Freud Revisited:
Learning from
Past Misconceptions

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INTRODUCTION

Clinicians practicing long-term psychotherapy that direct work at repairing the underlying roots of emotional illness have often come up against on age old question: How much therapy is enough? Intimately related to this question is the necessary query: Is the therapeutic work sufficiently effective, psychologically penetrating and deep enough to affect cure, thus truly protecting patients from future expressions of emotional illness.

These questions, appropriately asked today, were also considered by S. Freud close to sixty years ago. In his paper entitled "Analysis Terminable and Interminable," Freud asks what is meant by the phrase "the end of an analysis." He then answers his own question stating that analysis is completed when two conditions are met. "...the patient shall no longer be suffering from his symptoms and shall have overcome his anxieties and his inhibitions; and secondly that the analyst shall judge that so much repressed material has been made conscious, so much internal resistance conquered, that there is no need to fear a repetition of the pathological processes concerned." (p.219) Shortly thereafter Freud raises another significant point. "Instead of an enquiry into how a cure comes about...the question should be asked of what are the obstacles that stand in the way of such a cure."

What follows in this paper is a focus on advancements in the field of psychotherapy that address some of the "obstacles" that stood in the way of cure then, even as they might today. In addition, however, a look is taken at what indeed psychotherapeutic cure can be considered today, and what conditions allow for such a cure to be achieved. Toward this end examples used by Freud will be re-examined and interpreted from the perspective of that which has since been discovered about human behavior

and the therapeutic process. Additional current clinical examples are used to help elaborate various points.

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In the first several pages of "Analysis Terminable and Interminable" Freud provides three clinical examples. The third and most straightforward is that of a woman who underwent an analysis of under a year which proved effective at reversing leg pains which had subjectively made walking impossible for her since puberty. She remained symptom free for years. After many misfortunes in her family and financial losses she saw "every hope of happiness in love and marriage vanish" which she reportedly stood up to "valiantly." After requiring a hysterectomy for a hemorrhaging myoma, however, the woman's symptoms reappeared. Freud reports that she "wallowed in masochistic phantasies about the fearful changes in her inside and proved inaccessible to a further attempt at analysis. She remained abnormal to the end of her life."

Of the examples cited this example shows most clearly how analysis was effective in relieving a debilitating symptom even as the underlying foundation of the emotional illness remained intact. Freud recognized too that his patient's basic neurosis persisted and attributed the recurrence of her trouble to it. Though he had seen the woman in his earliest and most inexperienced years as an analyst, Freud nonetheless suggested that the treatment should not have been expected to have protected the woman over time. He writes, "The successful treatment took place so long ago that we should not expect too much from it."

Still more generally, this late paper of Freud's in contrast to earlier works carries a more pessimistic tone with respect to both the staying power and prophylactic power of psychoanalysis. Freud seems to recognize that the analytic work must somehow be deepened to have lasting impact and be capable of protecting the patient against future

expressions of illness. He struggles with finding a means of making "latent" conflicts "current" and therefore immediately available to treatment. Limited by his theoretical framework of instinctual drives, Freud resigned himself to concluding that the constitutional strength of the instincts and the relative weakness of the ego overdetermine the effectiveness of treatment. As Strachey noted in discussing "Analysis Terminable and Interminable," "the factors to which [Freud] largely draws attention to are of a physiological and biological nature. They are thus in the main unsusceptible to psychological influences." (p. 212) Unknown to Freud yet clearer today is that under carefully designed therapeutic settings psychological influences can be heightened and intensified to directly affect patients' physiology. In doing so permanent changes in patients' physiology can be affected. Once in place these changes fundamentally reverse pathological conditions thus protecting patients over a lifetime from circumstances where "new traumata" lead to "fresh outbreaks of neurosis."

In contrast to his own viewpoint, Freud believed that among his contemporaries in 1937 were those who would argue that the analytic cure is permanent. He suggested that these colleagues would charge that analytic technique had evolved and improved significantly since Freud's earliest days and as such the examples he cites in his paper provide an inaccurate sample. In what stands as a central statement of the paper, Freud concludes that his "optimistic" colleagues must make certain assumptions in coming to such a conclusion. They must have assumed that improved analytic technique had made it possible (1) to "dispos[e] of an instinctual conflict (or, more correctly, a conflict between the ego and an instinct) definitively and for all time, (2) to "inoculated against the possibility of any other such conflicts" while treating a patient for one instinctual conflict and (3) that an analyst "has the power, for purposes of prophylaxis, to stir up a pathogenic conflict...which is not betraying itself at the time."

