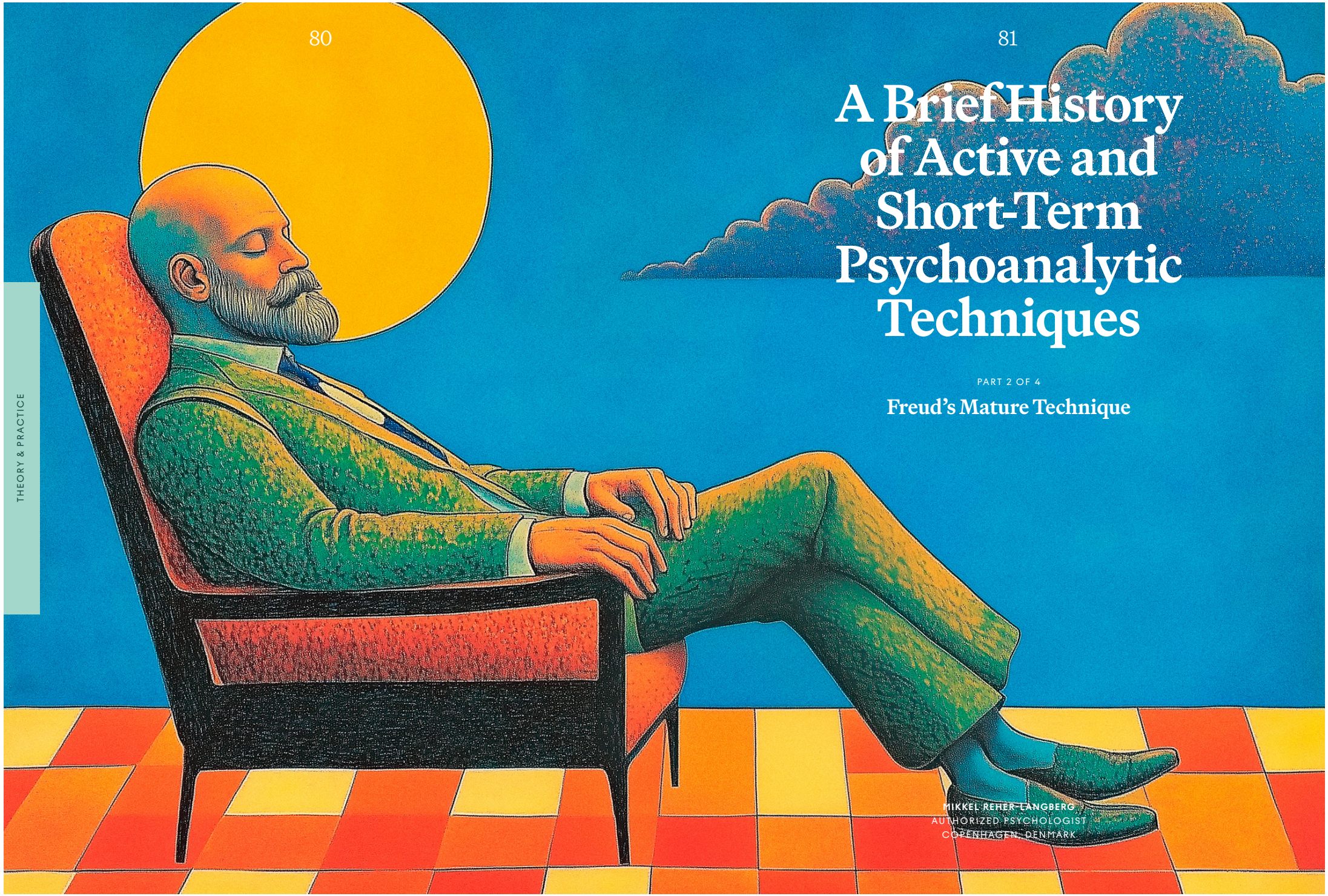
A Brief History of Active and Short-Term Psychoanalytic Techniques

PART 2 OF 4

Freud's Mature Technique



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Abstract: In this article, the author presents an overview of key aspects of Sigmund Freud's mature psychoanalytic technique: Its extent and physical setup, the use of free association, evenly suspended attention and therapeutic neutrality, the use of interpretation to bring about insight, and its approach to the transference. Lastly, the author draws parallels between Freud's technique and Davanloo's technique of ISTDP. This forms the basis for the next installment in this series of articles, in which the author will survey the history of the psychoanalytic movement during the 1920s, 30s, and 40s and the short-term and active modifications of Freud's psychoanalytic technique that were developed during this period.

Introduction

In part one of this four-part series, we saw how, as early as 1895, Freud's clinical experiments had allowed him to establish the basic building blocks of his psychoanalytic method of treatment. Its fundamental tenets can be shaved down to the following: Neurotic symptoms are caused by unconscious reminiscences of traumatic experiences. These experiences were rendered traumatic in the patient's past due to the strong distressing affects they caused, which the patient felt incapable of containing. Since reminiscences of these experiences threaten to evoke similar distressing affects, these reminiscences are pushed out of conscious awareness, i.e., "repressed," by mechanisms of defense. When this happens, the affective charge of said reminiscences is displaced into neurotic symptoms. The therapeutic procedure required to treat this condition reverses this original process: The therapist applies pressure on the patient to recall the experiences that caused his symptoms. This pressure activates resistance, which represents the mechanisms of defense upon which the patient's neurotic condition rests. The patient's resistance is clarified to him and challenged by the therapist, leading to its deactivation. This "unlocks" the patient's unconscious, allowing its contents to be recalled and talked through. If the patient is able and willing to endure the affects associated with his painful recollections, they will be integrated into his conscious understanding of himself and his past and stop causing neurotic symptoms.

