A Brief History of Active and Short-Term Psychoanalytic Techniques

PART 1 OF 4

Freud's early discoveries

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Abstract: In this article, the author presents a brief history of the early development of Sigmund Freud's psychotherapeutic technique, as well as some fundamentals of his early metapsychology. First, the influence of Joseph Breuer's work with Anna O on Freud's early research is considered. The author then reviews Freud's disagreements with Breuer in light of the former's exposure to French psychiatry. Following this, Freud's early clinical findings are reviewed. This forms the basis for a brief overview of the history of the psychoanalytic movement during the first two decades of the 20th century.

The present article is the first part of a series of four articles that will be presented across four issues of this Journal.

A Brief History of Active and Short-Term Psychoanalytic Techniques

Introduction to the series

This is the first part of a four-part article focused on the history of the short-term and active forms of psychodynamic psychotherapy. My purpose with these articles is twofold. On the one hand, I hope they will help readers grasp the uniqueness of Habib Davanloo's Intensive Short Term Dynamic Psychotherapy (ISTDP) through contrast with its predecessors. On the other hand, I hope to make the case that ISTDP is, in fact, not such a radical departure from psychoanalytic theory and practice. I hope to show that ISTDP shares an impulse to depart from classical techniques in search of a more authentic and practical approach to psychodynamic treatment with several of the most prominent figures of the psychoanalytic movement. Lastly, I hope to make a case that a study of traditional psychoanalysis and its history still has much to offer the serious student of ISTDP.

A Brief History Of Active And Short-Term Psychoanalytic Techniques

The first systematic attempts at shortening the duration of psychoanalytic treatment and rendering the technique more active were undertaken by Freud's students. Chief among them were Sándor Ferenczi (1873–1933), Otto Rank (1884–1939), Wilhelm Reich (1897–1957), and Franz Alexander (1891–1964). It is interesting to note that although the deviations from the so-called "standard technique" carried out by these analysts would come to be considered heretical, all of them were initially among the most highly esteemed representatives of clinical psychoanalysis. Ferenczi and Rank were original members of Freud's "secret committee" – the five ring-bearers appointed to lead the psychoanalytic movement. Together with H. Meng, Alexander was considered by Freud to be "the most promising of the younger generation of analysts" (Jones, 1957, p. 127). Similarly, until his eventual expulsion from the International Psychoanalytic Association in 1934, Reich was considered by Freud to be "the founder of modern technique" (Makari, 2008, p. 398) and protected by Freud against criticism from traditionalists in Vienna. It is therefore not entirely clear whether it is these figures who are to be considered heretics or whether they were really, as most of them protested, to be considered their times' bulwarks against the "history of ever more ambitious aims, combined with the increasing use of less and less effective tools" which critics have seen in the development of "classical" psychoanalytic technique (Molnos, 2004, p. 15).

In order to understand the innovations of these central figures, it is necessary to consider their significance within the broader context of the development of psychoanalysis. We will do so through a rough review of the history of its technique. Readers interested in a more thorough review of this fascinating history than I am able to offer here can refer to my primary sources for details: Jones (1953; 1955; 1957), Makari (2008), Ellenberger (1970), Borch-Jacobsen & Shamdasani (2012), and Etchegoyen (1999).

Joseph Breuer and "Neurosis"

The history of psychoanalytic practice does not begin with Sigmund Freud (1856-1939) but with the renowned Viennese physician Joseph Breuer (1842-1925). Breuer met the young medical student Freud, 14 years his junior, in 1880 while they were both conducting research at Ernst Brücke's Institute of Physiology in Vienna, "miserably housed in the ground floor and basement of a dark and smelly old gun factory" (Jones, 1953, p. 45). Freud was on his way toward specializing in neurology, and Breuer was conducting research alongside his private practice as a physician. The relationship between the two grew close, and Breuer soon became a mentor for the young Freud.

At this time, during the years 1880-1882, Breuer was undertaking the treatment of a 21-year-old woman by the name of Bertha Pappenheim, later to be known under the pseudonym of "Anna O." Freud was fascinated upon hearing of Breuer's treatment and would untiringly press his senior for details on this case, which famously planted the seed of Freud's interest in psychology, and in particular the so-called "neuroses" – a notion we will come to use frequently, and which therefore calls for definition before proceeding to the case of Anna O.

