should be assigned as part of any first-year residency reading list. The paper "Psychical Treatment" (1950B;7:282ff) should be read first. Freud presents a cogent argument for the legitimacy of mental treatment by the use of words as important media—in fact the most important media—by which one man seeks to bring his influence to bear on another. The historical background of mental treatment and the legitimacy of including treatment of the so-called functional disorders and hypochondrias in the practice of medicine are presented. This debate about the power of words continues today in both psychiatry

and philosophy.

At the same time, Freud admits that all the mental influences which have proved effective in curing illnesses "have something incalculable about them." Freud recognizes that the problem of the regularity of therapeutic results achieved by psychical treatment is a function of the individual nature of the personalities of the subjects, with their variety of mental differences. Even at this early date he stresses the importance of the patient finding a doctor who is suitable for his disorder. He explains that if the right of a patient to make a free choice of his doctor were suspended, "an important precondition for influencing him mentally would be abolished." He also recognizes the limitations of personal involvement placed upon the physician who attempts to treat mental disorders. These limitations have not been properly observed in the current practices of some schools of psychotherapy; Freud gives a timely warning of the effect of transgressing these obvious limitations, on the life of the patient as well as the personal life of the physician.

In the paper "On Psychotherapy" (1905A;7:256ff) Freud points out that all physicians are continually practicing psychotherapy

whether they want to or not, and clearly it is a disadvantage not to keep a check on it, administer it in doses, and intensify it as needed. He asks: "Is it not then a justifiable endeavour on the part of a physician to seek to obtain command of this factor, to use it with a purpose, and to direct and strengthen it? This and nothing else is what scientific psychotherapy proposes" (p. 259). He reminds us of the famous dictum that certain diseases are not cured by the drug but by the physician; that is to say, by the personality of the physician inasmuch as through this personality he exerts a mental influence. He warns us that scientific psychotherapy, which involves searching for the origins of a mental illness and removing its manifestations, is not an easy task which can be practiced offhand, and indeed it makes great demands "upon the patient as well as upon the physician. From the patient it requires perfect sincerity—a sacrifice in itself; it absorbs time and is therefore also costly; for the physician it is no less time-absorbing, and the technique that he must study and practice is fairly laborious" (p. 261).

The most important point in these early papers is that severe emotional disorders cause no less serious suffering than any of the dreaded major organic diseases. Therefore, psychoanalytically

informed psychotherapy "was created through and for the treatment of patients permanently unfit for existence, and its triumph has been that it has made a satisfactorily large number of these permanently *fit* for existence" (p. 263).

It is indeed difficult to understand the objections of many physicians even today, as it was in 1905, to the inclusion of intensive psychotherapy among legitimate medical procedures. It is true that, because of the varying personalities of physicians and patients and the variety of disorders that patients develop, it is hard to establish good results with statistical regularity; yet there is no question that for many patients suffering from chronic characterological and emotional disorders, intensive psychotherapy is the best treatment available and they will seek it out. If psychiatrists do not provide this form of treatment while observing the ethical limitations on the medical principles of protecting the patient and attempting to help the patient as scientifically as possible, charlatans of every possible description will move into the breach, as is already happening, and exploit patients without mercy.

Freud's wrath at physicians who attacked psychotherapy without

knowing anything about it, and his insistence that such attacks were based on personal resistances, is just as pertinent today as it was in 1905. The refusal of organized medicine generally to accept intensive psychotherapy as a legitimate medical technique has made it easier for third-party-payment business organizations to evade the obligation of helping patients with mental illness, and for untrained charlatans to take advantage of the suffering of the emotionally ill. Psychotherapy carries serious responsibilities and is a craft, which, like surgery, must be learned meticulously through arduous training; abandoning the mentally ill to charlatans in the field is analogous to the old tradition of allowing barbers to perform surgery.

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