The present article will review the form Freud's technique took during the 1910s. This technique has come to be viewed as the "classical" psychoanalytic technique. It is upon the basis of this technique that the early active- and short-term forms of psychoanalysis would be developed by Freud's colleagues during the 1920s, 30s, and 40s – developments that will be the subject of the next part in this series.

Freud's technique in the 1910s

In response to the pressures discussed previously, Freud published a handful of papers that have come to be known as his "papers on technique": *The Handling of Dream-Interpretation In Psycho-Analysis* (1911), *The Dynamics of Transference* (1912), *Recommendations to Physicians Practicing Psycho-Analysis* (1912), *On Beginning the Treatment* (1913), *Remembering, Repeating and Working Through* (1914), and *Observations on Transference-Love* (1915). In them, he presents a form of psychoanalytic technique that has matured significantly since his early publications in the 1890s.

Before these articles were published, Freud's mature psychoanalytic technique was largely passed on directly by Freud to his analysands. Even throughout the 1910s, psychoanalytic technique continued to be largely synonymous with Freud's technique since only very few expositions of it were published by other authors. Notable exceptions are Ferenczi's article on *Introjection and Transference* of 1909, Hitschmann's *Freud's Theories of the Neuroses* of 1913, and Stekel's *Conditions of Nervous Anxiety and Their Treatment,* published around the same time. W.A. White and Jelliffe's *The Modern Treatment of Nervous and Mental Diseases* of 1913, the latter's *The Technique of Psychoanalysis* of 1918, and Oskar Pfister's *The Psychoanalytic Method* of 1917 are other notable, though less authoritative and often criticized, works on the same topic.

Freud's Mature Technique

It has been credibly argued by Samuel D. Lipton (1977) that Freud's technique remained relatively stable throughout his career after having reached its point of maturity as early as 1907, as showcased in his analysis of the "Rat Man." Interestingly, however, one finds very few technical prescriptions in Freud's writings after the 1890s, when his early technique took shape. Even Freud's "papers on technique" contain none of the kind of technical instructions that the ISTDP therapist of today would expect. At best, these writings contain a handful of "recommendations" scattered among instructive metapsychological considerations. Before looking closer at what can be divulged from the few available documents about Freud's mature technique, it is relevant to consider the implications of this rather striking omission of clear instruction.

First of all, Freud's reluctance to be concrete with respect to clinical technique makes it clear that Freud the clinician was never a "Freudian" (Momigliano, 1992). Freud appears to have considered psychoanalytic practice a *craft* rather than a technique. This craft was to be acquired through a combination of insight into the psychological discoveries of psychoanalysis and the sophistication of the therapist's own character through self-analysis and the cultivation of empathy. Freud writes: "no psycho-analyst goes further than his own complexes and internal resistances permit; and we consequently require that he shall begin his activity with a self-analysis and continually carry it deeper while he is making his observations on his patients. Anyone who fails to produce results in a self-analysis of this kind may at once give up any idea of being able to treat patients by analysis" (Freud, 1910, p. 145).

Secondly, we find it a testament to the fact that Freud himself was never methodologically dogmatic but tended to approve of any practice he found to be in keeping with the spirit of his discoveries. This is apparent in his official defense of methodological "heretics" such as Sandor Ferenczi and Wilhelm Reich against the psychoanalytic traditionalists of their time. In a letter sent to Ferenczi around a decade after the publica-

tion of his first handful of technical papers, Freud lamented how "the docile analysts did not perceive the elasticity of the rules I had laid down, and submitted to them as if they were taboos" (Freud in Lohser & Newton, 1996, p. 15). We do not believe that Freud ever intended to lay down such a thing as a "standard procedure" to be rigidly followed. Indeed, Freud himself went so far as to suggest that his few technical recommendations ought really to be unnecessary as long as the therapist approaches the patient tactfully, i.e., with sophisticated empathy (cf. Ferenczi, 1928). Why, one might ask, was Freud then not more explicit about his skepticism towards a technification of his psychoanalytic procedure? Part of the answer may be found in another one of his letters to Ferenczi, whom Freud considered to be among the few people who truly mastered the craft of psychoanalysis. Freud writes: "All those who have no tact will see in [a rejection of technification, ed.] a justification for arbitrariness, i.e. subjectivity, i.e. the influence of their own unmastered complexes" (Freud in Roazen, 1975, p. 119). Knowing how much attention was paid to Freud's every word – as indeed this article attests to – one can understand how difficult it must have been for Freud to express the free spirit of his therapeutic method in technical terms. Instead, he opted to *show* it by publishing some of his most complex cases that taught him something about the practice of psychoanalysis.

In the following pages, I will outline a handful of central aspects of Freud's practice after 1895 that can be deduced from his own writings, as well as from scholarly commentaries on it. As the reader will note, however, Freud's mature "technique" consisted not so much of a cut-and-dried procedure. It is better understood as a method resting upon an array of basic principles, allowing for considerable procedural freedom - principles that also form the basis for Davanloo's ISTDP.