The term "neurosis" was coined in the 1700's to designate a broad range of medically unexplainable mental illnesses thought to be caused by afflictions of the nervous system. The term carried over into the vocabulary of psychoanalysis where, together with psychosis and perversion, it still constitutes one of three basic diagnostic categories. Although the term has since disappeared from mainstream diagnostic manuals, it remains well-suited to capture the essence of most mental illnesses, according to psychoanalytic theory. As we will come to see, Freud viewed mental illness as revolving around anxiety, i.e., *nervousness*, and attempts to compensate for it. A mentally ill or *neurotic* person is one whose life tends to be driven by anxiety rather than by his own will[1]. A perverted person, on the other hand, lives out his impulses with a striking absence of anxiety, while a psychotic person disintegrates due to anxiety.

Anna O

Following the illness and eventual death of her father, Anna O, whose actual name was Bertha Pappenheim, had begun to suffer from a host of "hysterical" symptoms, prime among them paralyses, anesthesias, hallucinations, as well as disturbances of the senses and speech. Upon close inspection, Breuer noted how these symptoms would fluctuate in accordance with what appeared to be a more fundamental disturbance. Somehow, Pappenheim appeared to be simultaneously living in two dimensions, drifting back and forth between them. One reflected her actual present reality and was accompanied by her habitual personality. The other consisted of a hallucinatory twilight state, known in the 1800s as an "absence," in which her personality would change dramatically:

> "Two entirely distinct states of consciousness were present which alternated very frequently and without warning and which became more and more differentiated in the course of the illness. In one of these states she recognized her surroundings; she was melancholy and anxious, but relatively normal. In the other state she hallucinated and was 'naughty'." (Freud & Breuer, 1895, p. 24)

It soon became apparent that Pappenheim's two states of consciousness – her normal waking state and her "unconscious" state – were not organized at random but contained experiences from different circumscribed periods of her life:

> "In the first she lived, like the rest of us, in the winter of 1881-2, whereas in the second she lived in the winter of 1880-1, and had completely forgotten all the subsequent events ... during the hypnosis she talked through whatever it was that had excited her on the same day in 1881, and [I could not have known this, ed.] had it not been that a private diary kept by her mother in 1881 confirmed beyond a doubt the occurrence of the underlying events." (Freud & Breuer, 1895, p. 33)

Under normal circumstances, a case such as Pappeneheim's would at the time have called for treatment by hypnotic suggestion. The physician would induce a state of hypnosis in his patient and urge her to relinquish her symptoms. If specific events were known to have precipitated the outbreak of the patient's symptoms, the doctor would, in many cases, modify or remove the patient's memories of these events in order to render them harmless to her[2].

Unfortunately for her—but fortunately for us—Pappenheim's intense intellect and critical sense rendered her "*completely unsuggestible*" (Freud & Freud & Breuer, 1895, p. 21), i.e., utterly unreceptive to hypnotic influence. Breuer, therefore, had to find other means of treating this complex patient. One day, he made a discovery that granted him a point of entry. He noticed that Pappenheim's twilight states would often be mixed with periods of deep sleep.

> "After the deep sleep had lasted about an hour she grew restless, tossed to and fro and kept repeating 'tormenting, tormenting' ... It happened then – to begin with accidentally but later intentionally – that someone near her repeated one of these phrases of hers while she was complaining about the 'tormenting'. She at once joined in and began to paint some situation ... A few moments after she had finished her narrative she would wake up, obviously calmed down." (Freud & Freud & Breuer, 1895, p. 28)

Whereas Pappenheim's states were not amenable to suggestion, they now proved receptive to recollection and conversation. Rather than suggestively induce changes in her symptoms or memories, Pappenheim was now invited to *speak*, putting her experiences into words. After a period of collaborative experimentation with this procedure, which Pappenheim named her "talking cure" (Freud & Breuer, 1895, p. 30), Breuer was able to conclude that "the hysterical phenomena disappeared as soon as the event which had given rise to them was reproduced in her hypnosis" (Freud & Breuer, 1895, p. 35). In this way, what came to be known as the "cathartic" therapy technique was born.

Ultimately, Breuer's treatment of Berta Pappenheim was unsuccessful and prematurely terminated. Their discovery of the talking cure, however, would turn out to be one of the greatest successes in psychiatric history.

Jean-Martin Charcot

It was not until after 1885, upon having obtained a traveling grant to study with the world-renowned neurologist Jean-Martin Charcot (1825-1893) at Paris' Hôpital de la Salpêtrière, that Freud finally convinced himself to pursue a career in psychiatry.