While such "optimists" were correct in believing that psychological intervention can cause permanent change, their framework for understanding human behavior and the treatment of pathogenic processes, like Freud's, made it difficult to explain how a lasting cure might be achievable. The "curative" elements, as Freud defined them, of making the unconscious conscious, and explaining the unintelligible (p. 219) have not proven to yield lasting results. Generations of patients since Freud's time have come to understand their dynamics and develop a psychological sophistication about their internal workings. But this heightened knowledge and insight alone has not been potent enough to overcome and basically change the more powerful force of feelings which, in fact, typically motivate and determine human behavior. In effect, the cognitive nature of the analytic model itself was perhaps one of the most major "obstacles" that stood in the way of cure.

Something beyond what Freud's model attempted was necessary in affecting basic and therefore lasting change in patients. The second and third examples described by Freud provide some clues. In the second example, Freud refers to a man, a successful analyst himself, who seeks out treatment with a someone he regarded as superior to himself to work out "neurotic impediments" in his "relations to men and women." Freud refers to the result of the analysis as "completely successful" noting that the patient "married the woman he loved and turned into a friend and teacher of his supposed rivals." After many years without symptoms, however, the patient "became antagonistic to the analyst and reproached him for having failed to give him a complete analysis. The patient, who according to Ernest Jones refers to Ferenczi, complained that the analyst, allegedly Freud himself, "ought to have known and to have taken into account the fact that a transference- relation can never be purely positive; he should have given his attention to the possibility of a negative transference." In defense of the "analyst," Freud argued that it is doubtful whether an analyst has the

power to activate the negative transference when it does not appear present. In Freud's estimation eliciting a negative transference would require "some unfriendly piece of behavior in reality on the analyst's part. Furthermore, he added, not every good relation between an analyst and his subject during and after analysis was to be regarded as a transference; there were also friendly relations which were based on reality and which proved to be viable."

In this brief response Freud highlights two elements of the therapeutic process that were barely discovered at that point in time and since have proven to be central to affecting cure. The first entails the place of the Real relationship in the therapeutic process and the second the use of force in psychotherapy. Let's address these in turn.

In Freud's day, attempts were made by analysts to remain fully anonymous not only with regard to personal details of their life but even humanly. The theory held that patients' transferences unfolded best when the analyst provided a "blank screen" for patients' projections. As such the analysts restricted their comments interpretive remarks, made as sparsely as possible and positioned their chairs behind the analytic couch minimizing the real contact between themselves and their patients.

Associations freely flowed under good circumstances. But the most fear filled and pain laden material must have remained unspoken and outside the realm of the therapeutic relationship. Human nature as it is, the most noxious of experiences are understandably avoided, even without conscious intent. Like the children all adult patients once were, they could not enter into frightening areas without a nudge, a push or at least the hold of a reassuring hand. Yet the "blank screen" provided none of these. The rule of abstinence made it impossible for patients to truly know the therapist and test his/her reliability, integrity and steadiness.

Without visceral "knowledge" of these qualities in the therapist, patients could not and cannot feel safe enough to re-experience emotional "traumata" of the earliest days of life. Yet it is exactly the experiences from this preverbal period that must be felt again in the therapeutic setting. For it is in the first formative days, weeks, and months of life that we humans form the rudiments of all later expectations throughout our lives. When we are most unable to make sense of the bombardment of experiences and stimuli, we form "impressions" about life. These are not intellectual frameworks since cognition is not truly functional for many, many months and years to come. But the record of these early experiences are nonetheless not lost. They are registered in subcortical brain pathways and influence everything about each being. How one breaths, sits, thinks and relates to others are all affected by this information.