Extent of Treatment

A review of Freud's caseload during the period from 1910 to 1920 done by Ulrike May (2008) reveals that Freud saw patients for rather short but intensive courses of therapy. The majority of his treatments would last for about half a year, with six to twelve (!) weekly sessions of approximately an hour's duration. Often, these treatments were spread out over several periods, each lasting about a few months. Freud's stance developed over time with respect to the length of his treatments. In 1904, he argued that a duration of six months to three years was necessary to bring about solid improvements (Freud, 1904, p. 254). By the 1920s, Freud had found analyses of four to six months' duration desirable and adequate (May, 2008, p. 79). Still, Freud found that his longer analyses were of greater scientific value. Perhaps for this reason, the analyses he chose to publish from the 1910s were also among his longest, such as the case of the Wolf Man, whose treatment lasted a total of 40 months and approximately 1100 sessions (May, 2008, p. 49). The conclusion that can be drawn from this is that Freud, by today's standards, conducted short-term therapy, even if his published cases would seem to indicate the opposite.

Physical Setup

In the 1890s, Freud's therapy was conducted in a somewhat vigorous manner characterized by the application of pressure on the patient. In keeping with this practice, his physical setup was one in which the patient and therapist sat facing each other. By the beginning of the 1900s, his sessions' pace and physical setup had changed significantly. Freud describes his new setting as follows: "Without exerting any other kind of influence, he [the therapist, ed.] invites them [the patient, ed.] to lie down in a comfortable attitude on a sofa, while he himself sits on a chair behind them outside their field of vision. He does not even ask them to close their eyes and avoids touching them in any way, as well as any other procedure that might be reminiscent of hypnosis. The session thus proceeds like a conversation between two people equally awake, but one of whom is spared every muscular exertion and every distracting sensory impression which might divert his attention from his own mental activity" (Freud, 1904, p. 250). This new setup was developed to support his new technique of free association, which we will return to shortly, but Freud also had other reasons for preferring it, some of which are less scientific in nature. Freud simply came to find his early procedure of applying incessant pressure on the patient "inexorable and exhausting" (Freud, 1910, p. 141). Furthermore, he simply could not "put up with being stared at by other people for eight hours a day (or more)" (Freud, 1913, p. 134), and so the new setting allowed Freud to endure his long working hours that were typically followed by meetings and extensive writing – the standard edition of Freud's psychoanalytic writings span no less than 23 volumes.

Free Association

From his relaxed position, Freud now invited the patient to relate the details of his presenting problems and their history, following just one "fundamental rule," which has come to be known as the "rule of free association." In an influential article, Freud suggests a way of introducing this fundamental rule to patients, which has become paradigmatic to the point that even to this day, analysts still introduce it in the same terms:

> "One more thing before you start. What you tell me must differ in one respect from an ordinary conversation. Ordinarily you rightly try to keep a connecting thread running through your remarks and you exclude any intrusive ideas that may occur to you and any side-issues, so as not to wander too far from the point. But in this case you must proceed differently. You will notice that as you relate things various thoughts will occur to you which you would like to put aside on the ground of certain criticisms and objections. You will be tempted to say to yourself that this or that is irrelevant here, or is quite unimportant, or nonsensical, so that there is no need to say it. You must never give in to these criticisms, but must say it in spite of them – indeed, you must say it precisely *because* you feel an aversion to doing so. Later on you will find out and learn to understand the reason for this injunction, which is really the only one you have to follow. So say whatever goes through your mind. Act as though, for instance, you were a traveller sitting next to the window of a railway carriage and describing to someone inside the carriage the changing views which you see outside. Finally, never forget that you have promised to be absolutely honest, and never leave anything out because, for some reason or other, it is unpleasant to tell it." (Freud, 1913, p. 134-135)

This procedure was based on Freud's finding that active thinking and goal-directed concentration on the part of the patient tended not to solve the riddles of his neurosis. This, he suggested, can only be achieved if the patient obeys

> "the psycho-analytic rule, which enjoins the exclusion of all criticism of the unconscious or of its derivatives. One must be especially unyielding about obedience to that rule with patients who practice the art of veering off into intellectual discussion during their treatment, who speculate a great deal and often very wisely about their condition and in that way avoid doing anything to overcome it." (Freud, 1912, p. 119)

Read too literally, Freud's invitation to say everything that comes to mind can easily lead to a robotic form of automatic speech, which is as far removed from the kind of engagement Freud intended as was the active censorship he wished to counteract. In this vein, it has been argued that the "fundamental rule" upon which Freud's mature method rested is really to be understood as a commitment to absolute honesty (Thompson, 2004, p. 2). This reading echoes another dictum found in Freud's writings, namely that "psycho-analytic treatment is founded on truthfulness. In this fact lies a great part of its educative effect and its ethical value ... we demand strict truthfulness from our patients" (Freud, 1915, p. 164).

The patient's commitment to honesty about his immediate inner experience forms the basis for the psychoanalytic endeavor, which Freud understood as a process of psychic maturation. Free association is not a procedure to be followed compliantly and mechanically but a way for the patient to act on his intention to be completely honest with himself and his analyst. Properly understood, it is, as put by Michael Guy Thompson, "an act of revelation by which the inner recesses of one's being are bared to another person. Hence, acts of self-disclosure serve to change the people who perform them because they alter the situation in which patients share their confidences" (Thompson, 2004, p. 28). As a practice of honesty, free association becomes an act of confiding and thus of attaching to, as opposed to detaching from, the therapist. Speaking one's mind with a commitment to complete honesty is not merely a means of amassing information. Rather, the very act of honestly confiding in the therapist constitutes a step towards agency, integrity, insight, and, finally, emotional health. In the terminology of ISTDP, Freud's fundamental rule can be understood as an injunction to seek emotional closeness with the therapist.

