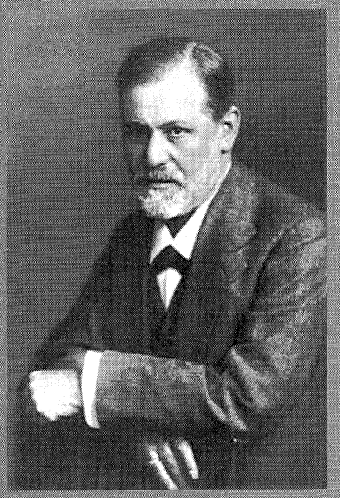

Sigmund Freud, 1856–1939

2 PSYCHOANALYSIS

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OVERVIEW

"It doesn't add up."

How could a seemingly nice person abuse a child? Why would someone not show up at her own wedding, one she'd planned for a year? How could a child from a great neighborhood with fine schools and an intact family never develop any ambition?

The next time you wonder, give credit where credit is due. Over one hundred years ago, Sigmund Freud pronounced that the surface, or manifest, level of life is but the topsoil of mental activity. Much of it happens at an unconscious level. Symptoms and problem behavior begin to make sense when the deeper levels are understood.

Psychoanalysis, a system of treatment as well as a way to understand human behavior, has given rise to discoveries and controversies that are actively with us today. It has seeped into the language ("Was that a Freudian slip?") and made an impact on our thinking.

Consider your reaction to the questions raised at the beginning of the chapter. Did you wonder whether the abuser had himself been abused? (Repetition of an early experience not consciously remembered.) Did you suspect that the woman who never showed up at her wedding had mixed feelings she couldn't face? (Inner conflict, with warded off emotional experience.) Did you think that the student without ambition had more issues than meet the eye? (The surface story functioning as a cover for, or defense against, inner emotional experience.)

Psychoanalytic thinking has evolved over the last century, so that classical and modern psychoanalytic approaches now coexist. It has spawned different forms of psychotherapy, with psychodynamic psychotherapy being its most direct descendant. According to Rangell (1963), most of the widely practiced forms of psychotherapy are based on some element of psychoanalytic theory or technique.

Psychoanalysis has affected fields that range from child development to philosophy to feminist theory. It has inspired thinkers and therapists who disagree with Freud's premises to come up with methods of their own. Whether because it is rejected, adapted, or accepted, Freud's legacy is still with us.

The purpose of this chapter is to better understand psychoanalysis, particularly those concepts that have had staying power. Freud's own concepts evolved over the course of his lifetime, and they continue to do so. Controversy and change have accompanied psychoanalysis since it began. The tests of time and of research have highlighted some ideas and discredited others. Both the clinical and the empirical evidence for the usefulness of psychoanalytic thinking will be explored.

The goals of this chapter are

- To present the central psychoanalytic concepts
- To examine the ways in which those concepts have evolved
- To demystify the language and principles of psychoanalysis
- To look at the treatment methods that have emerged from a psychoanalytic perspective
- To consider different applications of psychodynamic ideas
- To examine research evidence for psychoanalytically oriented treatment
- To give examples of how psychodynamic ideas can be used in psychotherapy

Basic Concepts

> You have been trained to find an anatomical basis for the functions of the organism and their disorders, to explain them chemically and view them biologically. But no portion of your interest has been directed to the psychical life, in which, after all, the achievement of this marvelously complex organism reaches its peak. (Freud, 1916, p. 20)

Psychoanalysis seeks to understand human behavior through an investigation of inner experience, and to treat psychological problems through a clinical application of that understanding. Consequently, the central tenets include both theoretical concepts and clinical methods.

Basic Theoretical Concepts

The Unconscious

> The division of the psychical into what is conscious and what is unconscious is the fundamental premise of psychoanalysis. (Freud, 1923, p. 15)

The *unconscious* consists of states of mind that are outside awareness. They include both emotional and cognitive processes, along with forms of memory that affect the patient's reactions and behavior. Although the concept of the unconscious mind predates psychoanalysis, Freud's unique contribution was to discover how the concept could be used to understand and inform the treatment of psychological problems.

The scientific status of the unconscious has been in question since the concept was proposed. Recent discoveries of neuroscience offer some support for the influence of mental processes that are outside conscious awareness.