The hundreds and thousands of experiences humans live through during the first year or two of life cannot be understood since no understanding is available. And babies regularly "interpret" these experiences wrongly. Hunger pangs, loud noises, bright lights and a shaky embrace can all be felt as life endangering. By contrast a quiet, firm, and soft hold, a full belly and "just right" environment can sooth. Still, the most sensitive of caretakers can not ensure the perfect modulation of a baby's existence that was so much better assured in utero. Thus the earliest life experiences of all humans are filled with disappointment, anger, hurt and, above all, moments of terrible fear. The greater the disquietude of the caretaker, Mother, and the greater her insensitivity to her child the greater are the disturbing residues. But none are exempt.

These are the experiences registered and recorded in every person which lie at the base of all emotional disorders. These experiences that exist before consciousness (as opposed to being merely unconscious) are those which must be tapped during the course of treatment to affect cures. The "working through" of these experiences must

ultimately amount to the laying down of new subcortical pathways that send different messages to the cortex than those recorded so early in life.

But how is such a lofty task to be achieved? How is the visceral "knowledge" of life as one has come to know it and live it to be changed? How are experiences coming so much later in life to challenge the "knowledge" assembled by the infant?

At the outset these questions suggest that the therapeutic relationship must be far more intense and real than was previously appreciated. An emotionally distant posture on the therapist's part could never suffice. Well beyond the notion of a blank screen, the therapist must allow him/herself to be known and experienced as considerably more secure than one's own original caretaker. This places a far greater burden on the therapist. He/she must not be threatened by patient's protests, hurt, withdrawal, provocations, or expressions of genuine love. He/she must have the freedom to give emotionally but only when it serves the patient. In short, the therapists' real human qualities must be exposed and must prove to be consistent with reality.

As R. Bar-Levav (1988) noted, "Constructing a safe setting begins by making real contact with the patient...The therapist must touch and welcome the patient's 'soul'. The hidden and denied fears and hurt must be recognized, verbalized and sensitively addressed. The patient's confusion and silence must be listened to, and heard. An immediate sense of relief follows when this is properly done, and contact is thus established. This is a solid base for the beginning of a solid real-relationship." (p. 232) The bedrock of the therapeutic relationship under such circumstances is the growing Real-relationship (Bar-Levav) between therapist and patient. In addition to, but far greater in importance than the positive transference, the Real-relationship becomes the glue that binds the patient to the therapeutic process.

In the therapists' manner, well beyond his/her words, the message is conveyed that the patient has a place in the world. The patient is seen, known, and his/her emotional expressions are welcomed. While all action on basis of feelings is strictly prohibited by contract established at the outset of treatment and reinforced as needed, all verbal expressions of feelings are not only given room but often are actively helped to intensify. An example. Kate was the oldest of four born to a deeply depressed mother and alcoholic father who was occasionally physically aggressive. Without any extended family nearby, Kate had nowhere to turn for solace and soon found greatest comfort in holding herself. Her body folded inward. As a child she sucked her thumb, later played with her hair and skin and as an adult habitually sat closed up, arms folded, legs crossed, and shoulders high.

When Kate was asked during an initial session to sit forward and uncross her arms and legs she immediately refused, polite as always noting she was "more comfortable sitting as she does." Moments before she agreed, in principle, to not act according to her feelings. But in this next breath she refers to her discomfort as justification for remaining as she was. Gently but assuredly the therapist insists on her assessing the real danger of unfolding and agreeing to do what makes objective sense. She understands there is no true danger in unfolding but her body "knows" otherwise. A flash of annoyance crosses her face. It is suggested she say to the therapist a few times angrily, "Don't tell me what to do!" Kate hesitates at first feeling awkward but then repeats the phrase several times, the last couple times with greater anger than even she expected. After a moment the therapist asks her again to unfold since she agrees there is no real danger to her. She unfolds and notices a moment later feeling scared and vulnerable. No interpretation is made. Kate simply takes a dew deep breaths, feels her fear, understands it makes "no sense" and at another level is aware of her therapist's presence with her. Weeks and months later Kate refers back to this and similar

exchanges, not knowing exactly what happened but being left with the sense that her therapist was truly on her side.