Evenly Suspended Attention and Therapeutic Neutrality

Insofar as the patient accepts the fundamental rule, it is assumed that his speech and behavior in the session eventually begin to include material related to his unconscious, which can then be identified by the therapist and brought to the patient's attention. To recognize these unconscious elements, the therapist must remain completely open to the unique aspects of the patient's way of expressing himself. Freud called this attitude of openness "evenly suspended attention" (Freud, 1912, p. 111). In this mode of attending to the patient, the therapist gives equal notice to everything the patient says and does during the session, taking everything as potentially important information about the patient's unconscious. It is said that the devil is in the details, and Freud soon recognized how expressions that may at first seem innocuous, such as recurring figures of speech, repeated facial expressions, or a characteristic smile, often have deep roots in the patient's unconscious. They may be the tip of the iceberg of the patient's unconscious, and if left unnoticed, the therapist may struggle to find openings into the unconscious layers of the patient's inner life.

Evenly suspended attention also involves a measure of what Paul Ricoeur (1970) has termed *suspicion* towards the patient's presentation of himself. Importantly, however, "suspicion" should not be understood as a skepticism towards the patient and his motives but as an openness to multiple levels of meaning in the patient's expressions. Since the patient suffers from neurosis, he is inevitably split into a manifest conscious personality and a deeper unconscious one, which remains hidden so long as the former is taken at face value. The therapist, therefore, remains curious, not only as to who the patient presents himself as being but also as to why he might want to present himself in this way and what deeper aspects of his personality this presentation may obscure.

In a central article, Freud describes this position by means of a metaphor: "The doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him." (Freud, 1912, p. 118). Like the metaphor of the railway carriage, that of the "opaque mirror" is easily misunderstood if it is read as a technical procedure to be reproduced

rather than an attitude to be embodied. Read literally, it would seem that Freud requires the therapist to remain detached from his patient and do nothing but describe the patient's behavior to him. This, however, is too far removed from Freud's actual practice to be a correct interpretation. The attitude Freud consistently calls for is one of *Einfühlung*; a "feeling into" or empathic attunement with the patient. We suggest that Freud's metaphor of the mirror should be understood in conjunction with another suggestion made by Freud, namely that the therapist must

> "turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient ... Just as the receiver converts back into soundwaves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which was determined in the patient's free associations." (Freud, 1912, p. 115)

In his descriptions of evenly suspended attention, Freud also introduces another important aspect of the therapist's attitude in the therapeutic encounter, which has come to be known as the principle of therapeutic "neutrality." As usual, Freud describes this attitude through a metaphor, namely that of the surgeon. Freud writes:

> "I cannot advise my colleagues too urgently to model themselves during psycho-analytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental forces on the single aim of performing the operation as skillfully as possible. Under present-day conditions the feeling that is most dangerous to a psycho-analyst is the therapeutic ambition to achieve by this novel and much disputed method something that will produce a convincing effect upon other people. This will not only put him into a state of mind which is unfavorable for his work, but will make him helpless against certain resistances of the patient, whose recovery, as we know, primarily depends on the interplay of forces in him." (Freud, 1912, p. 115)

The metaphor of the surgeon has tended to be interpreted as an incursion to refrain from wanting anything on behalf of the patient. Just as the surgeon's only task is to operate, the analyst's only task is to analyze – the rest is up to God. Wilfred Bion expresses this attitude aptly in a comment to one of his supervisees:

> "With this patient you can feel that he wants, or ought, to get back to work, and that it is a serious business that he is absent. But the analyst has to be ruthless; he has to resist the pressure because his business is not whether somebody gets back to work or not, but that somebody be given the correct analysis. While you try to listen to the patient, he keeps trying to shove you – "But doctor, I've got to go back to work", "I've got to do this", or, "I've got to do the other". All that has something to do with his life, but nothing to do with the analysis. If a surgeon is operating he cannot tolerate a great noise in the theatre; he cannot have people talking; there has to be a discipline so that he can concentrate on the particular job." (Bion, 1978, p. 16)

In American psychoanalysis, therapeutic neutrality has become conceptualized as a position of "equidistance" from the agencies of ego, id, and superego, which keeps the therapist from "crusading for or against" any of them (Schafer, 1983). But some analysts have tended to take therapeutic neutrality a step further, as calling for a relinquishing of any therapeutic ambitions on behalf of the patient. The ensuing attitude of aloof impartiality is aptly captured in Ralph Greenson's manual of psychoanalytic technique:

> "It is important to realize that the way the classical psychoanalyst handles the relationship between the patient and himself is both unique and artificial and runs counter to the way human beings usually relate to one another. It is a tilted and uneven relationship in that the patient is expected to let himself feel and express all of his innermost emotions, impulses, and fantasies while the analyst remains a relatively anonymous figure." (Greenson 1967, p. 278)

While the position described by Greenson surely has its benefits, other authors have argued that its "artificiality" is not in accordance with Freud's practice (Lohser & Newton, 1996; Thompson, 2004). If Freud's therapeutic position – as it is apparent from his cases, letters, and reports provided by his patients – is to be characterized as "neutral," it is by virtue of its receptiveness to the truth of the patient's experience. Although Freud's therapeutic style has been described as "impersonal" (Rieff, 1965, p. 12), he never seems to have lived up to the stereotype of the detached observer described by Greenson. Instead, Freud appears to have striven to embody an attitude of "sympathetic understanding" (Freud, 1913, p. 140) and to have met his patients in accordance with a dictum later formulated by Roy Schafer that the therapeutic encounter should always allow room for "courtesy, cordiality, gentleness, sincere empathic participation and comment, and other personal, although not socially intimate, modes of relationship" (Schafer, 1983, p. 32). For Freud, who famously invited his patient "The Rat Man" home for tea and kippers and sent him postcards while on holiday, the notion of therapeutic "neutrality" clearly still allowed

ample space for the "real" aspects of the relationship between patient and therapist. How, then, is Freud's version of therapeutic neutrality to be understood?