Charcot's neurology clinic at the Salpêtrière was founded in 1882 and was the first of its kind in Europe. By 1885, it had attracted researchers and students from all over Europe, who were curious to witness the spectacular presentations of Charcot's research, which was at the peak of its prestige. Much like Gaßner and Mesmer before him, Charcot's charisma was so great that near miraculous cures were known to take place under his influence:

> "Many patients were brought to Charcot from all over the world, paralytics on stretchers or wearing complicated apparatuses. Charcot ordered the removal of those appliances and told the patients to walk. There was, for instance, a young lady who had been paralyzed for years. Charcot bade her stand up and walk, which she did under the astounded eyes of her parents and of the Mother Superior of the convent in which she had been staying." (Ellenberger, 1970, p. 95)

Having solidified his reputation as the most excellent neurologist of his time, even serving as the consulting physician of kings and princes from all over the world (Ellenberger, 1970, p. 89), Charcot had begun to dedicate his genius to the controversial topic of the neuroses. Confident in the unshakability of his status, Charcot carried out his research by use of hypnosis – a procedure that was commonly looked down upon in the established scientific circles of the time.

Around 1885, when the then 29-year-old Freud came to Paris, Charcot's research was mainly focused on the various forms of hysterical paralyses that made up a common neurotic symptom at the time, but which are more rarely seen today. In his presentations, Charcot would demonstrate how such symptoms could be induced by hypnotic suggestion, such as by priming hypnotized subjects to react with paralysis to a specific stimulus in the waking state. By comparing these artificially induced symptoms with those found in patients referred to the clinic, Charcot concluded that the nature of the symptoms was identical in the two groups. On this basis, Charcot would argue that the hysterical symptoms of his "natural" patients were caused by the exact mechanism of hypnoid suggestion that he used to induce them artificially, and that such patients suffered from a generalized constitutional susceptibility towards self-hypnosis. Freud was convinced and firm in his determination to follow his new master Charcot's example in the study of neuroses.

Hippolyte Bernheim

Upon returning from Paris, Freud was a firm believer that hysterical symptoms were not, as many argued at the time, caused by subtle brain lesions but *functional* in nature, a viewpoint he stated confidently in an early article of 1888:

> "Hysteria is a neurosis in the strictest sense of the word – that is to say, not only have no perceptible changes in the nervous system been found in this illness, but it is not to be expected that any refinement of anatomical techniques would reveal any such changes." (Freud, 1888, p. 41)

In 1889, seeking to refine his hypnotic technique so as to follow in Charcot's footsteps, Freud undertook another journey to France, this time to Nancy, where Hippolyte Bernheim (1840-1919) had been conducting research into hypnosis since around 1882. Whereas Charcot was of the opinion that suggestibility was a pathology in itself, Bernheim worked under the assumption that every person is suggestible to a certain degree and that hypnosis only *enforces* this natural tendency of a healthy human constitution.

At Nancy, Freud witnessed how, like Charcot, Bernheim would hypnotize his subjects and induce them to perform acts in the waking state. Questioned why they performed these acts, the subjects would either rationalize or be entirely unable to offer explanation. If this were all Bernheim did in his experiments, he would merely have substantiated Charcot's research. But Bernheim would proceed to a subsequent step in his experiments which inspired Freud tremendously:

> "When he questioned them about their somnambulistic experiences, they began by maintaining that they knew nothing about them; but if he refused to give way, and insisted, and assured them that they did know about them, the forgotten experiences always reappeared." (Freud, 1910, p. 23)

Bernheim's experiments convinced Freud that even in the waking state, "It is by no means impossible for the product of unconscious activity to pierce into consciousness, but a certain amount of exertion is needed for this task" (Freud, 1912, p. 264).

The point that Bernheim's experiments brought home to Freud was not, as some have proposed, the mere fact that neurotic symptoms could be hypnotically induced – this Freud had already learned from Charcot. What Bernheim proved was that the invisible wall between the conscious and the unconscious minds could be breached and that this could be done in the waking state through an exertion of *pressure* towards the unconscious contents.

