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Autogenic Psychotherapy and Psychoanalysis

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Initiated by J.H. Schultz in Europe, autogenic training is a form of meditation which induces a slightly modified state of consciousness by passive concentration on selected proprioceptive sensations. Schultz attributed the therapeutic action of autogenic training to an increase on the self-regulatory capacities of the organism, operating through functional modifications in the central nervous system.

For a long time, it had been observed that many patients developed transient training symptoms, consisting of short-lived motor, sensory, emotional or experiential discharges. Those unwelcomed phenomena were considered unavoidable side effects, which occasionally forced the discontinuation of treatment. A major advance came in 1961, when W. Luthe discovered the meaning of these autogenic discharges, showing them to correlate with the symptoms, clinical course and traumatic history of the patient [1].

The paroxysmal involuntary complex manifestations, which could break through the most relaxed state, were then considered as homeostatic adjustment reactions, permitting the elimination of the neuronal excitation associated to memory engrams of traumatic events. To exploit the potential therapeutic value of this discovery, Luthe [2, 3] developed a new technique – *autogenic neutralization* – which encouraged the occurrence of autogenic discharges and assured its management in a safe technical environment.

The method was perfected and further developed in Canada by Luthe and Gonzalez de Rivera [4, 5], evolving progressively into a complex and most effective form of psychotherapy. Despite many differences in technique and in approach, autogenic psychotherapy and psychoanalysis share, to a certain extent, many conceptual similarities. Although it is impossible to review both fields in a short chapter, I will elaborate on some of the common areas.

The Abreactive Phase of Psychoanalysis

The concept of neuronal excitation in response to external and internal stimuli and its subsequent need for discharge is basic to the development of psychoanalysis. The pathological potentiality of undischarged neuronal excitation is discussed by Breuer and

Freud in their '*Studien über Hysterie*' [6]. According to them, a traumatic event that strongly aroused unpleasant emotions in the patient may form the basis of the hysterical psychopathology. The mental representations related to the event became repressed and thus could result in hysterical symptoms or psychophysiological disturbances.

The cathartic method of therapy is the logical consequence of this theoretical formulation. If the repressed memories of the traumatic event could be brought back to consciousness, and the associated affect allowed to discharge, a therapeutic result should ensue.

The first difficulty, of course, was the resistance of the patient to reexperiencing what he had already decided was better not to experience at all. To overcome this emotional resistance, Freud and Breuer made use of a popular tool of their time, heterohypnosis. When in a hypnotic state and encouraged to remember, the patient was often able to recall traumatic events, and to release the accompanying affect by emotional expression. Although a clinical improvement usually followed the procedure, it was often short-lived. Furthermore, the hypnotic technique introduced problems of its own.

The Interpretative Phase of Psychoanalysis

Hypnosis promoted strong dependency on the therapist, often with erotic overtones, a situation that greatly interfered with the abreactive process. Rather than uncovering his unconscious memories, the patient would tell what he felt the doctor wanted to hear, and superficial clinical change would appear out of a desire to please the therapist, rather than from discharge of repressed affects. This led Freud to abandon the cathartic method, especially after he discovered the phenomenon of transference.

Although the emotional resistance to remember traumatic events could be temporarily overcome by hypnosis, the patient would again repress the uncovered memories in his normal waking state, and the attached affect would recover its pathogenic potential. Furthermore, the unbearable mental representations not only aroused an unpleasant emotion, but also had the quality of being 'incompatible with the dominant mass of ideas constituting the ego' [7], and their logical incongruity, if not their unpleasant quality, would force them out of consciousness. This resistance to accept incompatible ideas is of a plastic nature, and is related to what Freud [8] termed 'psychic inertia', that is, the resistance of libidinal impulses to abandon their previous objects and modes of discharge, and, I may add, of the psychic structure to reorganize itself in order to include previously unacceptable mental contents.

After this discovery, the study and dissolution of resistance and transference became the basis of psychoanalytic technique, with the assumption that the unconscious memories would in this way come under the conscious control of the patient. However, resistance consisted not only of the suppression of unacceptable mental content, but also of a distortion of what was expressed [9]. When the repressed ideas finally reached consciousness, they did so in a disguised manner, and the analyst had to interpret the real meaning of those elaborations.