Psychodynamics

> Our purpose is not merely to describe and classify the phenomena, but to conceive of them as brought about by the play of forces in the mind. . . . We are endeavoring to attain a *dynamic concept* of mental phenomena. (Freud, 1917, p. 60)

Psychodynamics is the "play [that is, the interplay] of forces of the mind." The concept of *inner conflict* is a prime example of psychodynamics at work. The term *inner* or *intrapsychic conflict* refers to conflict between parts of the self that hold opposing perceptions or emotions, one or more of which is out of awareness. This may result either in problematic behavior or in symptoms. For example, a patient may express the conviction that he loves his wife and would never do anything to hurt her, while having affairs outside of the marriage. He may be *acting out* feelings that conflict with his consciously held beliefs. Or a patient may get a headache whenever Monday comes. The symptom may express a conflict between the part of her that knows she must go back to work and the part that dreads doing so.

Symptoms in psychodynamic theory are often seen as an expression of inner conflict. Whereas in the medical or diagnostic model a symptom is a sign of a disorder, here a symptom is a clue, expressed through the language of behavior, to the patient's core conflicts. Decoding its meaning in the course of treatment allows the feelings once expressed through the symptom to be expressed in less harmful ways. The *symptom-context method* is a clinical-research method that aids in that process.

Psychodynamic Psychotherapy. Psychotherapies that follow in a psychoanalytic tradition are referred to as psychodynamic treatments. They retain the central *dynamic* principles of psychoanalysis but do not make use of the *metapsychology*, or formal theories of the structure of the mind. Even Freud came to the conclusion that metapsychological hypotheses are "not the bottom, but the top of the whole structure [of science] and they can be replaced and discarded without damaging it" (Freud, 1915b. p. 77).

Dynamic psychotherapy evolved from psychoanalysis to fill the need for a form of treatment that was not so lengthy and involved. Whereas psychoanalysis is typically conducted three to five times a week, with the patient lying down, dynamic psychotherapy usually takes place once or twice a week, with the patient sitting up. *Supportive-expressive (SE)* psychotherapy is a current form of dynamic treatment that incorporates clinical-research methods.

Defenses

> The term "defense". . . is the earliest representative of the dynamic standpoint in psychoanalytic theory. (Freud, A., 1966, p. 42)

Defense mechanisms are automatic forms of response to situations that arouse unconscious fears or the anticipation of "psychic danger." Examples of common defenses include *avoidance* and *denial*. These both function as "ways around" situations that bring up thoughts or emotions that the patient cannot tolerate. Effective defenses are essential for healthy functioning because they render painful and potentially overwhelming feelings manageable. However, they often cause problems in real life, because they tend to obscure or distort reality. For example, a student who spends all of her time online instead of studying for exams may be using the defense

of avoidance to counteract the intense anxiety she would feel if she opened up the semester's untouched work. Other defenses will be discussed in the next sections of this chapter.

Transference. *Transference,* Freud's cornerstone concept, refers to the transfer of feelings originally experienced in an early relationship to other important people in a person's present environment. They form a pattern that affects the patient's attitudes toward new people and situations, shaping the present through a "template" from the past.

> Each individual, through the combined operation of his innate disposition and the influences brought to bear on him during his early years, has acquired a specific method of his own in the conduct of his erotic life. This produces a stereotype plate [or template], or several such, which is constantly repeated . . . in the course of a person's life. (Freud, 1912, pp. 99–100)

In psychoanalysis, the analysis of the transference is fundamental to the treatment. The patient's transference to the analyst enables them both to see its operating force and to work on separating reality from memories and expectations. The transference contains patterns from the past that may be remembered through actions or through repetition of the past, rather than through recollection; " . . . the patient does not say that he remembers that he used to be defiant and critical toward his parents' authority; instead he behaves that way to the doctor" (Freud, 1914, p. 150).

Transference has been investigated through clinical research on the Core Conflictual Relationship Theme (CCRT) method. This research, which both clarifies and validates the concept, will be explored later in this chapter.

Countertransference refers to the therapist's reactions to the patient. As the counterpart to the transference, it refers to the therapist's reactions to a patient that may be linked to personal issues the therapist needs to resolve. Countertransference has been used recently to evaluate whether the therapist's reactions may be responses to the patient's emotions or to nonverbal communications from the patient.