In Freud's original German, the word translated as "neutrality" is *indifferenz*, which, strictly speaking, means *indifference*. Its translation into "neutrality" is unfortunate since it is easily understood as designating an attitude towards the patient. The "indifference" called for by Freud, however, instructs the therapist about how he should relate towards *himself* – and specifically towards whatever motives he himself might have for wanting his patient to change. Read in this way, therapeutic neutrality does not conflict with Freud's attitude of empathic "feeling into" the patient. On the contrary, by arming himself with the appropriate measure of indifference towards his own needs in the session, the therapist can dedicate his attention all the better to the patient in front of him. Much as a botanist respects the uniqueness of a rare and precious specimen, the therapist must meet the patient's commitment to honesty with a complementary commitment to respecting the uniqueness and dignity of his patient as he is. If the therapist should set aside his own feelings, this is not a means of detaching from the patient but a way of preserving his ability to "feel into" the patient by not allowing his practice to be shaped by his own needs for success, prestige, or praise.

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Freud seems to have taken the therapist's respect, interest, and empathy for his patients as a matter of course, and even to the degree where he is easily, and quite absurdly, misread as calling for their opposites – skepticism, detachment, and emotional coldness. As argued earlier, one must read Freud's technical papers with consideration for the historical situation that called for their publication. By 1911, when the first of his technical papers appeared in print, psychoanalytic practice had come under pressure from the surrounding medical community. Due to the lack of official technical guidelines, unqualified doctors and even laypeople had begun conducting their own experimental psychoanalytic "cures" on patients, evoking Freud's name to justify their practices (Gay, 1988, p. 295). Even within the psychoanalytic community, certain types of practices, which in Freud's view reflected the neurotic tendencies of his followers more so than the tenets of his discoveries, were beginning to spread (Roazen, 1975, p. 117). Viewed in this light, the surgeon metaphor can be understood as Freud's attempt to curb the self-deceptive ambitiousness of these "wild analysts" (Freud, 1910b) as well as that of dissidents within the psychoanalytic community itself.

Freud's principles of evenly suspended attention and therapeutic neutrality reflect an important change in his technique compared to his early approach to psychoanalytic treatment. Whereas Freud's procedure in the 1890s was highly focused on specific contents, his mature technique was defined by a sophisticated *lack* of focus. In his technical papers, Freud describes how said principles assist the analyst in giving up "the attempt to bring a particular moment or problem into focus. He contents himself with studying whatever is present for the time being on the surface of the patient's mind, and he employs the art of interpretation mainly for the purpose of recognizing the resistances which appear there and making them conscious to the patient" (Freud, 1914, p. 147).

Despite their differences, Freud's mature technique of evenly suspended attention and his early technique of pressure can be understood as different means to the same end, namely supporting the patient's commitment to honesty. In his early technique, Freud would incessantly urge the patient to be honest in a way that inevitably compensated for the patient's resistance against it. In his mature technique, Freud let go of his tendency to battle with the resistance in order instead to mirror it back to the patient and interpret his motives for diverging from his commitment to the truth. In this way, Freud was able to utilize the patient's resistance as a means of propelling the process further towards their unconscious in a manner that kept the responsibility for overcoming it in the hands of the patient. Freud's mature technique can therefore be understood as a refinement of his early technique that remained in accordance with its essence, albeit radically different in form.

Interpretation and Insight

Like his technique in the 1890s, Freud's mature technique relied on keen attention to the inconsistencies and gaps in the patient's presentation of himself. These were assumed by Freud to reveal the "seams" at which the patient's conscious and unconscious realities were sewn together. In his early technique, these seams were taken apart by means of pressure. In his mature technique, this was done by means of *interpretation*.

In Freud's practice, interpretation consisted of *suggesting* to the patient what material might reside in these gaps. If he was right, his suggestions established a cognitive bridge that allowed the patient to recognize unconscious aspects of himself that were already making their way toward conscious awareness.

For interpretations to have an impact on the patient, Freud found that they had to be given just as the patient had only "one short step more to make in order to get hold of the explanation for himself" (Freud, 1913, p. 140). Attempting to interpret unconscious contents that had not yet come into close proximity of the patient's consciousness, however, had as much effect on his symptoms "as a distribution of menu-cards in a time of famine has upon hunger" (Freud, 1910b, p. 225). The difference between a correctly and incorrectly timed interpretation is that the former causes an *experience* on the part of the patient, whereas the latter causes only a cognitive form of knowledge. The psychoanalytic term for the former type of experiential knowledge of something previously unrecognized is *insight.* Applied correctly, interpretation is, therefore, not a way of explaining something to the patient but of revealing it.