Many reports of traumatic events turned out to be such distortions; new recognition had to be given to the pathogenic importance of unacceptable impulses and wishes, in contrast to the previously held view of real traumatic life events as sole determinants of psychopathology. The concept of psychic conflict was thus elaborated, together with that of the structural organization of the psychic apparatus.

The goals of psychoanalysis were expanded to include not only the mere abreaction of traumatic events, but also the resolution of intrapsychic conflicts and modifications of the personality of the patient, in particular of his defensive organization, by means of interpretations and other interventions.

The Autogenic State

The autogenic state is a particular state of consciousness, self-induced by the practice of passive concentration on selected proprioceptive sensations. The objective physiological concomitants of the autogenic state have been reviewed in detail by Luthe and Gonzalez de Rivera, and are similar to the relaxation response described by Benson et al. [10] with other forms of meditation. Subjectively, we may distinguish three types of changes during the autogenic state. The most important manifestation is of an affective nature, and consists in the reversal of the subjective experience of anxiety to a state of psychophysiological relaxation. Whereas we can define anxiety as a vague and diffuse feeling that something very damaging is about to occur, relaxation can be defined as an equally vague and diffuse feeling that everything is in order and nothing bad could possibly happen [11]. The second most relevant manifestation is of a cognitive nature, and consists in a marked increase in the awareness of internal processes. The autogenic state allows the subject to be more open to all inner experience, and, in the therapeutic session, to maintain the attitude of a descriptive observer of his internal processes. In psychoanalytic terminology, we could say that the ego, under conditions of reduced anxiety, increases its observing function, decreases its defenses, and allows the passage into consciousness of previously repressed ideas, memories and impulses. The enhanced awareness of unconscious material and the increase in introspective capacities is not restricted to what we may call the psychodynamic unconscious, but also includes awareness of engrams related to physical traumas (i.e., accidents, intoxication), spatial relationships, and mnemonic material of nonverbal nature. The third group of subjective phenomena during the autogenic state consists in the autogenic discharges, which we have mentioned above. While those discharges tend to be short-lived and of the most varied nature in the basic training method, they tend to develop into complex and vivid experiential sequences when the advanced methods of autogenic neutralization are applied.

Verbalization of Inner Processes

Continuous verbalization of all sensations, thoughts and feelings during the autogenic state is a mandatory requirement of the method of autogenic neutralization, as it is in psychoanalysis. Freud [12] considered that, to be conscious, an idea had to be connected with the linguistic system, or, stated in another way, a conscious idea consists of the idea plus its verbal representation. Of course, this does not mean that only verbalized ideas can be conscious, but that the idea must be 'verbalizable', that is, amenable to linguistic expression. This is exactly what happens during autogenic abreaction, when visual images, sensory and motor phenomena and their accompanying affects corresponding to stored neuronal information become amenable to verbalization and thus enter the field of consciousness.

In the light of current concepts of the implications of left and right cerebral specialization, we may say that during the autogenic state the symbolic and intuitive elaborations stored in the right hemisphere become amenable to the scrutiny of the analytical, verbal left hemisphere [13]. Incidentally, this facilitation of interhemispheric communication is also invoked as the neurophysiological correlate of the increased creativity, presumably involving facilitated participation of right-hemispheric functions, reported in individuals practicing autogenic training and related approaches [14].

Dreams, Autogenic Abreaction and Free Association

Dreams, the 'royal road to the unconscious', present, in disguised form, the dreamer's forbidden wishes and repressed conflicts. Free association of ideas connected with the dream's manifest content permit the uncovering of the real wishes, impulses and conflicts at the source of the dream, transformed by the 'dream work' into the actual dream [15].

The attitude recommended by Freud for the technique of free association is quite similar to the attitude of passive acceptance developed during the practice of passive concentration on the autogenic formulae. The verbal process of description of internal imagery and body perceptions during autogenic neutralization is comparable to the work of free association, but the contents, termed abreacts, are intermediate between dreams and free association in the waking state. Abreacts are subjected to the same mechanisms of condensation, displacement, symbolization and projection as dreams, but they tend to present repressed conflicts and traumatic events in a less distorted form. The verbal description of abreacts has a character of immediacy, being the description of something that is present in the mind's eye, as opposed to the reporting of dreams, which is always done under the influence of conscious censorship.