Basic Clinical Concepts

Free Association. "Say what comes to mind" is a typical beginning to any psychoanalytic treatment. Unlike other forms of treatment, psychoanalysis invites all thoughts, dreams, daydreams, and fantasies into the treatment. Psychoanalysts believe that the expression of unedited thoughts will bring richer material about the inner workings of the mind. The less edited the material, the more likely that it will contain clues to parts of the self that may previously have been expressed through symptoms. Free association also gives the patient a chance to hear himself.

Therapeutic Listening. Freud recommended maintaining a state of "evenly hovering attention" to what the patient says. That means that the analyst does not seize on one topic or another but, rather, listens to all the levels of the communication at once. That includes what the patient is literally saying, what kinds of emotions she conveys, and the analyst's reactions while listening. This form of listening is at the foundation of the analytic method, since it allows a full hearing of the patient. A second kind of therapeutic listening occurs when the analyst develops a sense of the patient's patterns—those that may form the transference as well as those that link symptoms with their meanings.

Therapeutic Responding. *Interpretation* is the fundamental form of responding in traditional psychoanalysis. It involves sharing an understanding of a central theme of the patient, often a facet of the transference. Interpretations are intended to help a patient

come to terms with conflicts that may have been driving his behavior or symptoms, offered when the analyst senses that the patient is ready to grapple with them.

The interpretation of dreams has a special place in psychoanalytic treatment. "The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind" (Freud, 1932, p. 608). Freud believed that the *manifest content,* or surface story, of dreams could be decoded to reach the deeper, *latent content*. Ways to understand the language of the dream will be explored in the next section.

Empathy as a form of therapeutic responding has received increasing attention since the second half of the twentieth century. Empathic responding means attuning to the patient's feeling states and conveying a sense of emotional understanding. Research now links the therapist's empathy with the outcome of the treatment.

The Therapeutic Alliance. The *therapeutic* or *working alliance* is the partnership between the patient and therapist forged around working together in the treatment. Greenson (1967) clarified the difference between the working alliance and the transference and emphasized the importance of the alliance to the treatment. Current research confirms that a positive *helping alliance* is one of the factors that is consistently associated with a good outcome in psychotherapy.

Other Systems

Psychoanalysis serves as both the grandfather and the current relative to many forms of psychotherapeutic practice. Some other systems and theorists (notably Jung and Adler) branched off from psychoanalysis during Freud's lifetime. Others began as later adaptations and either remained under the "analytic umbrella," as did dynamic psychotherapy, or highlighted an essential difference, as did Carl Rogers.

A number of distinct, but still essentially psychoanalytic, theories have emerged since Freud's time. These include classical psychoanalysis, ego psychology, interpersonal psychoanalysis, object relations and other relational perspectives, and self-psychology. Although psychoanalysis as a system of thought comprises many theories, three basic ideas are common to all and provide a framework for comparison with other systems of psychology: the role of the unconscious, the phenomenon of transference, and the relevance of past experiences to present personality and symptoms.

The Unconscious Mind

The first central concept that distinguishes psychoanalysis from many other systems of psychology is a belief in the importance of the unconscious in understanding the human psyche. Other systems of psychology that acknowledge the significance of the human unconscious are, understandably, those developed by theorists who studied directly with Freud. Most notable among these is Carl Jung. Jung retained Freud's belief in the unconscious but saw it as consisting of two important aspects. In addition to the type of personal unconscious that Freud described, Jungian analysts believe in a *collective unconscious.* The collective unconscious is made up of archetypal images, or symbolic representations of universal themes of human existence that are present in all cultures, as opposed to the more personal Freudian unconscious. Similar to psychoanalysis, neurosis in Jungian analysis results when one is excessively cut off from the contents of the unconscious and the meaning of the archetypes, which can be understood through various methods, including dream analysis. Jung brought in aspects of mysticism and spirituality that were rejected or ignored by earlier psychoanalysts but which are now beginning to receive attention from modern psychoanalysts, particularly those with an interest in meditation and Eastern religions.

Adler, another of Freud's students, departed from the belief in the unconscious as part of an intrapsychic system based on repression of drives, but he continued to believe that people know more about themselves than they actually understand.

The Existentialists are also concerned with the unconscious. Like psychoanalysts, they believe that people experience internal unconscious conflicts and that these are excluded from conscious awareness but still exert an influence on behavior, thoughts, and feelings. For them, it is anxiety about basic existential fears such as death, isolation, and meaninglessness that is being defended against.