From the start of the relationship highlighted here the therapist allied himself with the healthy, adult portion of Kate. Figuratively speaking, he took her hand and nudged her in a direction she would otherwise have naturally avoided. Kate had much reason to experience the world as unsafe. Her body, therefore, made chronic adaptations to protect herself from feeling vulnerable. A bright woman, she could easily understand that much of her fear was unrealistic and could cogently discuss its origin. When all was said and done, however, she lived like a prisoner repeatedly yielding to its dictates. Feeling a bit of her strength and power with her angry protest "Don't tell me what to do!" and "held" by the therapist's steady gaze and assured manner Kate experimented with a way of living she would not have naturally come to on her own. Ironically, in the midst of her fear Kate must have sensed her real safety in the world more immediately and this allowed her to dare living a few moments "out of character." An explanation or interpretation provided at the point she felt most fearful may well have diluted the value of the experience by engaging her cortex more actively. Providing her simply his steady presence instead, the therapist helped ensure the experience remain primarily at a subcortical level. No harm came to Kate even when she felt subjectively vulnerable. This, too, now became registered in her subcortical brain and in a minute way forever altered her pathologic foundation. This is what has come to be referred to as "physiologic working-through" (Bar-Levav, 1988) since the focus of the work was not toward achieving "insight" but rather the altering of brain pathways that are generally inaccessible to cognition yet directly affect the individual's physiology and patterns of living.

To refer back for a moment to Freud's second example it is worthy to note that even in this first session the therapist used force with the therapeutic contract as the lever and in doing so elicited features of the negative transference. The therapist was not being "unfriendly" as Freud suggested would be necessary to cause such a reaction. Yet, he was insistent and pushed the patent to separate her feelings from her thoughts and her actions. In doing so, mild anger was generated. The angry expression was purposely activated and intensified in a manner that Freud undoubtedly could not see as possible or perhaps saw as irreparably damaging the therapist's neutrality. Yet Ferenczi was correct in his assessment that "a transference relation can never be purely positive" and a complete working through of preverbal material must provide therapeutic "room" for anger, disappointment and hurt from that same early source.

While seemingly simple at first blush the example of Kate also raises many other issues. How emotionally neutral is this therapist in his use of force in the treatment? To what degree might Kate and other patients comply with the therapist out of fear, that is, in the context of the transferential relationship? How much freedom does Kate or other patients have to be truly angry at the therapist if he/she is the only point of emotional contact?
The scope of this paper does not allow these questions to be addressed fully. Nonetheless, they are reasonably raised at this point and require at least a brief response.

Patients have always attempted to please their therapist when the therapist serves as a good mothering figure. Therapists, being human, have also frequently misused their power relationship with patents if only at times, unwittingly and in the most minor of ways. Psychotherapeutic involvement that seeks to both be genuine and intense challenges the capacity of both therapist and patient alike to conduct the relationship realistically even as strong transferential forces influence them.

At the outset the therapist is, therefore, expected to be well beyond the patient in physiologically working through (as described with Kate) preverbal distortions and emotional forces. The patient is aided in this same endeavor by having a setting that broadens the base of security and maximizes the potential for transferential confusions to surface and expose themselves. This appears to be best achieved by having the patient be seen in combined individual and group psychotherapy. Optimally two or three therapists should be present in the group one of which is the patient's individual therapist.

The advantages of this framework are multiple. While the patient still has an opportunity to experience the unique safety of the dyadic relationship the individual therapist no longer is the only point of emotional attachment. The co-therapist(s) in the group also come to be experienced as reliable and trusted guides providing the patient more freedom to experience and more fully express all feelings and especially hurt, anger and disappointment towards the primary therapist that arises out of the negative transference. In addition, the patient has an opportunity further to witness the therapist with other patients. This in itself provides not only a stimulus for other transferential material (especially wishes for exclusivity) but also allows the real person of the therapist to be more fully exposed outside of the private realm of the patient-therapist dyad. Other patients may complain or openly appreciate features of the therapist the patient has not him/herself seen. The way the therapist relates to members of the opposite gender from the patient or patients that are older, younger, more or less professionally successful, of different character makeup, etc. can all be seen and noted by the patient. In short, the patient can come to know the therapist with greater depth and have many reality checks of his/her steadiness and strength. All this allows the patient to experience greater safety in the real relationship with the therapist while transferential material stands out in greater contrast to be observed by the watchful

ego. Over time many transferential distortions can be physiologically worked through in this way if sufficient therapeutic room is provided for the expression of intense feelings.