Freud's Early Experiments with the Cathartic Method

The point of departure for Freud's development of what in 1896 he would come to call his "Psycho-Analytic" (Freud, 1896, p. 151) procedure was a series of experiments with Breuer's cathartic technique, conducted by Freud in collaboration with Breuer upon the former's return from Nancy around 1890. At this point, Freud's technique consisted of hypnotizing his patients and taking "each separate symptom and enquir[ing] into the circumstances in which it had made its first appearance" (Freud, 1893, p. 30). As was the case with Bertha Pappenheim, Freud discovered that the experiences that could thus be shown to underlie the patient's symptoms were invariably "*completely absent from the patients' memory when they are in a normal psychical state*" (Freud & Breuer, 1893, p. 9). Following a series of such experiments with these memories, the two friends would conclude that:

> "We found, to our great surprise at first, that each individual hysterical symptom immediately and

permanently disappeared when we had succeeded in bringing clearly to light the memory of the event by which it was provoked and in arousing the accompanying affect, and when the patient had described that event in the greatest possible detail and had put the affect into words. Recollection without affect almost invariably produces no result. The psychical forces which originally took place must be repeated as vividly as possible." (Freud & Breuer, 1893, p. 6)

During their years of collaboration, Freud and Breuer both recognized the effectiveness of the technique they had developed, although Freud appears to have been more fascinated with it than Breuer. The two also agreed that neurosis was caused by hindrances to emotional satisfaction, as expressed by Freud in an early article: "There is an affectively coloured experience behind most, if not all, phenomena of hysteria ... *hysterical patients suffer from incompletely abreacted psychical traumas*" (Freud, 1893, p. 30; 38). Where the two had begun to diverge, however – and to divergence in a way that would eventually lead to the dissolution of their collaboration – was concerning the *mechanism* believed to render an experience "traumatic."

Disagreement and Disillusionment

Like Charcot, Breuer argued that significant emotional pressure would automatically cause neurotics to slip into a hypnoid state due to an inborn weakness in these patients' mental constitution. In this state, emotional experiences would become dissociated from ordinary consciousness and, for this reason, rendered traumatic (Freud & Breuer, 1895, p. 216). In this context, "dissociation" is to be understood as a purely descriptive term, originally coined by Pierre Janet and used by psychiatrists in Freud's time to denote splits between mental states and their associated contents.

Freud, on the other hand, argued that *"the splitting of the contents of consciousness is the result of an act of will on the part of the patient"* (Freud, 1894, p. 46). In an article from 1894, Freud describes the motivation for the splitting of consciousness into separate compartments as follows:

> *"an occurrence of incompatibility took place in their* [the neurotic patient's, ed.] *ideational life* ... their ego was faced with an experience, an idea or a feeling which aroused such a distressing affect that the subject decided to forget about it because he had no confidence in his power to resolve the contradiction between that incompatible idea and his ego by means of thought-activity." (Freud, 1894, p. 47)

Alongside his growing theoretical disagreement with Breuer, Freud was increasingly disappointed with the cathartic technique inherited from his collaborator. First of all, Freud found that although the technique did remove the proximal causes of symptoms, namely the unconscious pathogenic reminiscences, it did not seem to remove the *mechanism,* turning them into symptoms (Freud, 1905). Patients would, therefore, keep producing new symptoms from the storehouse of their unconscious. As was also the case with Pappenheim, the procedure would therefore often have to be repeated several hundred times (Freud & Breuer, 1895, p. 178) to bring about sustainable results. Secondly, it required that patients were first brought into a hypnotic state similar to that which Pappenheim had slipped into spontaneously. The problem with this was that, at least by his own standards, Freud turned out to be a very poor hypnotist (Freud & Breuer, 1895, p. 108).

The Development of Freud's Psychoanalytic Technique

Freud's difficulties with the cathartic technique led him to consider *why* some patients would not be sufficiently open and receptive toward hypnotic treatment. It soon occurred to him that a lack of hypnotizability might be due to a *resistance* against being hypnotized – or, indeed, against the therapist. This resistance in treatment would then effectively mirror the process of defense that Freud supposed to have caused the neurosis in the first place. The hypothesis that resistance in treatment reflects the defensive core of neurotic illness now formed the basis for Freud's first experiments with a new technique:

> "If, following the example of Bernheim when he awoke in his patients impressions from their somnambulistic state which had ostensibly been forgotten, I now became insistent – if I assured them that they *did* know it, that it would occur to their minds, – then, in the first cases, something did actually occur to them, and, in the others, their memory went a step further. ... Experiences like this made me think that it was in fact to be possibe for the pathogenic groups of ideas, that were after all certainly present, to be brought to light by mere insistence; and since this insistence involved effort on my part and so suggested the idea that I had to overcome a resistance, the situation led me at once to the theory that *by means of my psychical work I had to overcome a psychical force in the patient which was opposed to the pathogenic ideas becoming conscious (being remembered)*. A new understanding seemed to open before my eyes when it occurred to me that this must no doubt be the same psychical force that had played a part in the generating of the hysterical symptom" (Freud & Breuer, 1895, p. 268).