Gestalt therapy was also an outgrowth of psychoanalysis but departed from it in radical ways, not only in eschewing much of its basic theory, but also by developing very structured and active therapeutic techniques. Despite these substantial differences, Fritz Perls held on to a belief in the therapeutic value of bringing what is unconscious into consciousness. Similarly, Moreno's Psychodrama, by enacting problematic interpersonal situations, helps a patient get in touch with and express feelings she may not have realized she had. Alvin Mahrer's experiential psychotherapy also differs from psychoanalysis in a wide variety of ways. Mahrer regards unconscious material as unique to each individual and believes it represents one of many aspects of a deeper potential for experiencing life. Finally, certain schools of family therapy deal with the ways in which members unconsciously play out particular roles in relation to each other.

The "depth psychologies," those that acknowledge that deeper underlying processes and experiences have significant effects on human behavior, contrast sharply with behavioral and cognitive approaches. Such therapies, which include behavior therapy, rational emotive behavior therapy (REBT), cognitive and cognitive-behavior therapy (CBT), and multimodal therapy, are all rooted in learning theory. In these systems, the undesired symptom, behavior, or thought is understood as having been learned and reinforced by environmental events. These models do not look for meaning beyond observed behavior or conscious experience, and behavioral observation and self-report are their primary methods of assessment.

Some therapies derived from these models have demonstrated effectiveness in treating problems such as phobias and other well-defined anxiety disorders, as well as certain symptoms of major depression. Thus, they have made a valuable contribution to the alleviation of psychological suffering. However, many difficulties for which adults seek psychotherapy are not so readily delineated and categorized. A woman may seek psychological treatment, for example, because she is unable to maintain a close and satisfying relationship, or because she experiences a sense of malaise for which she has no explanation. Further, even with well-defined symptoms, when "treatment-resistant" cases occur, these systems offer no conceptual tools for looking beyond the observable to understand what might have gone wrong.

The Transference

A second idea common to psychoanalytic therapies is the transference. Freud was the first to recognize the therapeutic value of transference phenomena, in which the patient comes to experience others, the analyst in particular, in ways that are colored by his early experiences with important people in his life. Countertransference, or the response of the analyst to the patient and his transference, is also utilized in various ways in psychoanalysis. Most contemporary psychoanalysts regard countertransference as useful clinical information about the patient, including the types of feelings he might evoke in others. Attention to transference and countertransference reflects interest both in the unconscious and in the importance of childhood experiences and early relationships. Jungian analysts and contemporary psychoanalysts work actively with the transference

and countertransference, reflecting a move within both orientations toward recognizing the mutual influence between patient and therapist.

Gestalt, Adlerian, and Client-centered (Rogerian) therapists have less confidence in the therapeutic value of transference. They place greater value on actively cultivating a positive relationship with the client by maintaining a stance that is visibly empathic, supportive and non-judgmental and attempting to bypass any negative transference phenomena. Being empathic and non-judgmental are also highly valued by psychoanalysts, but they remain open to the expression of both positive and negative feelings about the therapist and attempt to understand and interpret either. They believe that understanding these feelings is important if deep and lasting therapeutic change is to occur.

In REBT, the therapist attempts to eradicate transference phenomena at the outset by demonstrating that the client's feelings are based on irrational, maladaptive wishes. Behaviorally and cognitively oriented therapists attempt to enhance the working alliance, but transference is not part of their theories. Their more active stance, in which homework assignments are routinely given and explicit instructions are provided about how to change thoughts and behavior, establishes the therapist as an authority figure, a role that is utilized to encourage compliance.

The Role of Childhood Experiences

A third characteristic shared by psychoanalytically oriented clinicians is a belief that childhood experiences influence personality development, current relationships, and emotional vulnerabilities. Many contemporary psychoanalysts incorporate research findings demonstrating the long-term impact of the quality of a child's early attachment, childhood trauma, early experiences of loss, and other related areas into their thinking about personality development. Any system for which transference is an important concept is necessarily one that recognizes this past-present relationship. Jungian analysts work actively with transference material and are similar to psychoanalysts in their view that aspects of early formative relationships affect the analytic relationship, affording the patient an opportunity to work through these feelings and move beyond their negative impact.