The distinction between cognitive knowledge and insight is important since the purpose of psychodynamic psychotherapy is to bring about changes in the patient's way of experiencing himself and others. Cognitive knowledge rarely changes that of which it knows. For instance, a patient's recognition that he "had a bad childhood" typically does not change the impact of this childhood on his psyche, such as by alleviating his symptoms. Freud (1910b) suggested that cognitive knowledge resides on a different mental level than experiential knowledge, which is touched only by insight. This paradoxical independence of opposed truths residing at different levels of the mind is well illustrated in a joke popularized by Slavoj Žižek (2014, p. 67):

> "... a man who believes himself to be a kernel of grain is taken to a mental institution where the doctors do their best to convince him that he is not a kernel of grain but a man; however, when he is cured (convinced that he is not a kernel of grain but a man) and allowed to leave the hospital, he immediately comes back, trembling and very scared—there is a chicken outside the door, and he is afraid it will eat him. "My dear fellow," says his doctor, "you know very well that you are not a kernel of grain but a man." "Of course I know," replies the patient, "but does the chicken?"

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Surface-level knowledge, such as this patient's conscious recognition that he is not really a kernel of grain, is easy to influence but changes little in terms of the patient's actual experience of himself and the world around him. Indeed, surface-level knowledge may serve to stabilize the patient's conscious self-image in such a way that he becomes even more entrenched in his neurosis. Or it may allow the patient to live with his underlying pathological experience in such a way that he loses motivation to get to the bottom of it. Lacanian psychoanalyst Bruce Fink makes this point succinctly when he writes:

> "Analysis need not provide meaning: for meaning is something the ego recrystallizes around, the ego using meaning to construct a story about who one is and why one does what one does. In a word, meaning serves the purpose of *rationalization*, which keeps the unconscious at bay. An emphasis by the analyst on meaning and understanding often leads the analysand to become very adept at finding psychological explanations of his behavior but does little or nothing to foster change in the analysand, thoroughgoing change such that he is no longer even tempted to feel or act as he has in the past. Part of the analyst's job is to take meaning apart, to undermine understanding by showing that far from explaining everything, it is always partial, not total, and leaves many things out. Just as the Zen master's work is premised on the notion that enlightenment does not stem from understanding but rather is a state of being." (Fink, 2010, p. 262)

Insight, on the other hand, is defined by the way in which it changes the object into which it sees. It is to be understood as an *act of seeing into* the nature of an experience and thereby altering it at its own level. The reader may intuitively grasp what this kind of "seeing into" feels like by recalling his own experience of waking from a dream and realizing: "Oh, it was just a dream!" Insight is also what happens when one suddenly finds the solution to a mathematical problem, and the formerly random numbers on a page come together in a comprehensible pattern. The same shift is felt when one recognizes the language spoken by a person and, in that same instant, understands what was just said. While the "objective" nature of the numbers, words, or the dream in question remains the same before and after this insight, their subjective significance has changed fundamentally.

In order to bring about insight rather than surface-level knowledge, interpretation must address the aspects of the patient's unconscious that are experientially available to him at any given moment. For this reason, psychoanalysts prioritize interpreting the aspects of the patient's unconscious that have already come alive within the therapeutic relationship, i.e., that have been "transferred" into this relationship.

Transference

In Freud's earliest conceptualization of the unconscious, *memories* of traumatic events were thought to lie at the heart of the unconscious. Freud eventually revised this notion. Instead of memories, Freud discovered that the unconscious consists of impulses to do something to or with someone. It is at this point that the notion of *transference* of these impulses from the past and into the present becomes a central concern for Freud.

Many definitions of transference can be found in Freud's writings. The simplest and most fundamental definition is arguably the one offered in *Interpretation of Dreams*:

> "an unconscious idea [ie. an unconscious *wish*, ed.] is as such quite incapable of entering the preconscious and ... it can only exercise any effect there by establishing a connection with an idea which already belongs to the preconscious, by transferring its intensity on to it and by getting itself "covered" by it" (Freud, 1900, p. 562)

Unconscious wishes stemming from past relationships make themselves felt by transposing themselves onto persons in the patient's present life. These present-day figures now become invested with unconscious emotional significance, experienced by the patient as "highly concrete emotional needs directed toward the person who happens to be present" (Fenichel, 1945, p. 29). It is important to recognize that Freud's notion of transference is, in this respect, quite restricted. It does not designate any and all repetitions of past attitudes in the present, but specifically the resurfacing of repressed impulses towards new persons:

> "It seems important to distinguish between the general tendency to repeat past relationships in the present (e.g. as can be observed in persisting character traits such as 'demandingness,' 'provocativeness,' 'intolerance of authority,' and the like) and a *process* characterized by the development of feelings and attitudes towards another person (or an institution) which represents a concentration of a past attitude or feeling, inappropriate to the present, and directed *quite specifically* towards the other person or institution. ... In this sense, transference can be regarded as *a specific illusion* which develops in regard to the other person, one which, unbeknownst to the subject, represents, in some of its features, a repetition of a relationship towards an important figure in the person's past. It should be emphasized that this is felt by the subject, not as a repetition of the past, but as strictly appropriate to the present and to the particular person involved" (Sandler, Dare & Holder 1973, p. 47)

As we have already seen, Freud's mature technique rests on the patient's compliance with the fundamental rule of honesty, enacted through free association and met by the therapist's interpretation, resulting in increasingly deep insights on the part of the patient into his inner life. According to Freud, this practice is supported by the development of what he calls an "unobjectionable transference" – a type of rapport tinged with receptivity, positive feelings, and hopes for satisfaction that were all originally directed towards early caregivers. Freud suggests that at the beginning of the treatment, the therapist must simply exhibit a serious interest and a standpoint of sympathetic understanding toward the patient in order for this type of alliance to develop and for the therapeutic process to deepen (Freud, 1913, p. 139).