Yet even when such transferential distortions are largely cleared up much preverbal fear can remain bound up in one's character structure and, by extension, in the characteristic ways in which a patient lives. Not infrequently this presents itself as a standstill in terms of real change either in the patient's life or in his/her therapy. Freud refers to such an instance in the first example of the paper. He describes the case of a "young Russian, a man spoilt by wealth who had come to Vienna in a state of complete helplessness..." After several years Freud reports that his "interest in life" was "awakened" and he was able "to adjust his relation to the people most important to him." Nonetheless, further progress stalled. Freud writes that "the patient found his present position highly comfortable and had no wish to take any step forward which would bring him nearer to the end of his treatment. It was a case of the treatment inhibiting itself."

As noted earlier in this paper the young Russian's treatment was limited in many ways. At the outset, the exclusive dyadic treatment setting allowed the Russian's wish for mothering to be sufficiently gratified. He had the uninterrupted attention of his good doctor on a steady basis and had little motivation to stir up his own emotional waters. Were Freud to insist on his being seen concomitantly in a group as well the Russian would have likely bristled, refused, and possibly left Freud's care altogether. But the mere use of therapeutic force would have been considered undesirable by the classic analytic model in any event as it would have introduced a contaminant to the treatment milieu that was believed to interfere with the unfolding of the transference. Moreover, without knowledge of the holding power of the Real-relationship Freud probably could

not have entertained disturbing the positive transference so dramatically. He writes, "Under the influence of the unpleasurable impulses which [the patient] feels as a result of the fresh activation of his defensive conflicts, negative transference may now gain the upper hand and completely annul the analytic situation. The patient now regards the analyst as no more than a stranger who is making disagreeable demands on him, and behaves towards him exactly like a child who does not like the stranger..."

Nonetheless these two features, the use of the Real-relationship and use of force in the treatment process were critically necessary in helping move the young Russian beyond his zone of emotional comfort. For the Real-relationship to be a significant factor in the treatment, however, the therapeutic relationship would have to have been based on different principles from the outset. Preserving neutrality, free association and the unhindered unfolding of the transference, would not be of central importance. Instead, a commitment to living by the reality principle would be primary. By this commitment the patient agrees to do what is realistic even if strong feelings compel him/her to do otherwise.

And indeed strong feelings must be consciously and purposely mobilized by the therapist repeatedly. The nature of the involvement must be such that the therapist becomes the most important person in the patient's life. Feelings that are viewed as "crazy" from an adult's perspective must find room to surface and be expressed in the therapeutic relationship. Such feelings include fear so intense that one's safety feels threatened, rage so strong one sometimes fears losing control, or tender loving feelings that mirror an infants craving for physical and emotional comfort by its mother. Here the non-acting out contract becomes central when such storms of affect temporarily threaten to overwhelm the observing adult ego. (L. Bar-levav) The more potent the experience of preverbal feeling on the part of the patient within the therapeutic

relationship the greater the beneficial effects providing the freedom to act according to the feeling is forestalled. The tension between the observing part and experiencing part of the patient or between his/her thinking and feeling is then greatest and in turn yields the greatest physiologic change.

If the therapist is truly comfortable with such powerful expressions of preverbal material, the patient often comes to develop realistic dependence on the therapist to help him/her develop areas of weak ego functioning. The patient slowly appreciates how therapy works and is even willing to join in mobilizing emotional crises by choosing to expose and explore areas that cause discomfort rather than waiting for the therapist to show the patient features of his/her pathology. In the end, however, it is the strength of the real relationship that is critical in the face of the strongest emotional turmoil. A second example.

Roy, who is himself a physician, calls to cancel a session for the coming week with his doctor who is a co-therapist in Roy's group that meets twice weekly. Though never his regular individual therapist, Dr. B had been intensely involved with Roy for many years. Dr. B., a senior clinician, had few available appointment times thus the session had been scheduled several weeks earlier.