Although Ellis does not use the term *transference,* he acknowledges that transferential thoughts and feelings toward the therapist might arise but regards them as little more than irrational beliefs. Rather than examine and attempt to understand them, he points out their unrealistic nature and applies his very systematic REBT procedure with the intention of eradicating them.

In psychodrama, early past experiences are thought to have an impact on one's current situation, and these are explicitly role-played in an effort to rework and replace the psychologically harmful experiences with more positive ones. Rogerians and existentialists are concerned with the therapeutic relationship, but past experiences do not figure prominently in their thinking.

For systems greatly influenced by learning theory, such as cognitive, behavioral, and cognitive-behavioral therapies, as well as multimodal therapy, the past is significant only in terms of the direct antecedents to the dysfunctional behavior. This major difference from the analytic perspectives may limit the types of psychological problems that the systems that rely on learning theory are able to address.

Common Factors

Various approaches to psychotherapy differ in what they see as fundamental to the process. Dynamic psychotherapies differ from behavioral forms of treatment in their understanding of the origins of psychological problems, as well as in aspects of technique.

Although the differences among forms of therapy are frequently highlighted in writings about treatment, they also share important fundamentals. Establishing a working alliance is important in all forms of treatment, whether it is made explicit, as in psychodynamic theory, or not. So is the frame, or structure, of the treatment and the establishment of treatment goals. The role of common factors will be further explored in the Evidence section of this chapter.

HISTORY

Precursors

Psychoanalysis, as originated by Sigmund Freud (1856–1939), represented an integration of the major European intellectual movements of his time. This was a period of unprecedented advance in the physical and biological sciences. The crucial issue of the day was Darwin's theory of evolution. Originally, Freud had intended to pursue a career as a biological research scientist, and in keeping with this goal, he became affiliated with the Physiological Institute in Vienna, headed by Ernst Brücke. Brücke was a follower of Helmholtz and was part of the group of biologists who attempted to explain biological phenomena solely in terms of physics and chemistry. It is not surprising, therefore, that models borrowed from physics and chemistry, as well as the theory of evolution, recur regularly throughout Freud's writings, particularly in his early psychological works.

Freud came to psychoanalysis by way of neurology. During his formative years, great strides were being made in neurophysiology and neuropathology. This was also the time when psychology separated from philosophy and began to emerge as an independent science. Freud was interested in both fields. He knew the works of the "association" school of psychologists (Herbart, von Humboldt, and Wundt), and he had been impressed by the way Gustav Fechner applied concepts of physics to problems of psychological research.

In the mid-nineteenth century, there was great interest in states of split consciousness. The French neuropsychiatrists had taken the lead in studying conditions such as somnambulism, multiple personalities, fugue states, and hysteria. Hypnotism was one of the principal methods used in studying these conditions. The use of the couch, with the patient lying down, began with the practice of hypnosis. The leading figures in this field of investigation were Jean Martin Charcot, Pierre Janet, Hippolyte Bernheim, and Ambrose August Liebault. Freud worked with several of them and was particularly influenced by Charcot.

Beginnings

Freud made frequent revisions in his theories and practice as new and challenging findings came to his attention. In the section that follows, special emphasis will be placed on the links between Freud's clinical findings and the consequent reformulations of his theories. These writings serve as nodal points in the history of the evolution of his theories: *Studies on Hysteria, The Interpretation of Dreams, Three Essays on Sexuality, On Narcissism,* the metapsychology papers, *Beyond the Pleasure Principle* (the Dual Instinct Theory), and *The Ego and the Id* (the Structural Theory).

Studies on Hysteria (1895)

The early history of psychoanalysis begins with hypnotism. Josef Breuer, a prominent Viennese physician, told Freud of his experience using hypnosis. When he placed the patient in a hypnotic trance and encouraged her to relate what was oppressing her mind

at the moment, she would frequently tell of some highly emotional event in her life. While awake, the patient was completely unaware of the "traumatic" event or of its connection with her disability, but after relating it under hypnosis, the patient was cured of her disability. The report made a deep impression on Freud, and it was partly in pursuit of the therapeutic potential of hypnosis that he undertook studies first with Charcot in Paris and later with Bernheim and Liebault at Nancy, France.