But Freud also came to recognize a more malignant type of transference that turned out to be an obstacle to the thera-

peutic process itself. According to Freud, it was his treatment of the 18-year-old Ida Bauer, whom he gave the pseudonym "Dora," that caused him to seriously reflect upon this type of transference and how to address it. Bauer was treated by Freud for eleven weeks in the year 1900 until she broke off her treatment in protest against what she found to be Freud's attempts at indoctrinating her into compliance with the patriarchal norms of her time. The case itself was not published until five years later. At this point, in 1905, Freud added a postscript to the case, in which he reflected on his technique and its shortcomings. In it, Freud suggests it was Bauer's "father conflict" that lay at the root of her neurosis, but one that he failed to recognize since it was hidden in plain view in the form of transference unto himself. More specifically, he emphasizes that it was his failure to recognize the transference unto him of aggressive impulses directed initially toward Bauer's father that undermined his ability to treat her. Rather than recognize this conflict and its compulsive influence on her life, Bauer played it out by rejecting Freud, just as she had rejected her father (Freud, 1905, p. 118). Bauer may have been right in her critique of Freud, who probably was not able to recognize her transference exactly due to his identification with the societal norms heralded by his patient's father. Nevertheless, Freud's work with Dora managed to open his eyes to the ways in which the root causes of neurosis may come to be re-enacted in the relationship with the therapist in the course of treatment. From this point on, the question of how to handle the transference became one of Freud's main concerns, and most of his technical papers from the 1910s were dedicated to this topic.

In his elaborations on the transference, Freud describes how the intimacy of the psychoanalytic relationship establishes a portal into the unconscious from which not only positive longings, but all the conflicted impulses and feelings from the patient's past, can make their way into the present. When impulses resurface in the form of transference, they do so with an urge for the satisfaction they never received. Convinced of the pertinence of his transference feelings to the therapeutic situation, whether positive or negative, the patient's typical response is to conceal them. If he does so, he breaks the fundamental rule of strict honesty, and the therapeutic process will grind to a halt. For this reason, the transference itself, understood as a way in which unconscious impulses surface as urgent present needs rather than memories of past experiences, was considered by Freud to be an obstacle to treatment in its own right.

Importantly, this does not mean that the transferred contents are obstacles to treatment. On the contrary, they are the most immediately available parts of the patient's unconscious – if the transference can be tamed. If the patient finds the courage to speak openly of his transference feelings and recognize the infantile impulses that cause them, they can become objects of collaborative scrutiny and linked to experiences in the patient's past. In this way, the transference can be turned into an opportunity for the patient to take a step towards his freedom:

> "We render the compulsion [to repeat in the transference, ed.] harmless, and indeed useful, by giving it the right to assert itself in a definite field. ... The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made. The new condition has taken over all the features of the illness; but it represents an artificial illness which is at every point accessible to our intervention. It is a piece of real experience, but one which has been made possible by especially favourable conditions, and it is of a provisional nature." (Freud, 1914, p. 154)

What Freud means by allowing the patient's transferred impulses to assert themselves in "a definite field" is for the patient to express any impulse he honestly experiences in the transference, but not to the extent that it begins to envelop and warp the therapeutic relationship. In other words, transferred impulses should be re-experienced but never re-enacted. Freud's approach would, therefore, be to nip transference in the bud in order to sustain the patient's intrapsychic focus[1]. Freud describes this stance towards the transference as follows:

> "It has been the physician's endeavor to keep this transference neurosis within the narrowest limits: to force as much as possible into the channel of memory and to allow as little as possible to emerge as repetition. The ratio between what is remembered and what is reproduced varies from case to case. The physician cannot as a rule spare his patient this phase of the treatment. He must get him to re-experience some portion of his forgotten life, but must see to it, on the other hand, that the patient retains some degree of aloofness, which will enable him, in spite of everything, to recognize that what appears to be reality is in fact only a reflection of a forgotten past. If this can be successfully achieved, the patient's sense of conviction is won, together with the therapeutic success that is dependent on it." (Freud, 1920, p. 18)

Analysts after Freud have sought to broaden the notion of transference to include more aspects of the situation that is reproduced when unconscious impulses emerge in relation to the therapist. In this way, they practically include aspects of the re-enactment that transference pulls for as integral parts of the transferred content. Anna Freud, for example, argued that the patient's defensive maneuvers should be considered as parts of the transference, which therefore consists not only of impulses and feelings but entire relational dynamics. In a similar fashion, analysts of the Kleinian school have argued that transference reproduces a "total situation" (Klein, 1952), understood as what we will later describe as an object relationship. For this reason, Kleinian analyst Betty Joseph argued that our understanding of what constitutes transference

> "...must include everything that the patient brings into the relationship, how he is using the analyst, alongside and beyond what he is saying. Much of our understanding of the transference comes through our understanding of how our patients act on us to feel things for varied reasons; how they try to draw us into their defensive systems; how they unconsciously act out with us in the transference, trying to get us to act out with them; how they convey aspects of their inner world built up from infancy" (Joseph, 1985, p. 447)

Understood as a total situation, transference also includes what is known as the therapist's *countertransference* – his emotional reactions to the patient's transference. Kleinian analyst Paula Heimann emphasizes the importance of countertransference for the proper appraisal of the patient's transference when she writes:

> "The analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's countertransference is an instrument of research into the patient's unconscious." (Heimann, 1950, p. 74)

Freud himself stood by his more restricted definition of transference, however, and viewed countertransference as a remnant of the therapist's own neurosis, due to which he allows himself to identify with the patient's transference unto him. Freud argued that this kind of over-involvement in the patient's inner life is a breach of therapeutic "indifference," which calls for the therapist himself to enter therapy in order to resolve it.