In Freud's new technique, defeating the patient's resistance in the session had now become an indirect means of defeating the very mechanism responsible for the patient's illness instead of bypassing it through hypnosis. He did so, like Davanloo did almost a hundred years later, by applying *pressure* to the contents of the patient's unconscious. In his earliest experiments, this pressure would be quite literal, as Freud supplemented his insistence with the physical pressure of his hand against the patient's forehead. Based on his experience with his new technique, Freud soon concluded:

> "The hysterical patient's "not knowing" was in fact a "not wanting to know" – a not wanting which might be to a greater or less extent conscious. The task of the therapist, therefore, lies in overcoming by his psychical work this resistance to association. He does this in the first place by "insisting", by making use of psychical compulsion to direct the patients' attention to the ideational traces of which he is in search." (Freud & Breuer, 1895, p. 270)

From this point on, the modus operandi of Freud's technique changed. Rather than hypnosis and cathartic abreaction, the treatment now revolved around "causing the resistance to melt and in thus enabling the circulation [of conscious experience, ed.] to make its way into a region that has hitherto been cut off" (Freud & Breuer, 1895, p. 291).

The importance of Freud's discovery of a resistance against recollection, its inevitable presence in the therapeutic endeavor, the possibility of overcoming it in a particular setting, and the connection between resistance and the defensive process causing the neurosis cannot be overstated. These basic tenets and the associated implications for treatment would continue to form the bedrock of his technique for the almost fifty years of clinical research that lay ahead. Indeed, twenty years later, Freud would stress that the entire theory of psychoanalysis was one extensive attempt to account for these "striking and unexpected facts of observation which emerge whenever an attempt is made to trace the symptoms of the neurotic back to their sources in his past life: the facts of transference and of resistance" (Freud, 1914, p. 16).

Freud's Early Clinical Findings

Freud soon found that his technique of applying pressure on the patient paid dividends. The insistent approach of the doctor seemed to allow him to establish contact with a deeper part of the patient that was striving for expression behind the wall of resistance:

> "All these consequences of the pressure give one a deceptive impression of there being a superior intelligence outside the patient's consciousness which keeps a large amount of psychical material arranged for particular purposes and has fixed a planned order for its return to consciousness." (Freud 1895, p. 272)

Neurosis, and with it the therapeutic process itself, was now increasingly presented by Freud as a struggle between two such forces within the patient: on the one hand, the "superior intelligence" of the unconscious with the therapist as ally, and on the other, the mechanism of defense and the force of resistance against the therapeutic process and the figure of the therapist.

In his writings from the 1890s, Freud describes how his patients would often initially respond to pressure with relevant recollections, thereby leading the therapeutic inquiry towards dynamically important material that, up until then, had been forgotten. Soon, however, resistance would emerge again, as if alarmed by the therapist's endeavors to reach the unconscious roots of the patient's neurosis:

> "The procedure by pressure is no more than a trick for temporarily taking unawares the ego which is eager for defence. In all fairly serious cases the ego recalls its aims once more and proceeds with its resistance ... The work keeps on coming to a stop and they keep on maintaining that this time nothing has occurred to them. We must not believe what they say, we must always assume, and tell them, too, that they have kept something back because they thought it unimportant or found it distressing. We must insist on this, we must repeat the pressure and represent ourselves as infallible, till at last we are really told something." (Freud & Breuer, 1895, pp. 278-279)

When resistance, and subsequently pressure, was increased, Freud found that his patients would often assume a position of more solid resistance towards the therapeutic process, arguing that his "mind is distracted today" or slowing down and becoming unresponsive (Freud & Breuer, 1895, p. 279). In Freud's words, the therapeutic process would reach a point at which his patients began to erect "a wall which shuts out every prospect and prevents us from having any idea whether there is anything behind it" (Freud & Breuer, 1895, p. 293).

Cunningly, Freud described how certain nonverbal cues given by his patients indicated that their apparent incapability to associate further was, in fact, rooted in an increasing inner discomfort with the therapeutic endeavor and, thus, an *unwillingness* to proceed: "We can then learn to distinguish without any difficulty the restful state of mind that accompanies the real absence of a recollection from the tension and signs of emotion with which he tries to disavow the emerging

recollection, in obedience to defence." (Freud 1895, p. 281). As Freud would later put it: "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his finger-tips; betrayal oozes out of him at every pore" (Freud, 1905, pp. 77-78).