When Freud returned to Vienna, he used Breuer's procedures on other patients and was able to confirm the validity of Breuer's findings. The two then established a working relationship that culminated in *Studies on Hysteria.* Freud and Breuer noted that recalling the traumatic event alone was not sufficient to effect a cure. The discharge of the appropriate amount of emotion was also necessary. Anna O., a patient whom Breuer cured in this way, referred to the treatment as "the talking cure."

The task of treatment, they concluded, was to achieve *catharsis* of the undischarged affect connected with the painful traumatic experience. The concept of a repressed trauma was fundamental in Freud's conceptualization of hysteria, which led him, in an aphoristic way, to say that hysterics suffer mainly from reminiscences.

Breuer and Freud differed on how the painful memories in hysteria had been rendered unconscious. Breuer's explanation was a "physiological" one, in keeping with theories of psychoneuroses current at that time. In contrast, Freud favored a psychological theory. The traumatic events were forgotten or excluded from consciousness precisely because the individual sought to defend herself from the painful emotions that accompany recollection of repressed memories. That the mind tends to pursue pleasure and avoid pain became one of the basic principles of Freud's subsequent psychological theory.

Breuer refused to continue this line of research, but Freud continued to work independently. Meanwhile, Freud learned from his clinical experience that not all patients could be hypnotized and that many others did not seem to go into a trance deep enough to produce significant results. He began using suggestion, by placing his hand on the patients' foreheads and insisting that they attempt to recall the repressed traumatic event. This method was linked to an experiment he had witnessed while working with Bernheim. In his *Autobiographical Study* (1925, p. 8), Freud described the incident:

> When the subject awoke from the state of somnambulism, he seemed to have lost all memory of what had happened while he was in that state, but Bernheim maintained that the memory was present all the same; and if he insisted upon the subject remembering, if he asseverated that the subject knew it all and had only to say it, and if at the same time he laid his hand on the subject's forehead, then the forgotten memories began to return, hesitatingly at first, but eventually in a flood and with complete clarity.

Accordingly, Freud abandoned hypnosis in favor of a new technique of forced associations. However, Elisabeth von R, the first patient whom Freud treated by "waking suggestion," apparently rebuked Freud for interrupting her flow of thoughts. Freud took her response seriously, and the method of "free association" began to emerge.

Clinical Experience and Evolving Technique. The responses of Freud's patients to his procedures made for modification in his technique as well as in his thinking. Not only did he attend to Elizabeth van R's response to his "forced" questions, but he also began to notice that she actively refused certain questions. This observation prompted his thinking about *resistance,* or a force of "not wanting to know" in the patient. That furthered his emerging use of free association, where the task was to bring the resistances to the fore, rather than trying to circumvent them.

This technical innovation coincided with another interest that pervaded Freud's thought at the time. He had found that two elements were characteristic of the forgotten

traumatic events to which he had been able to trace the hysterical symptoms. In the first place, the incidents invariably proved to be sexual in nature. Second, in searching for the pathogenic situations in which the repression of sexuality had set in, Freud was carried further and further back into the patient's life, reaching ultimately into the earliest years of childhood. Freud first concluded that the patients he observed had all been seduced by an older person. In his further investigation, Freud realized that this was not always true, and he began to develop his theory of childhood sexuality, eventually coming to believe in the importance of childhood fantasies about sexuality.

Following the same principle of learning from patients, dynamic therapists who work with the survivors of childhood sexual abuse have reopened the topic of abuse and its aftermath in patients' lives (Davies & Frawley, 1994). Thus, in the century that has followed Freud, attention has returned to actual abuse, along with the possibilities of complex, interwoven symbolic material.

The Interpretation of Dreams (1900)

The second phase of Freud's discoveries concerned a solution to the riddle of the dream. *Dreams* and *symptoms,* Freud came to realize, had a similar structure. He saw both as products of a compromise between two sets of conflicting forces in the mind—between unconscious wishes and the repressive activity of the rest of the mind. In effecting this compromise, an inner censor disguised and distorted the representation of the unconscious wishes. This process makes dreams and symptoms seem unintelligible, but Freud's descriptions of the mechanisms of representation in the dream gave way to the understanding of dreams and their symbols.