Insight and Working Through

Insight is defined as the awareness of repressed ideas, and of their attached affect. The view that intellectual insight does not, by itself, neutralize disturbing neuronal engrams was clearly stated by Alexander [16], who introduced the concept of 'corrective emotional experience'. Freud [17] insisted that, once obtained, the initial insight had to be followed by a period of working through, necessary to overcome the resistance of the psychic structure to make room for the previously unacceptable ideas. He correlated the process of working through with the freeing of small quantities of affect strangled by repression, similar to repetitive microabreactions.

Because of the special psychological characteristics of the autogenic state, insight is probably more easily achieved in this state than in the normal waking state. The mental elaborations verbalized during an autogenic abreaction are often of a diaphanous clarity as to the wishes, conflicts and impulses of the patient, so much so that interpretative activity, in the psychoanalytic sense, is reduced to a minimum. Of course, as in psychoanalytic therapy, there are in autogenic abreaction occasional resistances on the part of the patient to the free flow of his mental representations, and this requires appropriate handling by the therapist.

Transference

A doctor-patient relationship always carries with it a set of attitudes and feelings in the patient that do not have to do with the objective perception of the therapist, but with preconceived ideas about projective figures. This set of fantasies and impulses related to an earlier important figure are reactivated by the therapeutic situation and constitute 'transference'. Transference, considered by Freud in the beginning as an undesirable phenomenon and a form of resistance, later became a cornerstone of psychoanalysis, and therefore of therapeutic value. Because of the special characteristics of the psychoanalytic situation, mainly the neutrality of the analyst and his or her refusal to provide instinctual gratification, the transference aroused is more intense and clear-cut than in other therapeutic contexts, and is based more on the idiosyncratic fantasies of the patient than on the real characteristics of the analyst.

In contrast to this, the therapist practicing autogenic therapy approaches the patient in a consistent supportive and teaching attitude, and his personality may come across more readily than in the psychoanalytic situation. These factors tend to minimize the range of the patient's projections onto the therapist. However, inasmuch as the therapist cannot fulfill every possible need of the patient, and must impose on him the requirements for compliance and the giving up of resistances, for example, he also becomes the object of negative feelings which often trigger transference-like dynamics.

Almost invariably, the image of the therapist appears in the autogenic sessions, and the feelings directed at him are of a nature and intensity difficult to explain merely by the therapeutic relationship. Occasional links in autogenic abreactions are seen between sexual and aggressive impulses towards the therapist and similar feelings directed towards parents or other important figures in the patient's past. Be it as it may, the whole issue of transference undergoes a process of self-regulatory deflation during autogenic abreaction. The therapist presents himself consistently as a guide and a teacher of the method, and constant emphasis is shifted to the patient's own stored memories and experiences, and to his own self-regulatory, self-restorative capacities. Dependency is discouraged, and the role of the therapist is generally that of a technical advisor. Negative and positive transference, rather than interfering with and sometimes sabotaging or prolonging the therapy, would appear in the abreactions, becoming in this way fully evident to both patient and therapist, and become neutralized through thematic repetitions, the main vehicle of autogenic neutralization during autogenic abreaction.

Conclusion

Autogenic neutralization during autogenic therapy and psychoanalytic therapy had close theoretical roots initially, but followed a different technical development, particularly evident in the use made of interpretations and in the handling of resistances and transference. Despite many differences in technique and in approach, autogenic psychotherapy and psychoanalysis share some conceptual similarities, discussed here in the light of the abreactive and the interpretative phases of psychoanalytic development, the verbalization of inner processes, the structure of dreams, 'abreacts' (free associations during the autogenic state) and free associations during the waking state, the processes of insight and working through, and the handling of transference. The autogenic state is

a state of technical 'regression in the service of the ego' characterized by a reversal of the subjective experience of anxiety into a state of psychophysiological relaxation and increased awareness of internal processes. The ego, under conditions of reduced anxiety, increases its observing function, decreases its defenses, and allows the passage into consciousness of previously repressed ideas, memories and impulses. Traumatic events are thus recovered into consciousness, albeit distorted by the influence of repressed impulses and wishes. The therapeutic effect is achieved by (1) the neutralization of traumatic emotional experiences, and (a) the progressive reorganization of the psychic structures to include previously unacceptable mental contents.

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