Conclusion: Similarities Between Freud and Davanloo

In this paper and the one before it, we have seen Freud's model of treatment develop from traditional hypnosis through Breuer's cathartic technique and Freud's early pressure experiments into a mature therapeutic procedure in its own right. The reader familiar with Davanloo's ISTDP will recognize its similarities to Freud's early as well as mature techniques.

In Freud's early technique, as in Davanloo's, insistent pressure was applied on the patient to get in touch with the unconscious causes of his symptoms. In this process, Freud recognized and found ways to address an array of defenses, spanning from what Davanloo has called "major defenses" such as repression, "tactical" defenses such as evasiveness and vagueness, "characterological" defenses such as passivity and hopelessness, and finally transference resistance. Like Davanloo, Freud recognized the solidification of the patient's resistance in the transference as an opportunity to turn the patient against it and as a unique chance for the patient to work through the deeper causes of his neurosis *in vivo*. Like Davanloo, Freud would first clarify the patient's defenses and subsequently challenge him to relinquish them, to the point of applying interventions similar to what Davanloo has called "Head-On Collision with the Resistance."

In his mature technique, Freud abandoned the application of pressure and replaced it with a "golden rule" stated at the beginning of treatment, namely that the patient must speak his mind with absolute honesty, censoring nothing. Instead of applying constant pressure on the patient, Freud would take for granted that the patient had accepted this rule, and when he happened to "forget" it, Freud considered this as resistance. Although Freud's reliance on the golden rule in his mature technique caused it to differ significantly from Davanloo's technique in its form, the two techniques still carry important similarities. Just like Davanloo's, Freud's treatments were both brief and intense and were framed by a physical setup tailormade to facilitate it. Both Freud's and Davanloo's techniques rely on the patient's willingness to face his deeper thoughts and feelings with complete honesty, and both involve challenging the patient when he abandons his commitment to the truth. Both Freud's and Davanloo's techniques require the therapist to "feel into" the patient in order to mirror his healthy wishes for himself, albeit without becoming personally involved in the patient's inner conflict or in any way compensating for the patient's own responsibility for solving it. Both techniques utilize insight as a central therapeutic factor and follow the principle of interpreting only the contents of the unconscious that have become immediately available to the patient in the session. In Freud's mature technique, interpretation of unconscious contents was offered as these contents surfaced. This caused his treatments to be more cumulative in nature and to gradually shed light on the patient's unconscious. In Davanloo's technique, the resistance is first significantly lowered in order to bring the patient into direct

and powerful contact with the impulses in his unconscious. Only then does the therapist begin to make use of interpretations that show the patient their roots in his past and their repetition in his present life.

Both techniques rely heavily on the transference of unconscious material into the therapeutic relationship, where it becomes immediately available for therapeutic scrutiny. In neither Freud's nor Davanloo's techniques, however, is the transference allowed to gain a firm hold of the therapeutic relationship. Both involve actively safeguarding the patient's "aloofness" with respect to his transference experiences by addressing the transference as soon as it arises. In this way, the patient is assisted in recognizing and relinquishing his transferred impulses rather than reenacting them.

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Footnote

1 "Intrapsychic focus" simply means that the patient is engaging in "working on himself" ,i.e., that he is actively trying to change himself rather than changing others, and to understand his own emotional needs rather than to have them fulfilled in the therapeutic relationship.

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CALL FOR PAPERS

Spirituality and ISTDP

The Journal of Contemporary ISTDP would like to invite submissions for a special issue dedicated to the exploration of Spirituality and Intensive Short-Term Dynamic Psychotherapy. Some practitioners have found an implicitly spiritual dimension in Davanloo's work and, by extension, within their own as well. There seems to be an evolving interest in sharing these insights and understandings on both personal and professional levels.

We welcome contributions relating to meditation, psychedelics, religion, the "person of the therapist," somatic experiences, altered states of consciousness, transpersonal psychology, non-dual awareness, existential exploration, mystical experiences, spiritual emergencies, trauma recovery, cultural perspectives on healing, the collective unconscious, and so forth.

ARTICLES MAY TAKE ON ONE OF THESE THREE FORMS:

1. **Theory & Practice:** Scholarly articles that examine the integration of spirituality with ISTDP, exploring theoretical frameworks, clinical techniques, and their implications for practice.
2. **Transcript-Based:** Case studies or detailed transcripts that illustrate the role of spirituality in ISTDP, providing insight into its impact on the therapist, the patient and/or both.
3. **Learner Chronicles:** Reflections, personal narratives, or accounts from trainees and practitioners that describe the intersection of spirituality with their learning experiences in ISTDP.

The goal of this issue of the Journal is twofold: to present a range of existing experiences and explorations, and to share evolving forms of training that might be synthesized in ways that could help establish a new specialty of "spiritual psychotherapy." Such training would include the development of specific skills, while at the same time helping to foster changes on the levels of both character and consciousness. With this in mind, we're glad to review personal vignettes, current explorations, and visions for future possibilities.

We encourage innovative, insightful, and rigorous contributions that will help deepen our collective understanding of the role of spirituality within the practice of psychotherapy.

Submissions for this special issue are due by March 31, 2025.
Ideas, outlines, or initial drafts may be sent to both of us.

With much appreciation,
Lawson Sachter (Guest Editor)
and **Thomas Hesslow** (Editor-in-Chief)