The Interpretation of Dreams was the book where Freud first described the *Oedipus complex,* an unconscious sexual desire in a child, especially a male child, for the parent of the opposite sex, usually accompanied by hostility to the parent of the same sex, as well as guilt over this wish to vanquish that parent. The development of that theory coincided with Freud's own self analysis. Although the Oedipus complex continues to have an important place in classical psychoanalytic theory, more recent approaches that emphasize early attachment rather than childhood sexuality do not give it the same credence.

The Structure of Mind. In the concluding chapter of *The Interpretation of Dreams,* Freud attempted to elaborate a theory of the human mind that would encompass dreaming, psychopathology, and normal functioning. The central principle of this theory is that mental life represents a fundamental conflict between the conscious and unconscious parts of the mind. The unconscious parts of the mind contain the biological, instinctual sexual drives, impulsively pressing for discharge. Opposed to these elements are forces that are either conscious or readily available to consciousness, functioning at a logical, realistic, and adaptive level.

Because the fundamental principle of this conceptualization of mental functioning concerned the depth or "layer" of an idea in relation to consciousness, this theory was called the *topographic theory.* According to this theory, the mind could be divided into three systems: *consciousness,* resulting from perception of outer stimuli as well as inner mental functioning; the *preconscious,* consisting of those mental contents accessible to awareness once attention is directed toward them; and finally the *unconscious,* comprising the primitive, instinctual wishes.

The concepts developed in *The Interpretation of Dreams*—unconscious conflict, infantile sexuality, and the Oedipus complex—enabled Freud to attain new insights into the psychology of religion, art, character formation, mythology, and literature. These ideas were published in *The Psychopathology of Everyday Life* (1901), *Jokes and Their*

Relationship to the Unconscious (1905a), *Three Essays on Sexuality* (1905b), and *Totem and Taboo* (1913).

Libido Theory. Freud conceived of mental activity as representative of two sets of drives: Libidinal drives seek gratification and are ultimately related to preservation of the species; these are opposed by the ego drive, which seeks to preserve the existence of the individual by curbing the biological drives, when necessary. The term *libido* refers to sexual energies, although they have different meanings and manifestations at different ages.

Freud proposed a developmental sequence of the libidinal drives. The *oral phase* extends from birth to about the middle of the second year. One of the earliest analysts, Karl Abraham (1924), observed that people whose oral needs were excessively frustrated turned out to be pessimists, whereas those whose oral desires had been gratified tended to be more optimistic. The oral phase is followed by the *anal phase.* A child may react to frustrations during that phase by becoming stubborn or contrary. Through *reaction formation* the child may overcome the impulse to soil by becoming meticulously clean, excessively punctual, and quite parsimonious in handling possessions.

Somewhat later (ages 3 1/2 to 6), the child enters the *phallic phase.* In this stage, children become curious about sexual differences and the origin of life, and they may fashion their own answers to these important questions. They enjoy a sense of power and can idealize others. By this time, complex fantasies, including Oedipal fantasies, have begun to form in the mind of the child.

Today's child may still come home from nursery school saying he wants to marry his teacher. Freud's theories have allowed the culture to be relaxed about such statements, and the vast differences in the meaning of such feelings to a child and to an adult are better understood.

These early psychosexual phases are followed by a period of *latency,* from the age of 6 to the onset of puberty. Then, under the influence of the biological changes of puberty, a period of turbulence and readjustment sets in, and when development is healthy, this period culminates in the achievement of adequate mastery over drives, leading to adaptation, sexual and moral identity, and attachment to significant others.

On Narcissism (1914)

The next phase in the development of Freud's concepts focused on his investigation into the psychology of the psychoses, group formation, and love—for one's self, one's children, and significant others. He found that some individuals led lives dominated by the pursuit of self-esteem and grandiosity. These same factors seemed to operate in the relationship of an individual to the person with whom he or she was in love. The beloved was aggrandized and endowed with superlative qualities, and separation from the beloved was seen as a catastrophic blow to self-esteem. These observations on narcissism remain relevant to more recent attention to the narcissistic personality disorder.

The Ego and the Id (1923)

Having recognized that in the course of psychic conflict, conscience may operate at conscious and/or unconscious levels, and that even the methods by which the mind protects itself from anxiety may be unconscious, Freud reformulated his theory in terms of a structural organization of the mind. Mental functions were grouped according to the role they played in conflict. Freud named the three major subdivisions the ego, the id, and the superego.