Roy's prominent character feature is that of a pleaser of others driven by a profound fear of abandonment. As a result of his therapy, Roy married, entered and finished medical school and was now doing a residency in internal medicine. In explaining his need to cancel Roy said he would be unable to leave the hospital on the day of the appointment. Many, many times before Roy had been in similar situations compelled to giving up something for himself because he was unable or unwilling to disappoint another. Dr. B recognized Roy's interest in canceling as one in a long series of

capitulations to his fear at the expense of attending to his real needs. Dr. B reasoned that Roy felt safer with him than with his hospital colleagues with whom he felt more fragile, powerless and ungrounded. Dr. B answered Roy carefully and steadily. He stated that he does not accept the cancellation and will charge Roy if he did not show. He cautioned Roy to re-evaluate the situation, and added that he would not give Roy future appointments unless he understood that they were not cancelable. Finally, he suggested that Roy thank him for the phone call even though he probably did not like the exchange adding that he should do so only if he understood why a thanks was in order. Otherwise, he suggested that Roy wonder about the call and about what Dr. B had said. Roy responded that he could not thank Dr. B but would think about what he had said.

The intervention, particularly because it involved the use of force, required a calculated judgement about the real relationship between Roy and his doctor. Roy had tested Dr. B in countless ways over the years slowly coming to trust him to be an ethical, conscientious, and sensitive ally. Despite his cordial response, Roy was nonetheless gripped with strong feelings which revealed themselves in later sessions. His most immediate response was of anger and this covered much fear underneath. Dr. B had put him in an emotional dilemma that not only barred him from compulsively responding to his fear by accommodating others but also forced him to separate his emotional turmoil from his thinking.

It called upon Roy to evaluate Dr. B's motives for the stand he took. Was he trying to control Roy's life? Did he insist on the session because his feelings were hurt? Was Dr. B simply concerned about selling an hour of his time? If Dr. B had passed the myriad of tests Roy placed him into over time Roy could not summarily dismiss him as "a stranger making disagreeable demands on him." Instead he would have to stop

and consider what Dr. B was actually attempting to achieve. Ultimately he would conclude that Dr. B's intervention was in fact made in his best interest even though it felt quite differently at first. Roy then would be left to consider the issue, reason out how he might arrange coverage for himself at the hospital and face any fear he might experience in doing so separately.

In this example Dr. B used the power of the relationship which had been built carefully, decently, and responsibly over time to create an emotional crisis. This is what Freud sought as a means of "bringing about situations in which the conflict...becomes currently active" (p. 231). He believed this were possible only by the patient suffering some reality loss such as the termination of a marriage or of a place of employ which he understandably ruled out as an unjustified disruption of a patients life. By contrast, this and similar emotional crises mobilized during the course of Roy's treatment had little or no disruptive impact on his real life. They were effective however at jarring Roy's underlying character structure which functioned to bind early fear, hurt and rage. In process these feelings were freed up and made available for physiologic working through.

Summary

Sixty years ago Freud sought to find a means of heightening the therapeutic impact of analysis in an attempt to improve the prophylactic value of treatment. He correctly recognized that biological and physiologic factors determine the degree to which patients could truly change with treatment. Rather than being a factor that limits the effectiveness of treatment, modern theory recognizes patients' physiology as the very substrate requiring change. Gaining insight is largely a cognitive process, mediated by the cortex. Modern theory holds that to be lastingly useful psychotherapeutic work must impact subcortical pathways.

To this end, the relationship between therapist and patient must become far more intense and real than the neutrality of classical analytic technique allows. The patient must come to feel so safe in the therapeutic setting that early preverbal material has room to surface. Not infrequently, however, the active use of therapeutic force must also be used to mobilize affects that are embedded in the character structure and therefore, are not readily accessable for therapeutic work.

When the therapeutic setting is made safe enough through the holding power of the Real-relationship, and the non-acting out contract is firmly established, storms of affect can be mobilized. In process, the early formed subcortical pathways are stimulated. The differences in circumstances and time between what was experienced in early infancy when such pathways were laid down and the adult's real situation are registered by the adult observing ego. As such, old autonomic reaction patterns are extinguished as new experiences are recorded. These experiences yield lasting changes in the patient's physiology providing the prophylactic power Freud sought over half a century ago.

References

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