Furthermore, Freud recognized how *formal* aspects of the patient's speech, in the form of discontinuities, omissions, and vagueness, could help the therapist identify the areas that the patient's resistance sought to hide:

> "At one point the train of thought will be visibly interrupted and patched up by the patient as best he may, with a turn of speech or an inadequate explanation ... the physician will be right in looking behind these weak spots for an approach to the material in the deeper layers and in hoping that he will discover precisely there the connecting threads for which he is seeking with the pressure procedure." (Freud, 1895, p. 293)

Based on these observations, Freud increasingly turned his patients' resistance into a tool for treatment. In his early writings, Freud goes so far as to describe precisely how this is achieved. He suggests that the resistance must first be clarified to the patient so as to form an alliance around examining what lies underneath it: "By explaining things to him, by giving him information about the marvelous world of psychical processes into which we ourselves only gained insight by such analysis, we make him himself into a collaborator" (Freud & Breuer, 1895, p. 282).

But Freud also recognized that explaining the nature of his patients' resistance to them typically did not suffice. Having clarified it, he describes how he had to challenge them to actively overcome it. When his patients continued with their evasions, Freud describes how he would "remain unshakably firm. I avoid entering into any of these distinctions [rationalizations, ed.] but explain to the patient that they are only forms of his resistance and pretexts raised by it against reproducing this particular memory, which we must recognize in spite of all this" (Freud & Breuer, 1895, p. 280). In cases such as that of his patient Elizabeth von R., Freud would proceed to confront the patient directly with her responsibility for relinquishing her resistance and the consequences of not doing so: "Finally I declared that I knew very well that something *had* occurred to her and that she was concealing it from me, but she would never be free of her pains so long as she concealed anything" (Freud & Breuer, 1895, p. 154).

Freud found that if pressure and challenge were sustained in this manner, the patient's resistance would eventually be overcome, leading the patient to recall hitherto repressed material. The result, Freud noted, "may be compared with the unlocking of a locked door, after which opening it by turning the handle offers no further difficulty" (Freud & Breuer, 1895, p. 283).

Although it would take Freud almost twenty years to handle this phenomenon properly, his earliest clinical experiments allowed him to encounter a particularly tenacious form of resistance, namely *transference.* As inquiry began to close in on traumatic experiences, Freud noted that a shift would often take place in the therapeutic relationship itself. Rather than manifest as a resistance against the contents of his unconscious, the resistance would now become explicitly directed towards the therapist himself. Freud explains this phenomenon as a consequence of displacement. Rather than allow a traumatic memory that can hardly be kept out of conscious awareness any longer to be recollected, the resistance causes its contents to resurface as a present experience (Freud & Breuer, 1895, p. 302). In one of his later articles, Freud describes the signs that transference has taken place as follows:

> "No matter how amenable she [the patient, ed.] has been up till then, she suddenly loses all understanding of the treatment and all interest in it ... There is a complete change of scene; it is as though some piece of make-believe had been stopped by the sudden irruption of reality – as when, for instance, a cry of fire is raised during a theatrical performance. ... Moreover, this change quite regularly occurs precisely at the point of time when one is having to try to bring her to admit or remember some particularly distressing and heavily repressed piece of her life-history." (Freud, 1915, p. 162)

In his early career, Freud found transference to be a significant obstacle to treatment and the peak of the mobilization of the patient's resistance. In keeping with his principle of utilizing the manifestations of the patient's resistance against itself, however, Freud would soon begin to see the transference as an important opportunity for overcoming the pathogenic force in the patient. In Freud's words, a retreat at this point would amount to "summoning up a spirit from the underworld by cunning spells, [only to, ed.] ... send him down again without having asked him a single question" (Freud, 1915, p. 164). In his writings from the 1910s, Freud came to suggest that the resistance should be *allowed* to manifest fully in the form of transference in order for it to be overcome and for therapeutic ground to be gained since "when all is said and done, it is impossible to destroy anyone *in absentia* or *in effigie*" (Freud, 1912b, p. 108). From the viewpoint of his mature metapsychology, which we will elaborate on shortly, Freud writes:

> "Only when the resistance is at its height can the analyst, working in common with his patient, discover the repressed instinctual impulses which are feeding the resistance; and it is this kind of experience which convinces the patient of the existence and power of such impulses. ... it is a part of the work which effects the greatest changes in the patient and which distinguishes analytic treatment from any kind of treatment by suggestion." (Freud, 1914, p. 115)

The 1900's: Exploration and experimentation

During the 1890s, Freud published several articles on his early research and technique, culminating in 1895 with the publication of his first book, *Studies on Hysteria,* written together with Breuer. In the years after, Freud refined his technique of deciphering the formations of the unconscious, especially parapraxes, dreams, and jokes, and published three major works on these matters around the year 1900. By the turn of the 20th century, however, the psychoanalytic movement counted only a handful of dedicated followers. The small "Wednesday Psychological Society," founded in 1902, was named after the weekday on which it would adjourn at Freud's apartment in Vienna. Initially, the group consisted of Freud and a few other medical professionals – Wilhelm Stekel, Max Kahane, Rudolf Reitler, and Alfred Adler, increasing to 17 members within its first five years of existence. Of this germinal form of the psychoanalytic movement, psychiatric historian George Makari writes:

> "The Wednesday Society housed men of varying interests. Some were attracted to the French Freud of 1895 who studied hysteria and used psychical treatments; among them were those who were skeptical of Freud's later ideas, his psychosexual synthesis in particular. Others, fascinated by the dream book and the interpretative method it offered for myth and literature, had little interest in the requirements of scientific epistemology. Others still yearned for social and sexual reform but were less invested in clinical psychology. In short, Freud lured people interested in the very fields he had plundered. These Society members mixed and matched their Freud with a conglomeration of their own ideas on dynamic psychology, degeneration theory, brain science, and sexology." (Makari, 2008, p. 174)

All members shared the spirit of Freud's psychoanalysis, but what they made of it was, at this point, largely up to themselves. Thus, when Max Eitington visited the Wednesday Society in 1907 to inquire into the potential outcomes of psychoanalytic treatment, he left empty-handed. The degree of theoretical heterogeneity that reigned in the group rendered any consensus on the most fundamental questions about the therapeutic practice of psychoanalysis impossible to extract. To make matters worse, Freud himself appeared to tolerate this situation with undisturbed equanimity. Similarly, when the young Otto Rank joined the Society in 1906 and presented his theory of sexuality in the arts, he was widely criticized by the other members of the Society for being "too Freudian" in his views (Makari, 2008, p. 166).

This phase of theoretical heterogeneity within the psychoanalytic movement may appear to contrast strikingly with the dogmatism of its mature years. The reader should keep in mind, however, that in the first decade of the 21st century, only a few of the Society's members actually practiced psychoanalysis. As such, Freud was still the undisputed authority on therapeutic matters, as well as on the empirical side of his creation. As the examples of Stekel and Adler would soon reveal, any serious dispute over Freud's clinical authority would indeed not be tolerated.

In 1908, the first psychoanalytic congress was held in Salzburg with 40 participants, only 12 of which came from outside the two existing centers for Freudian psychology – Vienna, where Freud reigned, and Zürich where Carl Jung and Eugen Bleuler had recently formed their alliance with Freud. The group named itself "The Psychoanalytic Society," beckoning in the more authoritative status it would come to carry in the years ahead. This intentional change of image was not coincidental. Towards the 1910s, psychoanalysis had begun to attract increased interest at home in Vienna, as well as internationally. By the middle of the '00s, Freud's major works, *The Interpretation of Dreams* and *Studies on Hysteria*, published in 1895 and 1900, had not even sold out their first printing of around 600 copies each. Suddenly, towards 1910, they began to sell out, and second editions had to be printed. With this increased attention came an increased need for definition and coherence, which would define the psychoanalytic movement's development in the 1910s.

The 1910's: Psychoanalysis comes of age

By 1910, only a handful of clinicians were trained in the craft of psychoanalysis, let alone authorized by Freud to practice. Following the increasing popularity of Freud's ideas, however, this did not stop physicians and laypeople alike, without affiliation to Freud, from citing the Professor's discoveries as the basis for all sorts of intellectual sophistry and, more gravely, clinical intervention. The time had come, therefore, to clean up the practice of "wild psychoanalysis" which threatened to discredit the name of the movement in serious scientific circles. At 1910's second International Psychoanalytic Congress in Nuremberg, Freud declared that the psychoanalytic movement would have to strive towards uniformity in both methods and training.

Taking yet another step towards becoming an authoritative entity, Freud also went on to announce the foundation of The International Psychoanalytic Association (IPA), with Carl Jung as the first president. The Association was intended

to safeguard the true spirit of the Freudian movement. For this reason, membership was limited to only those clearly committed to Freud's inaugural vision. In particular, new members had to be thoroughly familiar with and explicitly faithful to Freud's psychosexual theory of neurosis, which at this point had become solidly centered around the theory of the Oedipus Complex. These increased demands, however, did not deter interest in the IPA, and the psychoanalytic movement grew faster than ever before. By the next congress in 1911, the IPA had 106 members, with branches in Berlin, Munich, and New York, as well as its well-established centers in Vienna and Zürich.

By the time it was founded, however, the Association was already torn within its own ranks. In 1911, Adler resigned and formed his own movement, which he called "Individual Psychology." In 1912, Stekel followed Adler's example, and in 1914, it was Jung's turn to resign from his presidency and establish his model of "Analytical Psychology." The strong characters of the early pioneers of the psychoanalytic movement had begun threatening to pull the direction of the psychoanalytic movement out of Freud's hands. Alongside the naturally growing divisions within, the Freudian cause was also, by this time, receiving plenty of attacks from without. The psychoanalytic movement itself often portrays this early opposition to psychoanalysis as a byproduct of the prudish self-deception of Victorian-era asceticism (e.g., Jones 1955, p. 109). The perspectives on this opposition by authors such as Henri Ellenberger (1970) and Borch-Jacobsen & Shamdasani (2012), however, paint an entirely different picture. These authors suggest that the more significant backlash came from within the medical profession, rejecting psychoanalysis as undisciplined, unoriginal, and sectarian in a rigid adherence to what was conceived of, often rightfully so, as quasi-philosophical principles. It soon became clear that the psychoanalytic movement needed to consolidate itself further to protect its scientific reputation. Thus, as a consequence of pressure from both within and without, the "traditional" form of psychoanalytic therapy, as known today, was laid down during the 1910s.

In the next issue

In this article, I have traced an outline of the early development of Sigmund Freud's psychoanalytic technique. In article 2, we will turn to the early years of the psychoanalytic movement and Freud's mature technique. In article 3, the main ideas and technical developments of the pioneers of short-term and active psychodynamic psychotherapy will be reviewed. Finally, in the fourth article, we will examine the new generation of short-term dynamic psychotherapists that surrounded Davanloo during the time he developed his model of ISTDP.

Footnotes

[1] In psychoanalytic terms, Otto Fenichel defines neurosis thus: "The normal and rational way of handling the demands of the external world as well as the impulses from within is substituted by some irrational phenomenon which seems strange and cannot be voluntarily controlled" (Fenichel, 1945, p. 18). This dysfunction is caused when one mental tendency striving for discharge is obstructed by another, which has turned against it (Fenichel, 1945, p. 129). Franz Alexander offers a similar definition: "In neurosis the central coordinating core of the organism, the ego, is disturbed. The ego is that part of the organism which assumes the task of harmoniously gratifying our needs and desires. The ego must reckon with different desires and interests and accepted standards and must compromise and muddle through by giving as much satisfaction as possible to each, even when they are in conflict among themselves or with the environment. Whenever the ego proves incapable of performing this task, we speak of a failure of its governing and coordinating function. This is the essence of a neurosis" (Alexander, 1948, p. 194). Also, the cause of this dysfunction can be described in dynamic terms. In Alexander's words, "The meaning of every neurosis consists in an attempt to cling to an instinctual satisfaction which has been condemned by conscience" (Alexander, 1929, p. 91). In terms of the notion of psychosexual development to be presented later in this chapter, Ferenczi and Rank propose that: "The neurosis is characterized by the projection into the phase of maturity [i.e., the present], of the first, from its very nature incomplete and also incompletely overcome, phase of sexual development and repression [i.e., the past]" (Ferenczi & Rank 1923, 18). It should be noted that Freud's "neurotic" patients, such as Anna O who was treated with purely psychotherapeutic means, were by no standards mild cases. Zetzel and Meissner note how they "impress most contemporary psychiatrists, however, as at best borderline, if not actually psychotic" (Zetzel & Meissner, 1973, p. 15).

[2] Having induced her into a hypnotic state, Freud "wiped out" certain memories of unpleasant experiences underlying the symptoms of his patient Emmy von N. This supposedly caused these symptoms to disappear (Freud & Breuer, 1895, p. 59). In a similar fashion, Freud, at another point, commanded the same patient's menstrual cycle to follow a 28-day interval (Freud & Breuer, 1895, p. 57)

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